



PRESCRIPTION DRUG CLAIM FORM

Health KiCC

Health KiCC Client Group Number: HK12484

Patient Name: _____ Date of Birth: _____
Last First MI

(Please mark the appropriate box for this patient.)

Health KiCC is primary payer Health KiCC is secondary payer

Provider Name: _____ Provider Tax ID #: _____

Provider Address: _____
Street or PO Box City State ZIP

Drug Name: _____ Quantity: _____

NDC#: _____ Date Filled: _____

Balance Remaining After Insurance _____

Drug Name: _____ Quantity: _____

NDC#: _____ Date Filled: _____

Balance Remaining After Insurance _____

Drug Name: _____ Quantity: _____

NDC#: _____ Date Filled: _____

Balance Remaining After Insurance _____

Drug Name: _____ Quantity: _____

NDC#: _____ Date Filled: _____

Balance Remaining After Insurance _____

Total Balance Remaining After Insurance: _____

All other fund sources must be billed prior to submission of this claim to Health KiCC

I agree that by accepting payment through Health KiCC this bill is considered paid in full. I declare and affirm under the penalties of perjury that this claim has been examined by me, and to the best of my knowledge and belief is in all things true and correct.

Provider Signature: _____

Mail claim to:
South Dakota Department of Health
Health KiCC Program
600 E. Capitol Avenue
Pierre, SD 57501

or FAX to: 1.866.579.8246
ATTN Health KiCC

Revised 12/09