

ACCOUNT FOR PRESCRIPTIONS

Instructions: This invoice claiming payment for prescriptions furnished to eligible patients should be forwarded to the Central Pharmacy/Pharmacy Service Center no less frequently than once per month.

Pharmacy Tax ID No.	Pharmacy Name	Submit Invoice to: Central Pharmacy Pharmacy Service Center 2150 West Broad Street Columbus, OH 43223-1200
Pharmacy Address (street, city, state, zip)		
Invoice No.	Invoice Date	

If remit address differs from pharmacy address, remit to:

Tax ID No.	Remit Name	DMH USE ONLY Agency No.
Remit Address (street, city, state, zip)		

Patient's Name	Date Prescription Filled	Prescription Number	MEDICATION			\$ Amount Claimed	DMH USE ONLY
			Amt.	Item	Strength		\$ Amount Approved
1.							
2.							
3.							
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18.							
19.							

I certify that amounts claimed are not in excess of charges allowed using Ohio Department of Mental Health Prescription Pricing Policy.	Grand Totals \$	
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Signature
