

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS  
MEDICAL ASSISTANCE PROGRAM  
DRUG ADJUSTMENT FORM

TPL

(1)

ADJ	VOID	OVR

(2)

RECIPIENT IDENTIFICATION NUMBER																			

(3)

QUANTITY																			

(4)

Rx PRICE																			

(5)

PRESCRIBING PROVIDER																			

(6)

Rx DATE (MM/DD/YYYY)																			

(7)

= # DAYS SPLY																			

(8)

Rx No.																			

(9)

PROVIDER NAME

(10)

Level of Serv.																			

(11)

Patient Location																			

(12)

PROVIDER NO.																			

(13)

DATE Rx FILLED (MM/DD/YYYY)																			

(14)

REFILL CODE.																			

0=NEW Rx  
1-5=REFILL

(15)

DIAGNOSIS CODE																			

(16)

ELIG CLAR																			

(17)

MANUFACTURER NO.																			

(18)

PRODUCT NO.																			

(19)

PKG NO																			

(20)

MAC OVERRIDE																			

DUR

(24)   REASON FOR SERVICE (DUR CONFLICT)

(25)   PROFESSIONAL SERVICE CODE (DUR INTERVENTION)

(26)   RESULT OF SERVICE (DUR OUTCOME)

(27) CONTROL NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

(28) DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID (MM/DD/YYYY)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(29) REASONS FOR ADJUSTMENT

01 THIRD PARTY LIABILITY RECOVERY

02 PROVIDER CORRECTIONS

03 FISCAL AGENT ERROR

90 STATE OFFICE USE ONLY - RECOVERY

99 OTHER - PLEASE EXPLAIN

(30) REASONS FOR VOID

10 CLAIM PAID FOR WRONG RECIPIENT

11 CLAIM PAID TO WRONG PROVIDER

99 OTHER - PLEASE EXPLAIN

I HAVE READ, UNDERSTAND, AND ACKNOWLEDGE THE CERTIFICATION STATEMENT ON THE REVERSE SIDE OF THIS ADJUSTMENT FORM. I HEREBY AGREE TO AND ACCEPT THE TERMS THEREOF.

(31) SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE

(32) DATE (MM/DD/YYYY)

## Instructions For Completing Drug Adjustment Form (Molina 211)

**NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE VENDOR OR AUTHORIZED REPRESENTATIVE.**

<u>Field No.</u>	<u>Field Name</u>	<u>Entry</u>	<u>Description</u>
1	ADJUSTMENT/VOID/OVR	Required	<b>ADJUSTMENT/VOID/OVR:</b> Check the appropriate box for Adjustment, Void, or DUR Override.
2	RECIPIENT IDENTIFICATION NUMBER	Required	<b>ADJUSTMENT/VOID:</b> Enter recipient's 13-digit Medicaid ID number exactly as it appeared on the original claim form.
3	QUANTITY	Required	<b>ADJUSTMENT:</b> Enter the correct information or exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
4	Rx PRICE	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
5	PRESCRIBING PROVIDER	Required	<b>ADJUSTMENT/VOID:</b> Enter the 5-digit Medicaid Provider ID for the prescribing practitioner.
6	Rx DATE	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
7	= # DAYS SPLY	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
8	Rx NO.	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
9	PROVIDER NAME	Not required	<b>ADJUSTMENT/VOID:</b> Enter the name exactly as it appeared on the original claim form.
10	LEVEL OF SERV	Not required	<b>ADJUSTMENT/VOID:</b> Enter NCPDP value of "03" if the service was provided on an emergency basis and no co-pay was collected.
11	PATIENT LOCATION	Not required	<b>ADJUSTMENT/VOID:</b> Enter NCPDP Patient Location Code value of "04" if the service was for an LTC recipient and no co-pay was collected.
12	PROVIDER NO.	Required	<b>ADJUSTMENT/VOID:</b> Enter the provider number exactly as it appeared on the original claim form.
13	DATE Rx FILLED	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
14	REFILL CODE	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form. Note: Where "0" = New Rx, "1,2, 3, 4, 5" = Refill of prescription

<u>Field No.</u>	<u>Field Name</u>	<u>Entry</u>	<u>Description</u>
15	DIAGNOSIS CODE	Required, if applicable	<b>ADJUSTMENT/VOID:</b> Enter valid ICD9-CM Diagnosis Code if applicable.
16	ELIG CLAR	Not required	<b>ADJUSTMENT/VOID:</b> Enter NCPDP value if applicable.
17	MANUFACTURER NO	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
18	PRODUCT NO.	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
19	PKG	Required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
20	MAC OVERRIDE	Required, if applicable	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
21	DRUG COVERAGE OTHER THAN TITLE XIX (TPL BOX)	Not required	<b>ADJUSTMENT:</b> Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. <b>VOID:</b> Enter the information exactly as it appeared on the original claim form.
22	TPL CARRIER CODE (TPL BOX)	Not required	<b>ADJUSTMENT/VOID:</b> Enter valid Louisiana Carrier Code if applicable.
23	PATIENT NAME	Required	<b>ADJUSTMENT/VOID:</b> Enter the name exactly as it appeared on the original claim form.

THIS BLOCK IS FOR PROVIDERS TO USE FOR DUR OVERRIDES

24	REASON FOR SERVICE	Not required	<b>(DUR CONFLICT) OVERRIDE:</b> Enter the Reason for Service Code associated with the Error to be overridden. (Example: ER for Early Refill).
25	PROFESSIONAL SERVICE CODE	Not required	<b>(DUR INTERVENTION) OVERRIDE:</b> Enter the Professional Service Code that describes the intervention activity performed by the pharmacist. (Example: MO for Prescriber Consulted).
26	RESULT OF SERVICE	Not required	<b>(DUR OUTCOME) OVERRIDE:</b> Enter the Result of Service Code describing the disposition of the prescription. (1G for Filled with Prescriber Approval).

BOTTOM OF FORM

27	CONTROL NUMBER	Required	Enter the 13-digit correct control number (CCN) exactly as it appears on your Remittance Advice).
28	DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID	Required	Enter the exact date of the Remittance Advice using (8) digits, i.e., MM/DD/YYYY format.

<u>Field No.</u>	<u>Field Name</u>	<u>Entry</u>	<u>Description</u>
29	REASONS FOR ADJUSTMENT	Required, if applicable	Place an "X" in the appropriate box and describe the reason for the adjustment, where the values are: ' <b>01</b> ' = Third Party Liability Recovery ' <b>02</b> ' = Provider Corrections ' <b>03</b> ' = Fiscal Agent Error ' <b>90</b> ' = State Office Use Only – Recovery ' <b>99</b> ' = Other – please explain.
30	REASONS FOR VOID	Required if applicable	Place an "X" in the appropriate box describing the reason for the void, where the values are: ' <b>10</b> ' = Claim Paid for Wrong Recipient ' <b>11</b> ' = Claim Paid to Wrong Provider ' <b>99</b> ' = Other – please explain
31	SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE	Required	<b>ADJUSTMENT/VOID:</b> Enter the complete and legal signature of vendor or his/her authorized representative.
32	DATE	Required	<b>ADJUSTMENT/VOID:</b> Enter the date this form was completed using (8) digits. i.e., MM/DD/YYYY format.

**IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE DRUG ADJUSTMENT FORM, PLEASE CONTACT THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT MOLINA (225) 237-3381 OR 800-648-0790.**