Appendix 4
Sample Non-Compound Drug Claim Form

Form 98–1141 (8/98). Replaces 482–020
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784–0002

I.M. Provider
1 West Williams
Anytown, WI 55555

12345678

Wisconsin Medicaid

NON–COMPOUND DRUG CLAIM FORM

RECIPIENT INFORMATION

1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

	AS7654321	12/20/00	12/20/00	00 00	00168 0199 15	30	15	$XX.XX
1	0	3942877	0	19. DRUG DESCRIPTION: Timolol 0.25% eye drops			08	
	V72.0	13	EX	MO	1C			
	AS1234567	11/20/00	12/20/00	00 00	00781 1232 13	30	60	$XX.XX
2	1	1279433	0	19. DRUG DESCRIPTION: Enalapril 10 mg tablet			08	
								$
3				19. DRUG DESCRIPTION				
								$
4				19. DRUG DESCRIPTION				

PHARMACIST' SOR
DISPENSING PHYSICIAN' S
SIGNATURE I.M. Provider DATE 01/01/01

2

PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV–IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR' S OFFICE)

30. O.C. AMOUNT $XX.XX

31. PATIENT PAID $

32. NET BILLED $XX.XX

Appendix