Fax completed form to (866-399-0929) or mail to Nebraska Total Care, Inc. MAP Dept. Attention: NE Senior Pharmacist, 2525 N. 117th Ave, Ste 100 Omaha, NE 68164

Nebraska Department of Health and Human Services - Medicaid
PRESCRIBER CERTIFICATION - this brand is medically necessary

Patient's Name (Please Print)

Patient's Case Number and ID

Drug Name and Strength _____

Drug NDC Number _____

Prescription Number (if known)

Prescriber's Name

Prescriber's ID Number

Dispensing Pharmacy

Dispensing Pharmacy's Medicaid Number

Pharmacy Phone **Pharmacy Fax**

Certification Dates

FROM: **TO:**

Handwritten Signature of Prescriber **Date**

Date: (Month/Day/Year) **Date: (Month/Day/Year)**

MC-6 Rev. 8/12 (63010) - (Prev. version should not be used)

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