MEDICAID DRUG REBATE INVOICE

DATE: ___/___/____
MM DD YYYY

STATE OF _____ PAGE ___ OF ____

_____ (Medicaid Agency)

Source: State Agencies
Target: Manufacturers

Manufacturer: _____
Address: _____
City: _____ State: ___ Zip: _____

STATE CODE: ____ INVOICE NO.: _____
PERIOD COVERED: _____(QYYYY)

NDC Number	FDA Product Name	Unit Rebate Amount	Record ID	Units Reimbursed	Rebate Amount Claimed	Number of Prescriptions	Medicaid Amount Reimbursed	Non-Medicaid Amount Reimbursed	Total Amount Reimbursed	Filler
		TOTALS:								

*Please remit this amount to: _____ (Medicaid Agency)
Address:
Attn:

CMS-R-144 (Exp. 05/31/2024)
OMB No. 0938-0582

Form CMS-R-144 is required from States quarterly to report utilization for any drugs paid for during that quarter. The use of Form CMS-144 by States is considered mandatory under the authority of Section 1927 of the Social Security Act. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0582. The time required to complete this information collection is estimated to average 46 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.