

ATTACHMENT 63



NYSIF Invoice - RFP entitled: "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"

PBM PAPER INVOICE:

Directory/Operator:

Billing Department:

Phone:

INV Date:

Payment Terms: Per the contract

Account Name: New York State Insurance Fund

INV Total:

NEW YORK STATE INSURANCE FUND

ATTN:

199 Church Street - 4th Floor

New York, NY 10007

DESCRIPTION	TOTAL	AMOUNT
MAIL ORDER BRANDED	: INGREDIENT	
	: DISPENSING	
	: ADMINISTRATION	
	: TAX	
	: LESS: COPAY	
	: CLAIMS	
	MAIL ORDER BRANDED	
MAIL ORDER GENERIC	: INGREDIENT	
	: DISPENSING	
	: ADMINISTRATION	
	: TAX	
	: LESS: COPAY	
	: CLAIMS	
	MAIL ORDER GENERIC	
NETWORK BRANDED	: INGREDIENT	
	: DISPENSING	
	: ADMINISTRATION	
	: TAX	
	: LESS: COPAY	
	: CLAIMS	
	NETWORK BRANDED	

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NETWORK GENERIC : INGREDIENT
: DISPENSING
: ADMINISTRATION
: TAX
: LESS: COPAY
: CLAIMS

NETWORK GENERIC

*NON-NETWORK BRANDED : INGREDIENT
: DISPENSING
: ADMINISTRATION
: TAX
: LESS: COPAY
: CLAIMS

NON-NETWORK BRANDED

*NON-NETWORK GENERIC : INGREDIENT
: DISPENSING
: ADMINISTRATION
: TAX

: LESS: COPAY
: CLAIMS

NON-NETWORK GENERIC

REMITTANCE INFORMATION

Remit Address

Payment Instructions

Wire:

Bank Information

ABA # :

ACCT# :

ACH/EFT:

Bank Information

ABA # :

ACCT# :

Customer : ANYSIFCOMP

Group :

INV NUMBER :

INV DATE :

INV TOTAL :