

S&U:2800
7/2016

2800

ALABAMA DEPARTMENT OF REVENUE
Pharmaceutical Provider Tax Return

DO NOT USE THIS SPACE		
Balance of Tax		
Interest		
Penalty		
Total		

PERIOD COVERED
DUE DATE

Account No. _____

Name _____

Address _____

TOTAL AMOUNT REMITTED

\$	_____
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CHECK THIS BOX IF PAYMENT
MADE THROUGH ELECTRONIC
FUNDS TRANSFER (EFT)

fold

TAX ON PHARMACEUTICAL PROVIDERS

- 1. Total number of prescriptions filled or refilled _____
- 2. Less nontaxable prescriptions filled or refilled _____
- 3. Total number of prescriptions filled
or refilled for Alabama citizens (Item 1 minus Item 2) _____

- 4. Gross Tax (Item 3 x \$.10) _____
- 5. Penalty due, if any (see instructions) _____
- 6. Interest due for late payment (see instructions) _____
- 7. LESS: Credit claimed _____
- 8. TOTAL AMOUNT DUE (Total of Lines 4, 5, and 6, minus Line 7) (transfer to front) _____

\$	_____	_____
\$	_____	_____
\$	_____	_____
\$	_____	_____
\$	_____	_____

Signature

Title

Date

fold

Do Not Cut or Staple.

Please be sure to put the proper name, account number,
and period covered on the return before submitting it.