



I D A H O D E P A R T M E N T O F  
**HEALTH & WELFARE**  
PHARMACIST USE ONLY

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Reimbursement Unit  
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**Note: The value of the unused medication returned from each prescription must equal \$15.00 or more.**

<b>* Provider Name:</b>				<b>* Provider #:</b>			<b>* Month:</b>			
<b>* Employee Name:</b>				<b>* Phone #:</b>			<b>* Date Submitted:</b>			
							<i>DEPARTMENT USE ONLY</i>			
							<i>Tracking #</i>			
<small>* Idaho Participant Medicaid ID # (MID)</small>	<small>* NDC #</small>	<small>* RX #</small>	<small>* Dispensing Date</small>	<small>* Billing Date</small>	<small>* Original Quantity</small>	<small>* New Quantity</small>	<small><i>Original Amount Paid</i></small>	<small><i>New Amount Paid</i></small>	<small><i>Paid Difference</i></small>	<small><i>√ IF FEE IS PAID</i></small>
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**\* Required Information**













