***1 INSURANCE SECTION***

Instructions: This section contains information about the cardholder and their plan identification.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 1 | ID of Cardholder | **Required.** Enter the recipient's 13 digit Medicaid ID. |
| 2 | Group ID | **Not Required.** |
| 3 | Last Name of Cardholder | **Optional.** Enter the recipient's last name |
| 4 | First Name of Cardholder | **Optional.** Enter the recipient's first name |
| 5 | Plan Name | **Not Required.** |
| 6 | BIN number | **Not Required.** |
| 7 | Processer Control number | |
| 8 | CMS Part D Defined Qualified Facility | **Not Required.** Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.<br>**Code** **Description**<br>Y Yes = CMS Qualified Facility<br>N No = Not a CMS qualified Facility |

***2 PATIENT SECTION***

Instructions: This section contains information about the patient.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 9 | Last Name of Patient | **Required.** Enter the recipient's last name |
| 10 | First Name of Patient | **Required.** Enter the recipient's first name |
| 11 | Person Code | **Not Required.** |
| 12 | Date of Birth (D.O.B.) | **Optional.** Enter the recipients date of birth (MMDDCCYY) |
| 13 | Gender Code | **Optional.** Enter the code indicating the gender of the individual.<br>**Code** **Description**<br>0 Not Specified<br>1 Male<br>2 Female |
| 14 | Relationship code | **Required.**<br>Enter the code indicating the relationship of the patient to the cardholder.<br>**Code** **Description**<br>1 Cardholder |
| 15 | Patient Residence | **Not Required.** |

***3 OFFICE USE***

Instructions: This section may be used by the receiver/payer of the form. It is not to be used by the submitter of the form.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 16 | Document Control Number | Internal number used by the payer or processor to further identify the claim for imaging purposes - Document archival, retrieval and storage. Not to be used by pharmacy. |

***4 PHARMACY SECTION***

Instructions: This section contains information about the pharmacy or dispenser of the product/service.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 17 | Service Provider ID | **Required.**<br>Enter the 7 digit Medicaid provider ID. |
| 18 | Qualifier | **Required.**<br>**Code Description**<br>05 Medicaid number |
| 19 | Name (name of pharmacy) | **Optional.** |
| 20 | Phone Number | **Optional.** Enter the phone number for the pharmacy in **(999) 999-9999** format. |
| 21 | Address | **Optional.** |
| 22 | City | **Optional.** |
| 23 | State | **Optional.** |
| 24 | ZIP | **Optional.** |

***5 SIGNATURE OF PROVIDER SECTION***

Instructions: Enter the legal signature of the pharmacy or dispenser of product or service representative,

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 25 | Signature | **Optional.** |
| 26 | Date | **Optional.** |

***6 PRESCRIBER SECTION***

Instructions: This section contains information about the prescriber of the medication or service.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 27 | Prescriber ID | **Required.**<br>Enter the 7 digit prescriber Medicaid provider number |
| 28 | Qualifier | **Required.**<br>**Code Description**<br>05 Medicaid number |
| 29 | Last Name of Prescriber | **Optional.** |

***7 PHARMACIST SECTION***

Instructions: This section contains information about the pharmacist who dispensed the medication or provided the service.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 30 | Provider ID (Pharmacist) | **Leave Blank.** |
| 31 | Qualifier | **Leave Blank.** |

## *8 CLAIM SECTION*

### 8.1 GENERAL INFORMATION

Instructions: This section contains information about the medication or service.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 32 | Prescription/Service Reference Number | **Required.**<br>Enter the prescription number |
| 33 | Qualifier | **Required.**<br>**Code** **Description**<br>1 RX Billing |
| 34 | Fill Number | **Required.**<br>Enter the code indicating whether the prescription is an original or a refill.<br>**Code** **Description**<br>Ø Original Dispensing<br>1-99 Refill number<br>**Example:**<br>**'0' if a new prescription,**<br>**'1' for the first refill,**<br>**'2' for the second refill, etc.** |
| 35 | Date Prescription Written | **Required.**<br>Enter the date the prescription was written by the prescriber<br>Format: **MMDDCCYY** |
| 36 | Date of Service | **Required.**<br>Enter the date the prescription was filled.<br>Format: **MMDDCCYY** |
| 37 | Submission Clarification Code | **Leave Blank.** |
| 38 | Prescription Origin Code | **Optional.** Enter the code indicating the origin of the prescription.<br>**Code** **Description**<br>0 Not known<br>1 Written – prescription obtained via paper<br>2 Telephone - Prescription obtained via oral instructions or interactive voice response using a phone.<br>3 Electronic - Prescription obtained via SCRIPT or HL7 Standard transactions.<br>4 Facsimile - Prescription obtained via transmission using a fax machine.<br>5 Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, established protocols, pharmacists authority to prescribe, etc. |

| | | |
|---|---|---|
| 39 | Pharmacy Service Type | **Not Required.** |
| 40 | Special Packing Indicator | **Not Required.** |
| 41 | Product/Service ID | **Required.**<br>Enter the NDC for the drug filled. |
| 42 | Product/Service ID Qualifier | **Required.**<br>**Code Description**<br>03 National Drug Code (NDC) |
| 43 | Product Description | **Optional.** |
| 44 | Quantity Dispensed | **Required.**<br>Enter the quantity dispensed expressed in Metric decimal units<br>Format: 9999999.999 |
| 45 | Days Supply | **Required.** Estimated number of days the prescription will last. |
| 46 | Dispense as Written (DAW)/Product Selection Code | **Situational.** Complete if appropriate or leave blank.<br>**Code Description**<br>**1** Substitution Not Allowed by Prescriber - This value is used when the prescriber indicates, in a manner specified by prevailing law that the product is to be Dispensed As Written.<br>**9** Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources |
| 47 | Prior Authorization Number Submitted | **Not Required.** |
| 48 | Prior Authorization Type | **Situational.**<br>**Code Description**<br>5 indicates exemption from service limits<br>8 indicates co-pay exemption due to pregnancy |
| 49 | Other Coverage | **Situational.**<br>Complete if the recipient has other coverage using the values noted Below<br>**Code Description**<br>0 not specified by patient<br>1 no other coverage identified<br>2 other coverage exists – payment collected<br>3 other coverage exists – this claim not covered<br>4 other coverage exists – payment not collected<br>8 claim is billing for a co-pay |
| 50 | Delay Reason Code | **Leave Blank.** |

| | | |
|---|---|---|
| 51 | Level of Service | **Leave Blank.** |
| 52 | Place of Service | **Leave Blank.** |
| 53 | Quantity Prescribed | **Optional.** |

### 8.2 CLINICAL INFORMATION

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 54 | Diagnosis Code | **Situational.**<br>Enter the diagnosis code, if relevant. See the point of sale users' manual for specific situations where the diagnosis code is applicable.<br>**Note:**<br>**Use ICD-9 for a date of service prior to October 1, 2015**<br>**Use ICD-10 for a date of service on or after October 1, 2015** |
| 55 | Qualifier | **Situational.**<br>If a diagnosis code is used in box 54, this field must be completed using one of the appropriate value codes below.<br><br>**Code** **Description**<br>01 Identifying an international classification of diseases (ICD-9) code.<br>02 Identifying an international classification of diseases (ICD-10) code. |

### 8.3 DRUG UTILIZATION REVIEW (DUR) INFORMATION

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 56 | Reason for Service code | **Leave Blank.** |
| 57 | Professional Service code | **Leave Blank.** |
| 58 | Result of Service code | **Leave Blank.** |
| 59 | Level of Effort | **Leave Blank.** |
| 60 | Procedure Modifier Code | **Leave Blank.** |

### 8.4 COORDINATION OF BENEFITS 1

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 61 | Other Payer ID | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. |
| 62 | Qualifier | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, enter "99". |

| | | |
|---|---|---|
| 63 | Other Payer Date | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, enter payment or denial date from the primary payer. |
| 64 | Other Payer Rejects | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage and the claim was rejected, enter the reject code from the primary payer. |

## 8.5 COORDINATION OF BENEFITS 2

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 65 | Other Payer ID | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. |
| 66 | Qualifier | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, enter “99”. |
| 67 | Other Payer Date | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage, enter payment or denial date from the primary payer. |
| 68 | Other Payer Rejects | **Situational.** If recipient has no other coverage, leave blank.<br><br>If there is other commercial insurance coverage and the claim was rejected, enter the reject code from the primary payer. |

## 8.6 COMPOUND INFORMATION

Instructions: This section contains information about a customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner’s prescription. This section is not used if the medication is not a compound.

### *8.6.1 COMPOUND GENERAL INFORMATION*

Instructions: This section describes information about the final result of the compound

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 69 | Dosage Form Description Code | **Leave Blank.** |
| 70 | Dispensing Unit Form Indicator | **Leave Blank.** |
| 71 | Route of Administration | **Leave Blank.** |
| 72 | Compound Ingredient Component Count | **Leave Blank.** |

### *8.6.2 COMPOUND INGREDIENT INFORMATION*

Instructions: This section describes information about the ingredients of the compound.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 73 | Compound Ingredient Product Name | **Leave Blank.** |
| 74 | Compound Product ID | **Leave Blank.** |
| 75 | Compound Product ID Qualifier | **Leave Blank.** |
| 76 | Compound Ingredient Quantity | **Leave Blank.** |
| 77 | Compound Ingredient Drug Cost | **Leave Blank.** |
| 78 | Compound Basis of Cost Determination | **Leave Blank.** |

## 8.7 PRICING SECTION

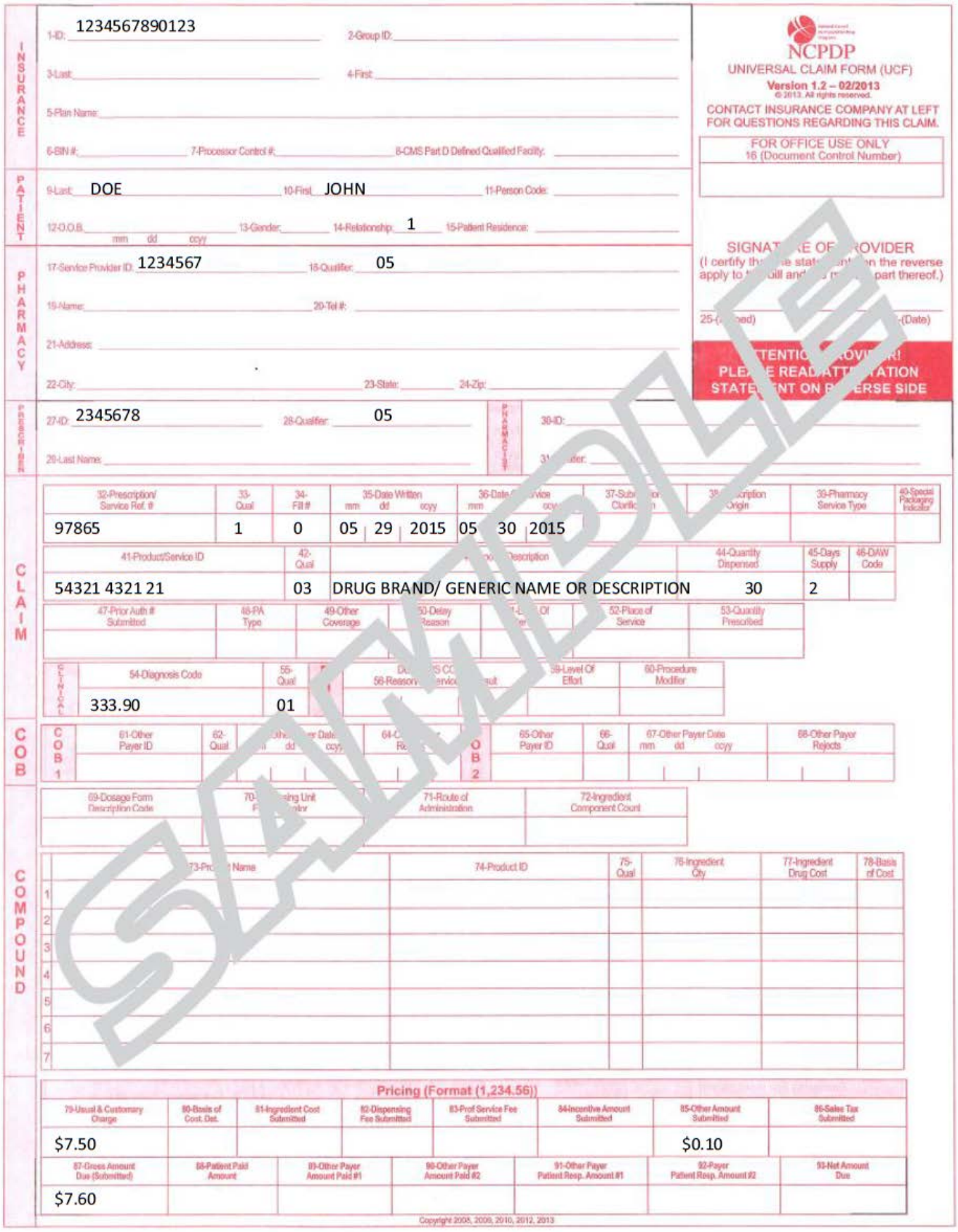
Instructions: This section contains information about the cost of the medication or service, any fees associated, and patient financial responsibility amounts.

| UFC Field Locator | Description | Instructions |
|---|---|---|
| 79 | Usual and Customary Charge | **Required.** Enter the billed charges for the claim |
| 80 | Basis of Cost Determination | **Leave Blank.** |
| 81 | Ingredient Cost Submitted | **Leave Blank.** |
| 82 | Dispensing Fee Submitted | **Not Required.** Standard Medicaid payable dispensing fee will be used to calculate payment |
| 83 | Professional Service Fee Submitted | **Not Required.** |
| 84 | Incentive Amount Submitted | **Leave Blank.** |
| 85 | Other Amount Submitted | **Required.** Enter the $0.10 Provider Fee in this field. |
| 86 | Sales Tax Submitted | **Situational.** Complete if appropriate or leave blank. |
| 87 | Gross Amount Due | **Required**. Enter total amount, including Provider Fee |
| 88 | Patient Paid Amount | **Situational.** Complete if appropriate or leave blank.<br>Enter the amount the pharmacy received from the patient for the prescription dispensed. |
| 89 | Other Payer Amount Paid 1 | **Situational.** Complete if appropriate or leave blank.<br>Enter the amount of any payment know by the pharmacy from other sources. |
| 90 | Other Payer Amount Paid 2 | **Situational.** Complete if appropriate or leave blank.<br>Enter the amount of any payment know by the pharmacy from other sources. |
| 91 | Other Payer-Patient Responsibility Amount 1 | **Situational.** Complete if appropriate or leave blank.<br>Enter the patients cost share from a previous payer. |

| | | |
|---|---|---|
| 92 | Other Payer-Patient Responsibility Amount 2 | **Situational.** Complete if appropriate or leave blank.<br>Enter the patients cost share from a previous payer. |
| 93 | Net Amount Due | **Situational.** Complete if appropriate or leave blank.<br>Enter the amount due to the pharmacy, less any other paid amounts. |

**A sample form follows.**

# SAMPLE PHARMACY CLAIM FORM
# WITH ICD 9 DIAGNOSIS CODE



NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013

CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.

**INSURANCE**
1-ID: 1234567890123
2-Group ID:
3-Last:
4-First:
5-Plan Name:
6-BIN #:
7-Processor Control #:
8-CMS Part D Defined Qualified Facility:

FOR OFFICE USE ONLY
16 (Document Control Number)

**PATIENT**
9-Last: DOE
10-First: JOHN
11-Person Code:
12-D.O.B. (mm dd ccyy)
13-Gender:
14-Relationship: 1
15-Patient Residence:

**PHARMACY**
17-Service Provider ID: 1234567
18-Qualifier: 05
19-Name:
20-Tel #:
21-Address:
22-City:
23-State:
24-Zip:

SIGNATURE OF PROVIDER
(I certify that the state[illegible] on the reverse apply to this bill and [illegible] part thereof.)
25-(Signed)
-(Date)

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

**PRESCRIBER**
27-ID: 2345678
28-Qualifier: 05
29-Last Name:
30-ID:
31-[illegible]

**CLAIM**

| 32-Prescription/ Service Ref. # | 33-Qual | 34-Fill # | 35-Date Written (mm dd ccyy) | 36-Date [illegible]vice (mm dd ccyy) | 37-Sub[illegible] Clarifi[illegible] | 38-[illegible]cription Origin | 39-Pharmacy Service Type | 40-Special Packaging Indicator |
|---|---|---|---|---|---|---|---|---|
| 97865 | 1 | 0 | 05 29 2015 | 05 30 2015 | | | | |

| 41-Product/Service ID | 42-Qual | [illegible] Description | 44-Quantity Dispensed | 45-Days Supply | 46-DAW Code |
|---|---|---|---|---|---|
| 54321 4321 21 | 03 | DRUG BRAND/ GENERIC NAME OR DESCRIPTION | 30 | 2 | |

| 47-Prior Auth # Submitted | 48-PA Type | 49-Other Coverage | 50-Delay Reason | 51-[illegible] Of | 52-Place of Service | 53-Quantity Prescribed |
|---|---|---|---|---|---|---|
| | | | | | | |

**CLINICAL**

| 54-Diagnosis Code | 55-Qual | [illegible] | Da[illegible]S CO[illegible] 56-Reason[illegible]ervic[illegible]sult | 59-Level Of Effort | 60-Procedure Modifier |
|---|---|---|---|---|---|
| 333.90 | 01 | | | | |

**COB**

| COB 1 | 61-Other Payer ID | 62-Qual | [illegible]her Date (mm dd ccyy) | 64-C[illegible] Re[illegible] | COB 2 | 65-Other Payer ID | 66-Qual | 67-Other Payer Date (mm dd ccyy) | 68-Other Payer Rejects |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

| 69-Dosage Form Description Code | 70-[illegible]sing Unit [illegible]her | 71-Route of Administration | 72-Ingredient Component Count |
|---|---|---|---|
| | | | |

**COMPOUND**

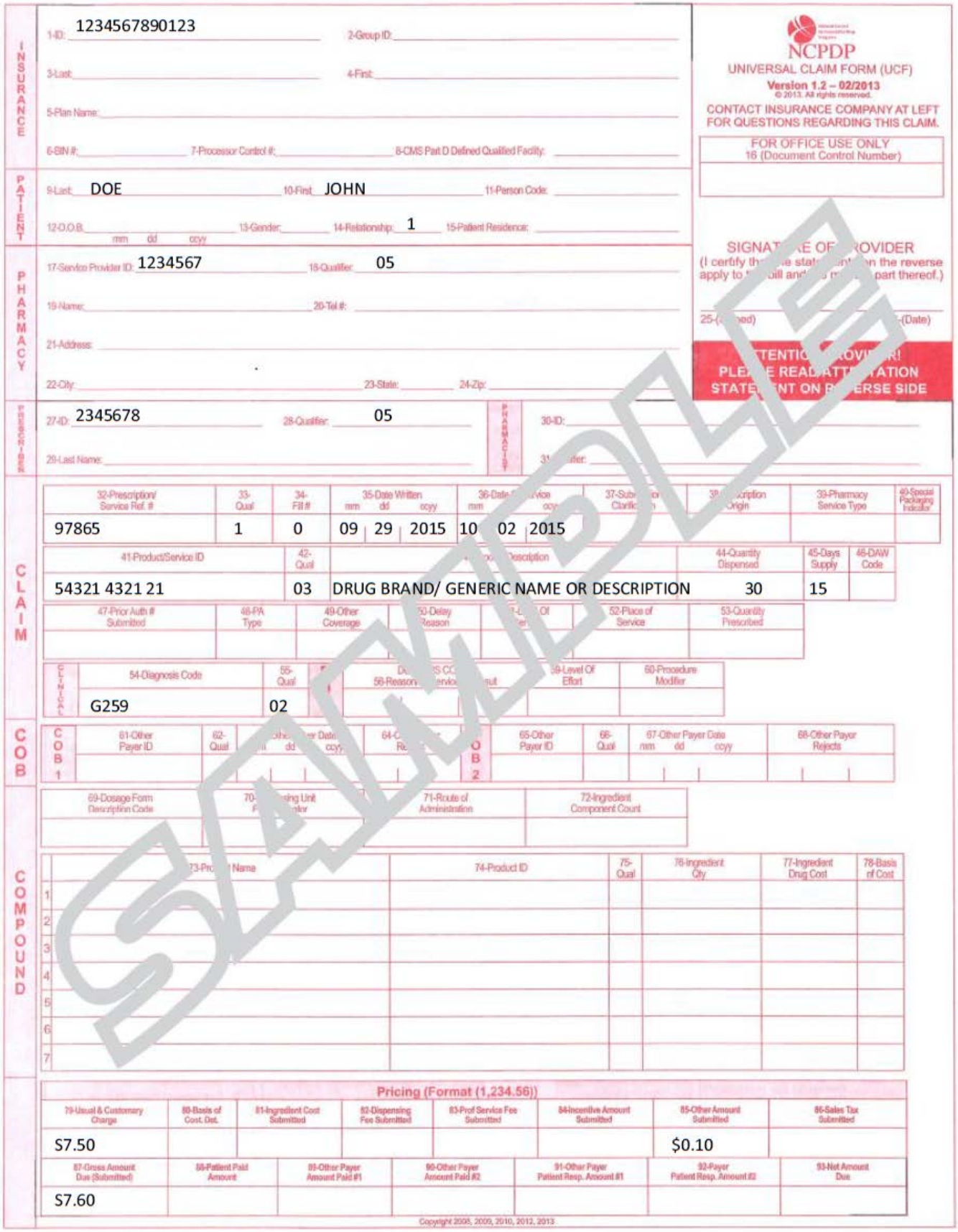
| | 73-Pro[illegible] Name | 74-Product ID | 75-Qual | 76-Ingredient Qty | 77-Ingredient Drug Cost | 78-Basis of Cost |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |

**Pricing (Format (1,234.56))**

| 79-Usual & Customary Charge | 80-Basis of Cost Det. | 81-Ingredient Cost Submitted | 82-Dispensing Fee Submitted | 83-Prof Service Fee Submitted | 84-Incentive Amount Submitted | 85-Other Amount Submitted | 86-Sales Tax Submitted |
|---|---|---|---|---|---|---|---|
| $7.50 | | | | | | $0.10 | |

| 87-Gross Amount Due (Submitted) | 88-Patient Paid Amount | 89-Other Payer Amount Paid #1 | 90-Other Payer Amount Paid #2 | 91-Other Payer Patient Resp. Amount #1 | 92-Payer Patient Resp. Amount #2 | 93-Net Amount Due |
|---|---|---|---|---|---|---|
| $7.60 | | | | | | |

# SAMPLE PHARMACY CLAIM FORM
# WITH ICD 10 DIAGNOSIS CODE



**INSURANCE**

1-ID: 1234567890123 2-Group ID:

3-Last: 4-First:

5-Plan Name:

6-BIN #: 7-Processor Control #: 8-CMS Part D Defined Qualified Facility:

**PATIENT**

9-Last: DOE 10-First: JOHN 11-Person Code:

12-D.O.B. (mm dd ccyy) 13-Gender: 14-Relationship: 1 15-Patient Residence:

**PHARMACY**

17-Service Provider ID: 1234567 18-Qualifier: 05

19-Name: 20-Tel #:

21-Address:

22-City: 23-State: 24-Zip:

**PRESCRIBER**

27-ID: 2345678 28-Qualifier: 05

29-Last Name:

**PHARMACY**

30-ID:

31-Qualifier:

NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013
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CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.

FOR OFFICE USE ONLY
16 (Document Control Number)

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

25-(Signature) 26-(Date)

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

**CLAIM**

| 32-Prescription/ Service Ref. # | 33-Qual | 34-Fill # | 35-Date Written (mm dd ccyy) | 36-Date Service (mm dd ccyy) | 37-Substitution Clarification | 38-Prescription Origin | 39-Pharmacy Service Type | 40-Special Packaging Indicator |
|---|---|---|---|---|---|---|---|---|
| 97865 | 1 | 0 | 09 29 2015 | 10 02 2015 | | | | |

| 41-Product/Service ID | 42-Qual | Product/Service Description | 44-Quantity Dispensed | 45-Days Supply | 46-DAW Code |
|---|---|---|---|---|---|
| 54321 4321 21 | 03 | DRUG BRAND/ GENERIC NAME OR DESCRIPTION | 30 | 15 | |

| 47-Prior Auth # Submitted | 48-PA Type | 49-Other Coverage | 50-Delay Reason | 51-Level Of Service | 52-Place of Service | 53-Quantity Prescribed |
|---|---|---|---|---|---|---|
| | | | | | | |

**CLINICAL**

| 54-Diagnosis Code | 55-Qual | DUR/PPS Code Counter 56-Reason for Service | Result of Service | 59-Level Of Effort | 60-Procedure Modifier |
|---|---|---|---|---|---|
| G259 | 02 | | | | |

**COB**

| COB | 61-Other Payer ID | 62-Qual | 63-Other Payer Date (mm dd ccyy) | 64-Other Payer Rejects |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |

| 65-Other Payer ID | 66-Qual | 67-Other Payer Date (mm dd ccyy) | 68-Other Payer Rejects |
|---|---|---|---|
| | | | |

**COMPOUND**

| 69-Dosage Form Description Code | 70-Dispensing Unit Form Indicator | 71-Route of Administration | 72-Ingredient Component Count |
|---|---|---|---|
| | | | |

| | 73-Product Name | 74-Product ID | 75-Qual | 76-Ingredient Qty | 77-Ingredient Drug Cost | 78-Basis of Cost |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |

**Pricing (Format (1,234.56))**

| 79-Usual & Customary Charge | 80-Basis of Cost Determination | 81-Ingredient Cost Submitted | 82-Dispensing Fee Submitted | 83-Prof Service Fee Submitted | 84-Incentive Amount Submitted | 85-Other Amount Submitted | 86-Sales Tax Submitted |
|---|---|---|---|---|---|---|---|
| $7.50 | | | | | | $0.10 | |

| 87-Gross Amount Due (Submitted) | 88-Patient Paid Amount | 89-Other Payer Amount Paid #1 | 90-Other Payer Amount Paid #2 | 91-Other Payer Patient Resp. Amount #1 | 92-Payer Patient Resp. Amount #2 | 93-Net Amount Due |
|---|---|---|---|---|---|---|
| $7.60 | | | | | | |

NCPDP

UNIVERSAL CLAIM FORM (UCF)

**Version 1.2 – 02/2013**



CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.

FOR OFFICE USE ONLY
16 (Document Control Number)

## INSURANCE

1-ID: 2-Group ID:

3-Last: 4-First:

5-Plan Name:

6-BIN #: 7-Processor Control #: 8-CMS Part D Defined Qualified Facility:

## PATIENT

9-Last: 10-First: 11-Person Code:

12-D.O.B. (mm dd ccyy) 13-Gender: 14-Relationship: 15-Patient Residence:

## PHARMACY

17-Service Provider ID: 18-Qualifier:

19-Name: 20-Tel #:

21-Address:

22-City: 23-State: 24-Zip:

SIGNATURE OF PROVIDER
(I certify the above statement on the reverse apply to this bill and are made part thereof.)

25-(Signed) (Date)

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

## PRESCRIBER

27-ID: 28-Qualifier:

29-Last Name:

## PHARMACIST

30-ID:

31-Qualifier:

## CLAIM

| 32-Prescription/ Service Ref. # | 33-Qual | 34-Fill # | 35-Date Written (mm dd ccyy) | 36-Date Service (mm ccyy) | 37-Substitution Clarification | 38-Prescription Origin | 39-Pharmacy Service Type | 40-Special Packaging Indicator |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| 41-Product/Service ID | 42-Qual | 43-Product Description | 44-Quantity Dispensed | 45-Days Supply | 46-DAW Code |
|---|---|---|---|---|---|
| | | | | | |

| 47-Prior Auth # Submitted | 48-PA Type | 49-Other Coverage | 50-Delay Reason | 51-Level Of Service | 52-Place of Service | 53-Quantity Prescribed |
|---|---|---|---|---|---|---|
| | | | | | | |

## CLINICAL

| 54-Diagnosis Code | 55-Qual | 56-DUR/PPS Code / Reason for Service / Professional Service / Result | 59-Level Of Effort | 60-Procedure Modifier |
|---|---|---|---|---|
| | | | | |

## COB

| | 61-Other Payer ID | 62-Qual | 63-Other Payer Date (mm dd ccyy) | 64-COB Payer Paid Amount | | 65-Other Payer ID | 66-Qual | 67-Other Payer Date (mm dd ccyy) | 68-Other Payer Rejects |
|---|---|---|---|---|---|---|---|---|---|
| COB 1 | | | | | COB 2 | | | | |

## COMPOUND

| 69-Dosage Form Description Code | 70-Dispensing Unit Form Indicator | 71-Route of Administration | 72-Ingredient Component Count |
|---|---|---|---|
| | | | |

| | 73-Product Name | 74-Product ID | 75-Qual | 76-Ingredient Qty | 77-Ingredient Drug Cost | 78-Basis of Cost |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |

## Pricing (Format (1,234.56))

| 79-Usual & Customary Charge | 80-Basis of Cost Det. | 81-Ingredient Cost Submitted | 82-Dispensing Fee Submitted | 83-Prof Service Fee Submitted | 84-Incentive Amount Submitted | 85-Other Amount Submitted | 86-Sales Tax Submitted |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| 87-Gross Amount Due (Submitted) | 88-Patient Paid Amount | 89-Other Payer Amount Paid #1 | 90-Other Payer Amount Paid #2 | 91-Other Payer Patient Resp. Amount #1 | 92-Payer Patient Resp. Amount #2 | 93-Net Amount Due |
|---|---|---|---|---|---|---|
| | | | | | | |