

PHARMACY CLAIM BILLING REQUEST - FORM 3700

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|---|---------------------|----------------|
| Pharmacy Name | | |
| Pharmacy Address (Street/P.O. Box, City, State & ZIP) | | |
| Service Provider ID (10-digit NPI) | Vendor ID (6 digit) | Date Submitted |

Revised 9 / 2009

**Please refer to instructions provided in the Vendor Drug Pharmacy Procedure Manual (txvendordrug.com).
Do not write in "HHSC Use" fields. The explanation field must be completed before the claim can be processed.**

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|-------------------------------|---------------------|---------------|----------------------|--------------------------|------------------|-----------------|
| Cardholder ID | Date of Birth | Loc. | Gender | Pregnancy | Date of Service | Date RX Written |
| Product ID (11 digits) | Quantity Dispensed | Unit | Days Supply | Quantity Prescribed | RX Number | |
| Refill Auth. Number | DAW | Prescriber ID | Prescriber Name | Prior Authorization Type | Number | U & C Amount |
| Gross Amount Due | Patient Paid Amount | Basis of Cost | HHSC USE ONLY | Process Code | Amount PD | |
| Explanation (Required) | | | | | | |

Coordination of Benefits

Other Coverage Code

| | | | | | | | | | |
|----------------------------|--------------|----|------|-----------------------|-------------|--|--|--|--|
| 1. Other Payer | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| Other Payer Rejects | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Reject Codes | | | | | |

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|----------------------------|--------------|----|------|-----------------------|-------------|--|--|--|--|
| 2. Other Payer | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
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| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| Other Payer Rejects | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Reject Codes | | | | | |

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|----------------------------|--------------|----|------|-----------------------|-------------|--|--|--|--|
| 3. Other Payer | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| | | | | Amount Paid Qualifier | Amount Paid | | | | |
| Other Payer Rejects | | | | | | | | | |
| Coverage Type | ID Qualifier | ID | Date | Reject Codes | | | | | |

MAIL TO **VENDOR DRUG PROGRAM (H-630)**
HEALTH AND HUMAN SERVICES COMMISSION
P.O. BOX 85200
AUSTIN, TEXAS 78708-5200

 Signature (Vendor or Authorized Representative)

 PHONE

 FAX