AUTHORIZATION AND REQUEST FOR PAYMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
VOCATIONAL REHABILITATION (Drug/Pharmacy)
SFN 302 (2-2008)

Clear Fields

VR

PLEASE TYPE OR PRINT CLEARLY ALL ENTRIES

(1) Patient Name	(6) Authorization Number	(7) Provider Number
Provider Name		

(13) Date of Service	(14) Prescription Number	(15) Prescription Date	(16) Refill	(17) Days Supply	(18) (A) Drug name (1) (B) NDC Number (2)	(21) Quantity (Metric)	(22) Prescribing Doctor NPI	(23) Unit Dose	(24) MD Cert	(25) Charge
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FORWARD TO REGIONAL VOCATIONAL REHABILITATION OFFICE STAMPED BELOW	(29) Total Charges
	(30) Less other insurance
	(31) Less recipient liability
	(32) **Balance due**

(26) Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND ACCEPTED AS PAYMENT IN FULL, THE AMOUNTS PAID AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim account or demand has been paid. That the services provided and billed for qualify for federal participation under 42 USC 1396 (a) et. seq. and the rules and regulations promulgated and adopted thereunder. I further certify that the goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan and to furnish the State Agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State Agency may from time to time request.

By	Date