

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

California Children's Services (CCS) Program Billing Example: Pharmacy Claim Forms

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The example in this section assists providers in California Children's Services (CCS) program billing on the pharmacy claim forms (30-1 or 30-4). The explanations on the following page emphasize billing issues common to all CCS providers – proper use of Service Authorization Request (SAR), National Provider Identifier (NPI) and client ID numbers. Refer to the *Pharmacy Claim Form (30-1) Completion* section in this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section in this manual.

Refer to the *California Children's Services (CCS) Program* section in this manual for policy information.

Billing Tips: Quantities must be in the metric decimal if the quantity is not a whole number. Do not round the quantity. For example, a quantity of 3.5 Gm should be expressed as 3.500, rather than rounding to 4. Do not include measurement units such as Gm or cc. All information on an attachment must match the information entered on the claim form. For information on rounding, see the *Pharmacy Claim Form (30-1) Completion* section in this manual.

**Important Fields for
CCS Claim Completion**

Figure 1. Completing Fields for CCS Claims: Service Authorization Request (SAR), Provider and Client ID Numbers.

This is an example only. Please adapt to your billing situation. Attachments are not illustrated in this example.

In this example, a pharmacy is billing for a pediatric/female catheter prescribed for a CCS client.

The following claim form field information applies both to the *Pharmacy Claim Form (30-1)* and the *Compound Drug Pharmacy Claim Form (30-4)*. Field box numbers, shown in parentheses, are the same for both forms unless stated otherwise.

Provider ID

Enter the provider number in the *Provider ID* field (Box 3).

Medi-Cal Identification No.

Enter the client's identification number in the *Medi-Cal Identification No.* field (Box 6) as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

Note: For providers billing without a SAR number with prefix "91" or "97" for CCS-only or CCS/Healthy Families clients, leave this field blank.

TAR Control No.

Enter the 11-digit SAR number in the *TAR Control No.* field (form 30-1, Box 27) (form 30-4, Box 29). The providing pharmacy must bill using the physician's SAR number.

Note: For providers billing without a SAR number with prefix "91" or "97," leave this field blank.

Prescriber ID

Enter the State license number of the prescriber or, if applicable, the license number of the certified nurse-midwife, the nurse practitioner, the physician assistant, the naturopathic doctor or the pharmacist who function pursuant to a policy, procedure or protocol as required by *Business and Professions Code* statutes. Do not use the Drug Enforcement Administration Narcotic Registry number. This information must be entered for your claim to successfully process.

CAL-POS

Pharmacy claims for CCS-only, CCS/Medi-Cal and CCS/Healthy Families clients may be submitted electronically using the California Point of Service (CAL-POS) system.

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DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER * FOR F.I. USE ONLY
 [REDACTED]

Fasten Here

PHARMACY CLAIM FORM

Provider Name, Address
ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA

Provider Phone Number: (916) 555-1212

2 ID QUALIFIER	3 PROVIDER ID
	XYZ123456
4 ZIP CODE	
999995555	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA

TYPEWRITER ALIGNMENT \longleftrightarrow

ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI) RATHBUN RAVYN	6 MEDICAL IDENTIFICATION NO 9000000A95001	7 SEX F	8 DATE OF BIRTH 01 07 1995	9 PATIENT LOCATION	10 MEDICARE STATUS
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11 PRESCRIPTION NO A1234	12 DATE OF SERVICE 07 19 2007	13 METRIC QUANTITY WHOLE UNITS 120.000	14 CODE 1 MET? Y	15 DAYS SUPPLY 30	16 BASIS OF COST DETERMINATION 00
17 PROD ID QUAL 03	18 PRODUCT ID 000046086781	19 ID QUAL 08	20 PRESCRIBER ID G11234	21 PRIMARY ICD-CM 34401	22 SECONDARY ICD-CM
23 CHARGE 54198	24 OTHER COVERAGE PAID	25 OTH COV CODE 0	26 PATIENT'S SHARE	27 TAR CONTROL NO 97234567890	28 COMP CODE 0
29 DELETE <input type="checkbox"/>					

20 PRESCRIPTION NO	21 DATE OF SERVICE MM DD YYYY	22 METRIC QUANTITY WHOLE UNITS DECIMAL	23 CODE 1 MET? Y	24 DAYS SUPPLY	25 BASIS OF COST DETERMINATION
26 PROD ID QUAL	27 PRODUCT ID	28 ID QUAL	29 PRESCRIBER ID	30 PRIMARY ICD-CM	31 SECONDARY ICD-CM
32 CHARGE	33 OTHER COVERAGE PAID	34 OTH COV CODE	35 PATIENT'S SHARE	36 TAR CONTROL NO	37 COMP CODE
38 DELETE <input type="checkbox"/>					

29 PRESCRIPTION NO	30 DATE OF SERVICE MM DD YYYY	31 METRIC QUANTITY WHOLE UNITS DECIMAL	32 CODE 1 MET? Y	33 DAYS SUPPLY	34 BASIS OF COST DETERMINATION
35 PROD ID QUAL	36 PRODUCT ID	37 ID QUAL	38 PRESCRIBER ID	39 PRIMARY ICD-CM	40 SECONDARY ICD-CM
41 CHARGE	42 OTHER COVERAGE PAID	43 OTH COV CODE	44 PATIENT'S SHARE	45 TAR CONTROL NO	46 COMP CODE
47 DELETE <input type="checkbox"/>					

32 PRESCRIPTION NO	33 DATE OF SERVICE MM DD YYYY	34 METRIC QUANTITY WHOLE UNITS DECIMAL	35 CODE 1 MET? Y	36 DAYS SUPPLY	37 BASIS OF COST DETERMINATION
38 PROD ID QUAL	39 PRODUCT ID	40 ID QUAL	41 PRESCRIBER ID	42 PRIMARY ICD-CM	43 SECONDARY ICD-CM
44 CHARGE	45 OTHER COVERAGE PAID	46 OTH COV CODE	47 PATIENT'S SHARE	48 TAR CONTROL NO	49 COMP CODE
50 DELETE <input type="checkbox"/>					

SPECIFIC DETAILS/REMARKS:

Line 1: Bard #430608 Pediatric/Female Catheter 8Fr.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

X *Jane Doe, Pharm D.*

54 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

57 MEDICAL RECORD NO R12345	58 BILL LIM EX <input type="checkbox"/>	59 ATTACHMENTS <input checked="" type="checkbox"/>
60 DATE BILLED 07 30 2007	61 DISCHARGE DATE MM DD YYYY	62 F.I. USE ONLY <input type="checkbox"/> <input type="checkbox"/>

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I. 30-1 RV7 03/07

Figure 1. Completing Fields for CCS Claims: SAR, NPI and Client ID Numbers.