

MAPS CLAIM FORM

Authority: P.A. 231 of 2001

Board of Pharmacy Rule 338.3162d requires this form to be completed for every controlled substance that is dispensed, and mailed or delivered to MAPS no later than 7 calendar days after the date the controlled substance has been dispensed.

Dispenser Information (Please Print)										
DEA Number			Dispenser's First Name			Middle Name		Last Name		
Street Address					City			State		Zip Code
Telephone Number with Area Code				Email Address						
Patient Information (If veterinary patient – use pet owner information)										
Customer ID (Driver's License or State ID Number)				Patient's First Name (human)				Last Name		
Street Address					City			State		Zip Code
Date of Birth (human)				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			Species Code <input type="checkbox"/> Human <input type="checkbox"/> Veterinary Patient			
Controlled Substance Dispensed										
Issued Date			Filled Date			Prescriber DEA Number				
NDC Number (Must be eleven digits)						Drug Name				
Quantity		Refill Number			Transmission Form <input type="checkbox"/> Written Prescription <input type="checkbox"/> Telephone <input type="checkbox"/> Telephone Emergency <input type="checkbox"/> Fax					
Days Supply		Authorized Refills			Mode of Payment <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Major Medical <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Indian Nations <input type="checkbox"/> Other					
RX Number										
Controlled Substance Dispensed										
Issued Date			Filled Date			Prescriber DEA Number				
NDC Number (Must be eleven digits)						Drug Name				
Quantity		Refill Number			Transmission Form <input type="checkbox"/> Written Prescription <input type="checkbox"/> Telephone <input type="checkbox"/> Telephone Emergency <input type="checkbox"/> Fax					
Days Supply		Authorized Refills			Mode of Payment <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Major Medical <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Indian Nations <input type="checkbox"/> Other					
RX Number										

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