5.1 Pharmacy Claim Form Instructions

Medicaid Title XIX Pharmacy Invoice

Check One Box:
☐ Retro Eligibility
☐ TPN

State of Mississippi
Division of Medicaid
P.O. Box 23076
Jackson, MS 39225

PROVIDER INFORMATION

[1]Provider Name	[2]NPI	[3]Medicaid Number	[4]Phone # Fax #
[5]Street Address	[6]City	[7]State	[8]Zip Code
	[9]Medicaid ID		Medicare #

BENEFICIARY INFORMATION

[10]Last Name	[11]First Initial	[12]DOB

1	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17] ☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
2	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17] ☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
3	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17] ☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
4	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17] ☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
5	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17] ☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ 27. Date: _____

28. Pharmacist's Name Printed: _____

MS-PHARM REV. 2/2014 ORIGINAL TO FISCAL AGENT

CLAIM FORM INSTRUCTIONS FOR PHARMACY SERVICES

Field	Requirement	Field Name and Instructions for Pharmacy Claim Form
1	Required	**Provider's Name:** Enter the Billing Provider's Name.
2	Required	**NPI:** Enter the Billing Provider's10 digit National Provider Identifier.
3	Optional	**Medicaid Number:** Enter the Billing Provider's 8- digit Medicaid Provider Number.
4	Required	**Phone #, Fax #:** Enter the Billing Provider's 10 digit phone and fax numbers.
5	Required	**Street Address:** Enter the Billing Provider's **Mailing** Street Address.
6	Required	**City:** Enter the Billing Provider's City.
7	Required	**State:** Enter the Billing Provider's State.
8	Required	**Zip Code:** Enter the Billing Provider's **Mailing** Zip Code.
9	Required if Applicable	**Medicaid ID, Medicare #:** Enter the Beneficiary's 9 digit Medicaid Identification Number (include Medicare number, if applicable).
10	Required	**Last Name:** Enter the Beneficiary's Last Name as it appears on Medicaid Card.
11	Required	**First Initial:** Enter the Beneficiary's First Name Initial.
12	Required	**Date of Birth:** Enter the Beneficiary's Date of Birth (MM/ DD/ YYYY).
13	Required	**Rx Number:** Enter the pharmacy prescription number.
14	Required	**Prescriber NPI:** Enter the Prescriber's 10 digit National Provider Identifier.
15	Required if applicable	**Prescriber Medicaid #:** Enter the Prescriber's 9 digit Medicaid Provider Number.
16	Required	**Date of Service:** Enter the date the prescription was filled (MM/ DD/ YYYY).
17	Required	**New or Refill:** Check appropriate box to indicate if prescription is New or a Refill.
18	Required	**Drug Name:** Enter the Name of the Drug.
19	Required	**Days Supply:** Enter the estimated number of days supply for the drug billed.
20	Required	**Quantity:** Enter the quantity of the drug dispensed
21	Required	**Dispensing Fee:** Enter the appropriate dispensing fee code. A= IV drugs C= hyperalimentation.
22	Required	**NDC:** Enter the 11 digit National Drug Code for the drug dispensed.
23	Not Required	Blank: Do NOT write in this field.
24	Required	**TPL Amount:** Enter the total third party insurance payment received.
25	Required	**U&C Price:** Enter the usual and customary charge for the drug dispensed.
26	Required	**Pharmacist's Signature:** The pharmacy claim form must be signed by the pharmacist.
27	Required	**Date:** Enter the date that the claim form was completed (MM/ DD/ YYYY).
28	Required	**Pharmacist's Name Printed:** Print the submitting pharmacist's name.