INVOICE - NON-CRITICAL

Pharmacy Name:	[enter Pharmacy's Name]	**Invoice No:**	NAME-SRPGP22-01
Street Address:	[enter Pharmacy's Street Address]	**Invoice Date:**	[enter MM-DD-YYYY you completed this form]
City, State Zip:	[enter Pharmacy's City, State Zip Code]		

Pharmacy NPI:	[enter Pharmacy's NPI]	
Final Invoice?	**[X]**	**Yes**
Sponsor:	**Maryland Department of Health** **Office of Pharmacy Services - Maryland Medicaid Pharmacy Program** **Deanna Beebe, Program Adminstrator** **Small Rural Pharmacy Grants Program FY22** **300 W. Preston St., Rm 410** **Baltimore, MD 21201** **United States**	

FOR ADMINISTRATIVE STAFF:	**NON-CRITICAL**
I certify that the following invoice is original and has not yet been paid.	
X_____	
Date: _____	

Total Award Amount:	**$XX,XXX.XX**	**Pharmacy Grant Manager:**	[enter Name of Authorized Representative from Application]
Project Title:	**Small Rural Pharmacy Grants Program**	**Pharmacy Grant Manager's Title:**	[enter Pharmacy Grant Manager's Title at Pharmacy]

Description	**11/1/21-6/30/22**
Small Rural Pharmacy Grants Program FY22	**Bill Amount**
1) Prescription Fees & Dispensing Costs	**$XX,XXX.XX**
TOTAL AMOUNT DUE:	**$XX,XXX.XX**

Wires:	[enter Routing #: XXXXXXXXX]; [enter Account #: XXXXXXXXXX]; [enter Bank Name: _____]
PCA:	**#T313G**
Vendor#:	**(Tax ID #)**
Mail Code:	**000**

I certify that the above invoice is just and correct and that payment has not been received. <<[enter Above Person's initials]

Signature:	[Signature of Authorized Representative - now known as Pharmacy Grant Manager]
	Pharmacy Grant Manager
Grant Manager's Title:	[enter Pharmacy Grant Manager's Title at Pharmacy]
Pharmacy Name:	[enter Pharmacy's Name]
Pharmacy Phone #:	[(XXX) XXX-XXXX <<enter Pharmacy's phone #]

KEY:	
[text]	Awardee fills in
Text	**Pre-filled by Program**