Revised 5/00

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

State Medical Care Card # ______________________________

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

Rx Number ______________________________

Drug Name (Generic) ______________________________

NDC # ______________________________

Rx. Qty. ______________________________

Average Wholesale Price of Drug $ __________

Established Medicaid
Dispensing Fee $ ______________________________

TOTAL $ ______________________________

Rx Number ______________________________

Drug Name (Generic) ______________________________

NDC # ______________________________

Rx. Qty. ______________________________

Average Wholesale Price of Drug $ __________

Established Medicaid
Dispensing Fee $ ______________________________

TOTAL $ ______________________________

Rx Number ______________________________

Drug Name (Generic) ______________________________

NDC # ______________________________

Rx. Qty. ______________________________

Average Wholesale Price of Drug $ __________

Established Medicaid
Dispensing Fee $ ______________________________

TOTAL $ ______________________________

Rx Number ______________________________

Drug Name (Generic) ______________________________

NDC # ______________________________

Rx. Qty. ______________________________

Average Wholesale Price of Drug $ __________

Established Medicaid
Dispensing Fee $ ______________________________

TOTAL $ ______________________________

By: ______________________________ TOTAL RX CHARGES TO DVR ______________