MA-34
Revised: October / 2023

DEPARTMENT OF HEALTH

MEDICAID PROGRAM

CERTIFICATION OF MEDICAL EXPENSES FOR **CONTINUOUS USE**

MEDICAL CERTIFICATION		**PHARMACEUTICAL CERTIFICATION**	
I certify that:		I certify that the pharmacy dispatches the patient the following medications (indicate if it is generic or brand) and that **the monthly cost of each of the medications dispensed is**:	
is my patient and I prescribe the following medications for its continuous use: (please do not include medications for temporary use).			
1.		1.	☐ Generic ☐ Brand
2.		2.	☐ Generic ☐ Brand
3.		3.	☐ Generic ☐ Brand
4.		4.	☐ Generic ☐ Brand
5.		5.	☐ Generic ☐ Brand
6.		6.	☐ Generic ☐ Brand
7.		7.	☐ Generic ☐ Brand
8.		8.	☐ Generic ☐ Brand
9.		9.	☐ Generic ☐ Brand
10.		10.	☐ Generic ☐ Brand
11.		11.	☐ Generic ☐ Brand
12.		12.	☐ Generic ☐ Brand
13.		13.	☐ Generic ☐ Brand
14.		14.	☐ Generic ☐ Brand
15.		15.	☐ Generic ☐ Brand
16.		16.	☐ Generic ☐ Brand
17.		17.	☐ Generic ☐ Brand
18.		18.	☐ Generic ☐ Brand
19.		19.	☐ Generic ☐ Brand
20.		20.	☐ Generic ☐ Brand
NAME OF THE DOCTOR IN BOLD LETTERS		NAME OF PHARMACEUTICAL IN BOLD LETTERS	
SIGNATURE		SIGNATURE	
LICENSE NUMBER	DATE	LICENSE NUMBER	DATE
		PHARMACY STORE NAME	

FOR USE OF THE MEDICAID PROGRAM OFFICE			
MPI NUMBER:		EVALUATION DATE:	
SIGNATURE OF THE APPLICANT/BENEFICIARY/OR REPRESENTATIVE:			

Any person who commits a fraudulent act for obtaining the benefits granted by the Puerto Rico Medicaid Program may be excluded as a participant and may be referred to the Anti-Fraud Unit of the Puerto Rico Medicaid Program and / or the Department of State Justice and Federal.