CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2017 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 INITIAL prescription/ visit	**date of REFILL**	**patient name (last, first)**	**date of birth**	**ordering provider**	**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 and retains pink copy.
- Participating Provider signs and submits white copy of Pharmaceutical Voucher to CRVFHP and retains 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 Director or Manager.
- Staple receipts to back of Voucher.

PRESCRIPTIONS GREATER THAN $250 MUST BE PREAPPROVED BY CRVFHP MANAGER OR DIRECTOR BEFORE REIMBURSEMENT IS MADE

NOT VALID WITHOUT ORIGINAL SIGNATURE OF REGISTERED PHARMACIST OR PARTICIPATING PROVIDER

ALL PATIENT-IDENTIFIABLE DOCUMENTATION MAILED TO THE CRVFHP MUST BE MARKED CONFIDENTIAL OR SENT VIA ENCRYPTED EMAIL

I certify that these pharmaceuticals have been dispensed to these patients and that the stated prices are true and accurate. I also certify that processes are in place to prevent duplicate discounts for patients covered under Medicaid and who receive a 340B drug.

Pharmacist Signature: _____ Date: _____

Participating Agency: _____

Agency Provider Signature: _____ Date: _____

White Copy – CRVFHP (mail) **Yellow Copy – Participating Provider** **Pink Copy - Pharmacy**