



INVOICE

HIDALGO COUNTY
Vendor: INDIGENT HEALTH
 Report Period: 1/30/2018-02/12/2018
Payee/Remit Address: HEB Grocery Company
PO Box 202905
Dallas, TX 75320-2905
Tax Id: 743010657

Invoice #: 01642
 Invoice Date: 2/15/2018

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
	39319	00421	4501765	943576	2/7/2018	12/6/2017	0	53746022010	METFORMIN TAB 1000MG	60	30	\$5.15
	44168	00421	4501765	964424	2/8/2018	2/7/2018	0	00378182310	LEVOTHYROXIN TAB 137MCG	30	30	\$17.19
	73035	00448	4507907	1234256	1/31/2018	1/31/2018	0	53746021810	METFORMIN TAB 500MG	180	90	\$3.89
	73035	00448	4507907	1234259	1/31/2018	1/31/2018	0	49884093547	DICLOFENAC GEL 1%	100	13	\$37.83
	73035	00448	4507907	1238446	2/9/2018	2/9/2018	0	60505257908	ATORVASTATIN TAB 20MG	90	90	\$5.82
	73035	00448	4507907	1238449	2/9/2018	2/9/2018	0	65162005703	RALOXIFENE TAB 50MG	30	30	\$29.85
	73035	00448	4507907	1238450	2/9/2018	2/9/2018	0	68180051303	SINOPRIL TAB 5MG	90	90	\$2.73
	73036	00448	4507907	1238451	2/9/2018	2/9/2018	0	00469260130	MYRBETRIQ TAB 25MG	30	30	-
	4409	00421	4501765	1234255	1/31/2018	1/31/2018	0	69097085207	KAPROXEN DR TAB 500MG	60	30	\$19.52
	57233	00421	4501765	963332	2/5/2018	2/5/2018	0	00054418325	DEXAMETHASON TAB 2MG	15	5	\$8.55
	57233	00421	4501765	960133	2/5/2018	1/26/2018	0	16714063301	ALENDRONATE TAB 70MG	4	28	\$4.21
	57233	00421	4501765	960134	2/5/2018	1/26/2018	0	68180051703	SINOPRIL TAB 40MG	30	30	\$4.24
	57233	00421	4501765	960135	2/5/2018	1/26/2018	0	00093092606	LOVASTATIN TAB 10MG	30	30	\$3.93
	65999	00421	4501765	960136	2/5/2018	1/26/2018	0	16714048202	LOSARTAN TAB 10MG	30	30	-
	65998	00421	4501765	965104	2/9/2018	10/31/2017	0	43547036211	ZOSARTAN POT TAB 100MG	30	30	\$4.87
	65998	00421	4501765	964582	2/8/2018	10/31/2017	0	65862059805	TAMSULOSIN CAP 0.4MG	30	30	\$6.73
	65998	00421	4501765	965128	2/9/2018	1/30/2018	0	00169368712	LEVEMIR INJ	10	30	\$288.53
	65998	00421	4501765	965129	2/9/2018	1/30/2018	0	53746022010	METFORMIN TAB 1000MG	180	90	\$5.15

Count: 16
Amount Due: \$448.19

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.



HIDALGO COUNTY
Vendor: INDIGENT HEALTH
Report Period: 02/13/2018-02/26/2018

Invoice #: 01647
Invoice Date: 2/15/2018

INVOICE

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

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Cardholder ID	Store ID	NCPDP ID	Rx #	Fill Date	Date Written	Refill	NDC	NDC Description	Quantity Dispensed	Days Supply	Amount Due
72362	00421	4501765	934956	2/16/2018	11/2/2017	3	53746022010	METFORMIN TAB 1000MG	60	30	\$5.15
72362	00421	4501765	936437	2/16/2018	11/2/2017	3	68180098103	CISINOPRIL TAB 20MG	30	30	\$4.24
72362	00421	4501765	936523	2/16/2018	11/2/2017	2	60505257808	ATORVASTATIN TAB 10MG	30	30	\$4.56
44168	00421	4501765	970864	2/27/2018	2/27/2018	0	75834012401	ACYCLOVIR CAP 200MG	50	10	\$10.74
73035	00448	4507907	1243719	2/22/2018	2/22/2018	0	68180098003	CISINOPRIL TAB 10MG	90	90	-
73036	00448	4507907	1243360	2/21/2018	2/21/2018	0	60505257808	ATORVASTATIN TAB 10MG	30	30	\$4.56

Count: 5

Amount Due: \$ 29.25

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.



INVOICE

HIDALGO COUNTY
 Vendor: INDIGENT HEALTH
 Report Period: 02/27/2018-03/26/2018

Invoice #: 01666
 Invoice Date: 04/04/2018

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

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Name	Cardholder ID	Store ID	NCPDP	Rx #	Fill Date	Date Written	Refill	NDC	NDC Description	Quantity Dispensed	Days Supply	Amount Due
	39319	00421	4501765	943576	3/21/2018	12/6/2017	1	53746022010	METFORMIN TAB 1000MG	60	30	\$ 5.15
	39319	00421	4501765	943577	3/21/2018	12/6/2017	1	23155005701	GLYBURIDE TAB 2.5MG	30	30	\$ 5.82
	39319	00421	4501765	943579	3/21/2018	12/6/2017	1	60505257908	ATORVASTATIN TAB 20MG	30	30	\$ 5.82
	72701	00448	4507907	1253776	3/21/2018	3/19/2018	0	68180098003	LISINAPRIL TAB 10MG	30	30	\$ 3.93
	72701	00448	4507907	1253777	3/21/2018	3/19/2018	0	64380080307	RANITIDINE TAB 150MG	30	30	\$ 4.56
	72399	00172	4580141	1087228	3/17/2018	1/22/2018	1	60505257808	ATORVASTATIN TAB 10MG	30	30	\$ 4.56
	44168	00421	4501765	974021	3/9/2018	3/9/2018	0	00378182310	LEVOTHYROXIN TAB 137MCG	26	30	\$ 15.10
	73035	00421	4501765	974135	3/9/2018	2/9/2018	0	65162005703	PARLOXIFENE TAB 60MG	30	30	\$ 29.85
	4409	00421	4501765	971118	2/28/2018	2/28/2018	0	69097085512	NAPROXEN TAB 500MG	30	15	\$ 10.51
	4409	00421	4501765	971119	2/28/2018	2/28/2018	0	67877022305	GABAPENTIN CAP 300MG	60	10	\$ 7.61
	57233	00421	4501765	960133	3/11/2018	1/26/2018	1	16714063301	ALENDRONATE TAB 70MG	4	28	\$ 4.21
	57233	00421	4501765	960134	3/11/2018	1/26/2018	1	68180051703	LISINAPRIL TAB 40MG	30	30	\$ 4.24
	65998	00421	4501765	978792	3/27/2018	3/27/2018	0	16729002301	BICALUTAMIDE TAB 50MG	30	30	\$ 23.11

Count: 13

Amount Due: \$ 124.47

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.



INVOICE

HIDALGO COUNTY
Vendor: INDIGENT HEALTH
Report Period: 03/27/2018-04/23/2018

Invoice #: 01679
Invoice Date: 04/26/2018

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

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Name	Cardholder ID	Store ID	NCPDP ID	Rx #	Fill Date	Date Written	Refill	NDC	NDC Description	Quantity Dispensed	Days Supply	Amount Due
	72701	00448	4507907	1257498	3/30/2018	3/27/2018	0	13668000905	CITALOPRAM TAB 10MG	90	90	\$ 4.24
	73035	00448	4507907	1264206	4/18/2018	2/9/2018	0	53746021810	METFORMIN TAB 500MG	120	30	\$ 6.29
	73035	00448	4507907	1264207	4/18/2018	2/9/2018	0	00469260130	MYRBETRIQ TAB 25MG	20	20	\$ 242.65
	73035	00448	4507907	1264208	4/18/2018	2/9/2018	0	60505257908	ATORVASTATIN TAB 20MG	30	30	\$ 5.82
	73036	00448	4507907	1243360	4/18/2018	2/21/2018	1	60505257808	ATORVASTATIN TAB 10MG	30	30	\$ 4.56
	57233	00421	4501765	960133	4/10/2018	1/26/2018	2	6714063301	ALENDRONATE TAB 70MG	4	28	\$ 4.21
	57233	00421	4501765	960134	4/10/2018	1/26/2018	2	68180051703	LISINAPRIL TAB 40MG	30	30	\$ 4.24
	65999	00421	4501765	984742	4/17/2018	1/30/2018	0	43547036211	LOSARTAN POT TAB 100MG	30	30	\$ 4.82
	65998	00421	4501765	965128	4/10/2018	1/30/2018	1	00169368712	LEVEMIR INJ	10	30	\$ 288.53
	65998	00421	4501765	982754	4/10/2018	1/30/2018	0	60505257908	ATORVASTATIN TAB 20MG	30	30	\$ 5.82

Count: 10

Amount Due: \$ 571.23

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.