## CABINET FOR WORKFORCE DEVELOPMENT KENTUCKY DEPARTMENT OF VOCATIONAL REHABILITATION

TO:

FROM:

Counselor, Department of Vocational Rehabilitation

DATE:

SUBJECT: Prescription for Vocational Rehabilitation Client

Patient's Name:

Patient HAS DOES NOT HAVE Kentucky State Medical Care Coverage

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State Medical Care Card #

The above named patient has been approved by Vocational Rehabilitation for payment of the prescriptions listed below for <u>one</u> time only. <u>All</u> other sources of payment should be xhausted before billing to Vocational Rehabilitation.

Rx Number	Rx Number
Drug Name (Generic)	Drug Name (Generic)
NDC #	NDC #
Rx. Qty	Rx. Qty
Average Wholesale Price of Drug \$	Average Wholesale Price of Drug \$
Established Medicaid Dispensing Fee \$	Established Medicaid Dispensing Fee <u>\$</u>
TOTAL §	TOTAL <u>\$</u>
Rx Number	Rx Number
Rx Number   Drug Name (Generic)	Rx Number   Drug Name (Generic)
Drug Name (Generic)NDC #	Drug Name (Generic)
Drug Name (Generic)	Drug Name (Generic)
Drug Name (Generic) NDC # Rx. Qty	Drug Name (Generic)
Drug Name (Generic) NDC # Rx. Qty Average Wholesale Price of Drug \$ Established Medicaid	Drug Name (Generic)

By:

TOTAL RX CHARGES TO DVR

The Kentucky Department of Vocational Rehabilitation does not discrminate on the basis of race, color, national origin, sex, age, religion or disability.