

PHARMACY ASSESSMENT  
MONTHLY DOCUMENTATION FORM

Assessment for: \_\_\_\_\_ (month)

\_\_\_\_\_ (year)

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

NPI #: \_\_\_\_\_

Prescriptions and Refills (quantity): \_\_\_\_\_

Amount due the State (quantity X \$0.10): \$ \_\_\_\_\_

I attest that the above is a true and accurate count of all prescriptions and refills dispensed. This count includes all prescriptions and refills (private insurance, self-pay, Medicaid, etc.).

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Please send completed form and check payable to DVHA to:

Lockbox  
State of Vermont State Agency of Human Services  
Supplemental/Tax Assessment  
PO Box 1335  
Williston, VT 05495

The above address is for use after July 1, 2011.