

11707

The CHAIRMAN. I was thinking of additional administrative time imposed upon the pharmacist vis-a-vis dealing with the individual purchaser who was paying him and charging it but not under any program, versus an individual who is under, say, blue cross, versus an individual who is under your program. Now, as between your program and blue cross, is there any difference in the paper work involved?

Mr. PEEBLES. Oh, yes, they ask more questions than we do.

The CHAIRMAN. Blue cross does?

Mr. PEEBLES. Right.

The CHAIRMAN. So a pharmacist under your program can go through the necessary paper work in less time than he can under blue cross or a private insurance plan?

Mr. PEEBLES. Right.

The CHAIRMAN. Any private insurance plan?

Mr. PEEBLES. Any private one that I have investigated. I don't know how many there are, but there are a lot of them, and ours is the simplest.

Incidentally, I have copies of these forms, and I will be glad to leave them.

The CHAIRMAN. I will appreciate it if you will leave them for the record.

[Testimony resumes at page 11708. The information referred to follows:]

COUNTY	STATE ID. NUMBER	CAT.	DRUG NUMBER	DAYS OF SUPPLY	QUANTITY	DOLLARS	CENTS
1	2	3	4	5	6	7	8
NAME OF RECIPIENT		ADDRESS (IF REQUIRED)		STATE USE ONLY			
VENOR NAME AND NUMBER		CHECK HERE ☐ FLEET L 11	PK NUMBER	BUZZE R. NAUSE OTH NO. 12		BILL NO. 13 3554110	
DATE FILLED		NAME OF RECIPIENT		I HEREBY CERTIFY THAT THE MEDICATION HEREIN BILLED HAS BEEN RECEIVED. 14			
R 15		C D S 16		PRESCRIPTION: DO NOT WRITE FOR OTHERS 17			
MED. SERV. LTD. 18		PHARMACIST SIGNS THIRD COPY 19		SIGNATURE OF PHARMACIST 20			

COUNTY	STATE ID NUMBER	CAT.	DRUG NUMBER	DAYS OF SUPPLY	QUANTITY	DOLLARS	CENTS
1	2	3	4	5	6	7	8
NAME OF PRECIDENT		(ADDRESS IF REQUIRED)		STATE USE ONLY			
9		10		11			
VENOR NAME AND NUMBER		CHECK HERE IF REFILL ☐	RX NUMBER		PRESCRIPTION NO. OR NO. 3554111		BILL NO. 3554111
12		13		14		15	
DATE FILLED		NAME OF PRECIDENT		I HEREBY CERTIFY THAT THE MEDICATION HEREIN FILLED HAS BEEN RECEIVED. RECIPIENT SIGNS THIRD COPY			
16		17		18			
SIGNATURE OF PRECIDENT OR AUTHORIZED REP.		SIGNATURE OF PRECIDENT SIGNATURE OF PHARMACIST					
19		20					

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FRAUD, CLAIM, STATEMENT, OR DOCUMENT, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED AND MAY BE APPLICABLE TO FEDERAL OR STATE LAWS THIS BILLING IS MADE PURSUANT TO THE PUBLISHED REGULATIONS OF THE COLORADO DEPARTMENT OF SOCIAL SERVICES AND IS IN ACCORDANCE WITH THE PROVISIONS SET FORTH BY THE CURRENT PARTICIPATION AGREEMENT NOW ON FILE WITH THE STATE AGENCY.

PHYSICIAN C.O. LEO, M.D.
 PHYSICIAN C.O. LEO, M.D.
 SIGNATURE OF PHYSICIAN
 PHYSICIAN C.O. LEO, M.D.

PHARMACIST SIGNS THIRD COPY
 SIGNATURE OF PHARMACIST

WRITE WITH BALL POINT PEN PRESS HARD
 MED 2000, 1/75

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