Received 2/7/18

H-E-B Pharmacy

HIDALGO COUNTY
Vendor: INDIGENT HEALTH
Report Period: 01/02/2018-01/15/2018

Invoice #: 01626
Invoice Date: 01/18/2018

INVOICE

Payee/Remit Address: HEB Grocery Company
PO Box 202905
Dallas, TX 75320-2905
Tax Id: 743010657

PLEASE RETURN ONE COPY WITH PAYMENT

Name	Cardholder ID	Store ID	NCPDP	Rx #	Fill Date	Date Written	Refill	NDC	NDC Description	Quantity Dispensed	Days Supply	Amount Due
	72362	00421	4501765	934956	1/11/2018	11/2/2017	2	53746022010	METFORMIN TAB 1000MG	60	30	$ 6.40
	72362	00421	4501765	936437	1/11/2018	11/2/2017	2	68180098103	LISINOPRIL TAB 20MG	30	30	$ 5.05
	72362	00421	4501765	936523	1/11/2018	11/2/2017	1	60505257808	ATORVASTATIN TAB 10MG	30	30	$ 22.24
	44168	00421	4501765	952837	1/5/2018	1/5/2018	0	00378181510	LEVOTHYROXIN TAB 150MCG	30	30	$ 15.85
	44168	00421	4501765	955261	1/12/2018	1/12/2018	0	68462039610	OMEPRAZOLE CAP 20MG	30	30	$ 5.06
	57233	00421	4501765	948352	1/16/2018	9/22/2017	1	68180051703	LISINOPRIL TAB 40MG	30	30	$ 5.05
	57233	00421	4501765	948353	1/16/2018	10/25/2017	1	00093092606	LOVASTATIN TAB 10MG	30	30	$ 4.60
	57233	00421	4501765	948357	1/16/2018	9/22/2017	1	16714063301	ALENDRONATE TAB 70MG	4	28	$ 4.90

Count: 8

Amount Due: $ 69.15

Invoice Received by: Lulu Date 2/7/18
Goods/Services Received by: Darren Date 1/2 to 1/15/18
1100-444-00-240-0100-337
Payment Amount $ 69.15
PO# Claim

Darren Gunnels

By submitting payment for the services received, I am certifying that (i) any service(s) listed have been rendered by me or by my authorized agent; (ii) all charges are correct; and (iii) I understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law.

Received 2/7/18

H-E-B Pharmacy

HIDALGO COUNTY
Vendor: INDIGENT HEALTH
Report Period: 01/16/2018-01/29/2018

Invoice #: 01630
Invoice Date: 02/01/2018

INVOICE

Payee/Remit Address: HEB Grocery Company
PO Box 202905
Dallas, TX 75320-2905
Tax Id: 743010657

PLEASE RETURN ONE COPY WITH PAYMENT

per email 30 day supply amount Charges only.

Name	Cardholder ID	Store ID	NCPDP	Rx #	Fill Date	Date Written	Refill	NDC	NDC Description	Quantity Dispensed	Days Supply	Amount Due
	014860	00421	4501765	956959	1/18/2018	1/17/2018	0	23155007101	METHIMAZOLE TAB 10MG	90	90 30	$ 14.40
	014860	00421	4501765	956961	1/18/2018	1/17/2018	0	62037083110	METOPROL SUC TAB 50MG ER	90	90 30	$ 24.08
	72399	00172	4580141	1087228	1/22/2018	1/22/2018	0	60505257808	ATORVASTATIN TAB 10MG	30	30	$ 22.24
	4409	00421	4501765	959357	1/24/2018	1/24/2018	0	67877022305	GABAPENTIN CAP 300MG	90	30	$ 14.50

Count: 4

Amount Due: $ 75.22

Invoice Received by: Lulu Date 2.7.18
Goods/Services Received by: Darren Date 1/16 to 1/29/18
18-1100-444-00-240-00-0-337
Payment Amount $ 75.22
claim

Darren Summers

By submitting payment for the services received, I am certifying that (i) any service(s) listed have been rendered by me or by my authorized agent; (ii) all charges are correct; and (iii) I understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law.