60-6 (10/01)

Kansas Medical Assistance Programs

P. O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

PHARMACY CLAIM

PLEASE TYPE OR PRINT

LINE	1 BENEFICIARY LAST NAME	2 FIRST NAME (2 POS.)	3 BENEFICIARY'S IDENTIFICATION NUMBER	4 NURSING HOME Y OR N	5 E P S D T Y OR BLANK	6 OTHER INS. Y OR BLANK	7 PRESCRIPTION NUMBER	8 PRESCRIBING PHYSICIAN MEDICAID NUMBER	9 DATE DISPENSED MM DD YY	10 NATIONAL DRUG CODE (NDC)	11 REFILL CODE	12 METRIC QUANTITY	13 DAYS SUPPLY	14 DIAGNOSIS/ REFERENCE	15 TOTAL CHARGE
0															
1															
2															
3															
4															
5															
6															
7															
8															
9															

LINE 16. REMARKS (COMPOUNDS, OTHER INS. AMOUNT, ETC.)

17. TOTAL AMOUNT BILLED

18.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and Medical Assistance Program and to furnish information regarding any payments claimed for providing such services as the State Agency, its designee, or Health and Human Services may request. I further agree to accept, as payment in full, subject to audit, the amount paid by the Medicaid (Medical Assistance) program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment and spenddown.

I certify that (1) the services listed above are medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess, of regular fees; (3) the information provided hereon is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

RETURN ORIGINAL TO: MEDICAID

19. PROVIDER NAME AND NUMBER

20. SIGNATURE

21. DATE

SAMPLE

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Pharmacy Claim Form Instructions

Pharmacy providers must use the Pharmacy Claim Form when requesting payment for items provided under KMAP (unless submitting electronically). The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

For paper claim submissions for compounds, bill only one compound prescription per paper claim; do not mix compound claims with noncompound claims. See the special instructions for compound drug claims following the regular instructions.

Completing the Pharmacy Paper Claim Form

Field 1 **Beneficiary Last Name**
Enter beneficiary's last name.

Field 2 **First Name**
Enter first three characters of the beneficiary's first name.

Field 3 **Beneficiary Identification Number**
Enter the 11-digit number from beneficiary's State of Kansas Medical Card.
DO NOT RECORD THE PROGRAM NUMBER.

Field 4 **Nursing Home**
If appropriate, enter the correct indicator:
Y = Yes
N = No

Field 5 **KAN Be Healthy**
Leave blank (automated).

Field 6 **Other Insurance**
This field represents insurance information. Valid entries in this field are:
Y = If the beneficiary has other health insurance
Note: Indicate the amount paid in Field 16 (Remarks).
N = No other insurance
X = Insurance denied
R = No response from insurance

Field 7 **Prescription Number**
Enter the seven-digit prescription number assigned by the pharmacy.

Field 8 **Prescribing Physician Medicaid Number**
KMAP requires pharmacy providers to submit the prescribing provider's unique national provider identifier (NPI).

Field 9 **Date Dispensed**
Enter the date the drug was dispensed in MM/DD/YY format.

Field 10 **National Drug Code**

Enter the 11-digit national drug code (NDC) number assigned to the product actually dispensed. (The last two digits of the NDC number are indicative of package size.) **It is critical that each claim reflects the NDC that appears on the drug package being dispensed.**

NDCs must be given in standard 11-digit format. In cases where the NDC has only three digits in the "product" section (center digits), it is necessary to fill this field to four digits by preceding the three digits with a zero.

Field 11 **Refill Code**

Enter the number of times the prescription has been filled. Enter "00" for original and "01" through "99" for refills.

Field 12 **Metric Quantity**

Enter number of tablets or capsules dispensed, number of grams of ointments or powders, or number of ccs of liquids. Rounding up to the nearest whole number will not be accepted. The actual decimal amount must be entered.
Do not insert descriptive designations such as "ccs," "gm," or "each".

Field 13 **Days Supply**

Estimate in days the duration of this prescription supply.

Field 14 **Diagnosis/Reference**

For allowable diagnosis codes and coverage information, see each drug/drug class in the *Drug Benefit Limitations* portion of Section 8400 in the Pharmacy Provider Manual. The drugs are not covered for diagnoses other than what is specified.

When diagnosis is applicable, the pharmacy will need to contact the prescribing provider if no diagnosis is noted on the prescription. The pharmacy must maintain documentation of physician-supplied diagnosis and contact information in the prescription records.

Field 15 **Total Charge**

This field represents the usual and customary total charge of the item billed. This amount should always reflect the usual and customary total charge. When a claim is submitted to a third-party payer and payment is received, submit to KMAP the same charge that was submitted to the insurance carrier.

Field 16 **Remarks**

When adding a remark, identify the line number of the claim that corresponds to the remark. (The Line field is on the left-hand side of the Pharmacy Claim Form.) This field is used to:

- Indicate insurance carrier and the payment made. (When listing the insurance payments in this field, use the same number as designated in the beneficiary field to indicate the claim that goes with the payment.)
- Enter the original ICN number from previously submitted claims being resubmitted, if applicable.
- Enter the approved prior authorization number, if applicable.
- Identify which lines are part of a compound drug. For each line that is to process as a compound, the word "compound" is to be clearly written. For additional information on the submission of paper compound claims, see the **Compound Drug Claims** section below.
- Enter a Submission Clarification Code Value, if applicable. For example, write Submission Clarification Code: XX.

Field 17 **Total Amount Billed**

Total of detail line items billed.

Field 19 **Provider Name and Number**

Enter the name, address, and NPI or 10-digit Medicaid provider number of the billing provider.

Field 20 **Signature**

Read statement on claim form and sign.

- Phrase "signature on file" is acceptable.
- Provider's name typed or stamped is acceptable.

Field 21 **Date**

Enter the date the form was signed.

Compound Drug Claims

- Compound drug claims may be submitted on the Pharmacy Claim Form or via POS (online). Only one dispensing fee will be allowed per compound. Only one copayment fee will be assessed (if applicable) per compound. The first NDC entered for a compound will be considered the primary ingredient. If any NDC in the compound is not covered, the entire compound will deny. Providers may resubmit the compound without the noncovered NDC(s). Claims identified as a compound but which contain only one ingredient will not be allowed a dispensing fee. If billing for a single NDC compound, do not identify the claim as a compound.

- **For compound submissions using the paper Pharmacy Claim Form, use the following steps:** Enter each NDC making up the compound as a single line, starting with the NDC considered to be the primary ingredient. If you are submitting more than 10 lines (NDCs) for the same compound, staple the paper claim forms together and note which NDC is the primary ingredient.

  Fields 1-11: Complete the same as for any pharmacy claim.
  Note: Field 7 (Rx number) will be the same for all lines within the same compound.

Field 12: Enter the metric quantity for the NDC on this individual line only not the total quantity for the entire compound.

Fields 13-14: Complete the same as for any pharmacy claim.

Field 15: Enter the charge for the NDC on this individual line only not the total quantity for the entire compound. The charge for the primary (first) ingredient should include a dispensing fee in addition to the drug cost.

Field 16: If both of the following conditions apply, be sure to separate these in this field.

- For each claim (line) that is to process as a compound, the word "Compound" is to be clearly written. Submit only one compound per paper claim form.
- For a compound where the primary insurance has made a payment, the line number(s) must be indicated along with the insurance carrier and payment made. Remember to mark Field 6 accordingly.

Fields 17-21: Complete the same as for any pharmacy claim.

Note: For paper claim submissions for compounds, bill only one compound prescription per paper claim; do not mix compound claims with noncompound claims.

SUBMISSION OF CLAIM

Send completed claim to:

Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

Copies of the Pharmacy Claim Form can be ordered through the fiscal agent. Refer to Section 1100 in the ***General Introduction Fee-for-Service Provider Manual***.

Pharmacy providers can contact Customer Service at 1-800-933-6593 for assistance.