** PAID CLAIM INFORMATION **

Patient: [redacted] ID: [redacted]
ADDR: [redacted]

Drug: ALCORTIN A GEL Qty: 48 NDC: 68040-0705-13
Cvg: SMD Phone: 800-865-8715 Ref# [redacted]

Rx# 1191369 Date: 3-03-16 Trans. Date: 3-03-16 Time: 14:15

	Transmitted	Received	Difference	
Cost	4,186.80	3,707.06	479.74	(11.46%)
Fee	15.00	1.75		
Tax		0.00		
Cost+Fee+Tax	4,201.80	3,708.81	0.00	Acq Cost
Copay		3,713.81-		
Amt.Paid		5.00-		

Benefit Stage Qualifier	Benefit Stage Amount
	3713.81

Insurance Information

Group ID: [redacted]
Plan ID: [redacted]
Network Reimbursement ID: [redacted]
Payer ID Qualifier:
Payer ID:
Cardholder ID:

URL:

Patient Information

First Name: [redacted]
Last Name:
Date Of Birth:

---------- Optional Data Review ----------

Plan Identification: MENH
Network Reimbursement ID: NET=9101
Basis of Reimbursment: Unknown code: 13

Addl. Resp. Msg: CMS EXCLUDED DRUG