

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM

2012 PHARMACEUTICAL VOUCHER

Pharmacy Name: _____
 Address: _____
 City, State: _____
 Phone #: _____

Participating Provider sends to: Massachusetts League of Community Health Centers
 Attention: CRVFHP
 40 Court Street, 10th Floor
 Boston, MA 02108
 617-426-2225

Patient Information					Drug Information			Price Information		Office Use Only
date of <u>INITIAL</u> office visit that first generated prescription	If refill, date of <u>REFILL</u>	patient name (last, first)	date of birth	physician	national drug code & drug name	strength	qty	co-pay amount	amount	total due
Grand Total:										

Instructions / Process

- Patient presents prescription to Participating Providers' Pharmacist.
- Pharmacist fills prescription and fills out applicable row(s) of Pharmaceutical Voucher. (Please use generic drugs unless contraindicated by physician.)
- Drug code, strength and quantity must be included.
- Pharmacist signs and submits white and yellow copies of completed Pharmaceutical Voucher to Participating Provider retaining pink copy.
- Participating Provider signs and submits white copy of Pharmaceutical Voucher to CRVFHP retaining yellow copy.
- The CRVFHP will reimburse the Participating Provider the lesser of the Average Wholesale Price (AWP) or actual charge of each prescription.
- Participating Provider can also submit pharmaceutical voucher in other payment format with prior approval from CRVFHP Manager.
- Staple receipts to back of Voucher.

NOT VALID WITHOUT ORIGINAL SIGNATURE OF REGISTERED PHARMACIST OR PARTICIPATING PROVIDER

I certify that these pharmaceuticals have been dispensed to these patients and that the stated prices are true and accurate.

Pharmacist Signature: _____ Date: _____

Participating Agency: _____

Agency Provider Signature: _____ Date: _____