Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

NDC DETAIL ATTACHMENT

This form is a required attachment for any Kansas Medicaid paper claim billed using a drug code on a CMS-1500 or a UB-04. If this information is not included on the CMS-1500 or UB-04 forms in the appropriate fields as instructed, this form must be attached and contain all of the applicable NDC information.

Provider Name _____ Provider Number_____

Beneficiary Name_____ Beneficiary ID Number_____ Date of Service_____

LINE	NDC	DESCRIPTION	UNITS	BASIS OF MEASUREMENT					*UNIT PRICE
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
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				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$
				GR	ML	ME	UN	F2	$

Please fill in:

- The corresponding line number from the CMS-1500 or the UB-92
- NDC number used
- The drug description
- The actual quantity (units) given to the patient
- Circle the appropriate basis of measurement
- * The unit price (If known)

Legend:

GR – Gram
ML – Milliliter
ME - Milligram
UN – Unit
F2 – International Unit

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