Health KiCC Prescription Drug Claim Form

Provider Name _____ **Provider Tax ID #** _____

Provider Address _____

Street or PO Box City State Zip

Patient Name _____

Last First

Date filled	Drug Name	NDC number or UPC code	Quantity	Health KiCC is only pay source * (√ if appropriate)	Primary denied * (List denial reason)	Health KiCC is secondary (√ if appropriate)	Balance Due

* Health KiCC will re-price at established SD Medicaid rates

Total _____

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 penalty 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: _____ **Phone Number:** _____

Printed Name: _____ **FAX Number:** _____

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 12/14