Invoice

Responsible Party Name & Address:

Invoice Number:

Invoice Date:

Invoice Period:

Plan Name:

Group Number:

Description	Qty	Cost	PBM Paid	Total
Total Prescriptions Dispensed During Invoice Period				
Pharmacy's Total Drug Acquisition Cost for Invoice Period				
Total Amount Reimbursed by PBM for Invoice Period				
Pharmacy Net Loss from PBM Reimbursement				
Dispensing Fee per Prescription				
Transaction Fees Charged to Pharmacy by PBM				
Total Loss Incurred by Pharmacy for Invoice Period				
Amount Due Pharmacy for Product & Services Rendered				

Invoice Terms: Payable Upon Receipt

Make all checks payable to: _____

Thank you for the opportunity to serve you & our community!