CAUTION: Read the ICD-9 Policy Holding Library page about policy in this document.

Medicare/Medi-Cal Crossover Claims: Pharmacy Services Billing Examples

This section illustrates billing examples of Medicare/Medi-Cal crossover claims for pharmacy services on the *CMS-1500*, *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) and their correlating *Medicare Remittance Notice (MRN)/Remittance Advice* (RA) examples. Refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section in this manual for detailed policy information. Refer to the *CMS-1500 Completion* section, the *Pharmacy Claim Form (30-1) Completion* section or the *Compound Drug Pharmacy Claim Form (30-4) Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Note: A crossover claim reflects what was billed to Medicare, but only Medi-Cal-required fields are used for claims processing.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9 codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the *CMS-1500* or in the *Specific Details/Remarks* area of the 30-1, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Hard Copy Billing Examples

The following examples show how to bill hard copy Medicare/Medi-Cal crossover claims:

- *Figures 1a* and *1b*. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: Medicare-Covered Drugs not billed via NCPDP.
- *Figures 1c* and *1d*. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: Non-Drug Crossover Claims.
- *Figures 2a* and *2b*. Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Medicare-Covered Drugs.
- *Figures 2c* and *2d*. Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Non-Drug Crossover Claims.
- *Figures 3a and 3b.* Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Drugs with Other Health Coverage.
- *Figures 4a and 4b.* Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Drugs.
- *Figures 5a and 5b.* Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Compound Drugs with Other Health Coverage.
- *Figures 6a and 6b.* Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Compound Drugs.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JOHN

3. PATIENT'S BIRTH DATE MM 06 DD 21 YY 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 95823 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 34461 3. _____

2. 7822 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	15	07	10	15	07			00015050401			4013	30		NPI	
2	10	15	07	10	15	07			00015309145			8291	30		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 12304

29. AMOUNT PAID $

30. BALANCE DUE $ 12304

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Smith* DATE 10/30/07

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1a. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: Medicare-Covered Drugs not billed via NCPDP.

PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN, CA 95823-5555
0123456789

10/29/07

MEDICARE REMITTANCE NOTICE
NORIDIAN

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN DOE	10 15 07	10 15 07		30	00015050401	40.13	32.10		0.00	8.03	24.07	
570570271A	10 15 07	10 15 07		30	00015309145	82.91	66.32		0.00	16.89	49.43	
CLAIM TOTALS						123.04	98.42		0.00	24.92	73.50	0.00

Figure 1b. Medicare Remittance Notice (MRN) Simplified Example.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐☐☐ — PICA ☐☐☐

CARRIER

1. MEDICARE [X] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JOHN

3. PATIENT'S BIRTH DATE MM 06 DD 21 YY 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 95823 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 78830 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	15	07	10	15	07	12		E0168						175 00	1		NPI	
2	10	15	07	10	15	07	12		E0326						15 00	1		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 190 00

29. AMOUNT PAID $

30. BALANCE DUE $ 190 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Smith* DATE 10/30/07

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Figure 1c. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: Non-Drug Crossover Claims.

Professional Pharmacy
1027 MAIN STREET
ANYTOWN, CA 95823-5555
0123456789

10/30/07

MEDICARE REMITTANCE NOTICE
NORIDIAN

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN DOE	10 15 07	10 15 07	12	1	E0168	175.00	154.18		0.00	12.33	141.85	
570570271A	10 15 07	10 15 07	12	1	E0326	15.00	9.96		0.00	.80	9.16	
CLAIM TOTALS						190.00	164.14		0.00	13.13	151.01	0.00

Figure 1d. Medicare Remittance Notice (MRN) Simplified Example.

medi cr ph ex
6

DO NOT STAPLE IN BAR AREA

[redacted]

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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
01	0123456789
4 ZIP CODE	
999995555	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI): DOE JOHN
6 MEDI-CAL IDENTIFICATION NO: 900000 00A95001 (CHECK DIGIT)
7 SEX: M
8 DATE OF BIRTH: 01 07 1965
9 PATIENT LOCATION
10 MEDICARE STATUS

1
11 PRESCRIPTION NO: 1234567
12 DATE OF SERVICE: 10 01 2007
13 METRIC QUANTITY: WHOLE UNITS 30 . 000 DECIMAL
14 CODE 1 MET?: Y
15 DAYS SUPPLY: 30
16 BASIS OF COST DETERMINATION: 00
17 PROD ID QUAL: 03
18 PRODUCT ID: 99999999996
19 ID QUAL: 01
20 PRESCRIBER ID: 1234567890
21 PRIMARY ICD-CM
22 SECONDARY ICD-CM
23 CHARGE: 6000
24 OTHER COVERAGE PAID: 1200
25 OTH COV CODE: 0
26 PATIENT'S SHARE
27 TAR CONTROL NO
28 COMP CODE: 2
29 DELETE: Y

2
30 PRESCRIPTION NO
31 DATE OF SERVICE: MM DD YYYY
32 METRIC QUANTITY: WHOLE UNITS . DECIMAL
33 CODE 1 MET?: Y
34 DAYS SUPPLY
35 BASIS OF COST DETERMINATION
36 PROD ID QUAL
37 PRODUCT ID
38 ID QUAL
39 PRESCRIBER ID
40 PRIMARY ICD-CM
41 SECONDARY ICD-CM
42 CHARGE
43 OTHER COVERAGE PAID
44 OTH COV CODE
45 PATIENT'S SHARE
46 TAR CONTROL NO
47 COMP CODE
48 DELETE: Y

3
49 PRESCRIPTION NO
50 DATE OF SERVICE: MM DD YYYY
51 METRIC QUANTITY: WHOLE UNITS . DECIMAL
52 CODE 1 MET?: Y
53 DAYS SUPPLY
54 BASIS OF COST DETERMINATION
55 PROD ID QUAL
56 PRODUCT ID
57 ID QUAL
58 PRESCRIBER ID
59 PRIMARY ICD-CM
60 SECONDARY ICD-CM
61 CHARGE
62 OTHER COVERAGE PAID
63 OTH COV CODE
64 PATIENT'S SHARE
65 TAR CONTROL NO
66 COMP CODE
67 DELETE: Y

4
68 PRESCRIPTION NO
69 DATE OF SERVICE: MM DD YYYY
70 METRIC QUANTITY: WHOLE UNITS . DECIMAL
71 CODE 1 MET?: Y
72 DAYS SUPPLY
73 BASIS OF COST DETERMINATION
74 PROD ID QUAL
75 PRODUCT ID
76 ID QUAL
77 PRESCRIBER ID
78 PRIMARY ICD-CM
79 SECONDARY ICD-CM
80 CHARGE
81 OTHER COVERAGE PAID
82 OTH COV CODE
83 PATIENT'S SHARE
84 TAR CONTROL NO
85 COMP CODE
86 DELETE: Y

SPECIFIC DETAILS/REMARKS:

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

87 MEDICAL RECORD NO
88 BILL LIM EX
89 ATTACHMENTS: X
90 DATE BILLED: 10 30 2007
91 DISCHARGE DATE: MM DD YYYY
F.I. USE ONLY 92 93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

30-1 RV7 03/07

Figure 2a. Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Medicare-Covered Drugs.

ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA 999999-5555

MEDICARE
REMITTANCE ADVICE

ABB
1835

Provider Number: 0123456789 Reimbursement Rate: 100 Claim Type: Part B Date: 10/30/07 Remittance Number: 933 Page: 1

PATIENT NAME	HIC NUMBER	BILL FROM	DATES THRU	VSTS	BILLED CHARGES	LAB CHGS	LAB REIMB	DME CHGS	DME REIMB	PATIENT DED	LIABILITY COINS	BLOOD	HMO CODE	ESRD IND	ADJ CODE
	PATIENT CONTROL NO	MED COV CHARGES			PATIENT PAID	PATIENT REFUND	NETWORK REDUCTION			NON-COV CHARGES		UNC RSN CD OR INT AMT	PROVIDER REIMBURSEMENT		
	MEDICARE PRIMARY PAYMENT	DEDUCTIBLE		MSP IND	COIN-SURANCE	BLOOD		PRIMARY PAYER AMT						MSP PROVIDER REIMBURSEMENT	
DOE, JOHN	06635281	100107	100107		60.00	0.00	0.00	0.00	0.00	0.00	48.00	0.00			
				0.00		0.00			0.00				12.00		

Figure 2b. Medicare *Remittance Advice* Simplified Example.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JOHN

3. PATIENT'S BIRTH DATE MM 06 DD 21 YY 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 95823 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM 05 DD 01 YY 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8472 3. ____.____

2. 8470 4. ____.____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	07	07	01	07	21		A4340						100 00	1		NPI	
2	07	01	07	07	01	07	21		A4244						40 00	1		NPI	
3	07	01	07	07	01	07	21		A4357						25 00	1		NPI	
4	07	01	07	07	01	07	21		A4209						30 00	1		NPI	
5	07	01	07	07	01	07	21		A4310						25 00	1		NPI	
6	07	01	07	07	01	07	21		A4647						100 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 320 00

29. AMOUNT PAID $

30. BALANCE DUE $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Doe* DATE 07/30/07

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2c. Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Non-Drug Crossover Claims.

PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN, CA 95823-5555

MEDICARE
REMITTANCE ADVICE

ABB
1835

Provider Number: 0123456789 Reimbursement Rate: 100 Claim Type: Part B Date: 07/25/07 Remittance Number: 933 Page: 1

PATIENT NAME	HIC NUMBER	BILL FROM	DATES THRU	VSTS	BILLED CHARGES	LAB CHGS	LAB REIMB	DME CHGS	DME REIMB	PATIENT DED	LIABILITY COINS	BLOOD	HMO CODE	ESRD IND	ADJ CODE
	PATIENT CONTROL NO	MED COV CHARGES			PATIENT PAID	PATIENT REFUND	NETWORK REDUCTION			NON-COV CHARGES		UNC RSN CD OR INT AMT		PROVIDER REIMBURSEMENT	HCPC
	MEDICARE PRIMARY PAYMENT	DEDUCTIBLE		MSP IND	COIN-SURANCE	BLOOD		PRIMARY PAYER AMT						MSP PROVIDER REIMBURSEMENT	
DOE, JOHN	06635281	070107	070107	0	320.00	0.00	0.00	0.00	0.00	0.00	64.00	0.00			
						0.00	0.00				0.00				256.00

Figure 2d. Medicare *Remittance Advice* Simplified Example.

DO NOT STAPLE IN BAR AREA

[redacted]

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

Fasten Here

8

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: **0123456789**
4 ZIP CODE: **999995555**

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI): **DOE JOHN**
6 MEDI-CAL IDENTIFICATION NO: **90000000A95001**
7 SEX: **M**
8 DATE OF BIRTH: **04 01 1938**
9 PATIENT LOCATION
10 MEDICARE STATUS

1

11 PRESCRIPTION NO: **1234567**
12 DATE OF SERVICE: **10052007**
13 METRIC QUANTITY: **150.000**
14 CODE 1 MET?: Y
15 DAYS SUPPLY: **30**
16 BASIS OF COST DETERMINATION: **00**
17 PROD ID QUAL: **03**
18 PRODUCT ID: **99999999996**
19 ID QUAL: **01**
20 PRESCRIBER ID: **1234567890**
21 PRIMARY ICD-CM: **V427**
22 SECONDARY ICD-CM
23 CHARGE: **27555**
24 OTHER COVERAGE PAID: **27044**
25 OTH COV CODE: **9**
26 PATIENT'S SHARE
27 TAR CONTROL NO
28 COMP CODE
29 DELETE: Y

2

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

3

49 PRESCRIPTION NO
50 DATE OF SERVICE: MM DD YYYY
51 METRIC QUANTITY: WHOLE UNITS . DECIMAL
52 CODE 1 MET?: Y
53 DAYS SUPPLY
54 BASIS OF COST DETERMINATION
55 PROD ID QUAL
56 PRODUCT ID
57 ID QUAL
58 PRESCRIBER ID
59 PRIMARY ICD-CM
60 SECONDARY ICD-CM
61 CHARGE
62 OTHER COVERAGE PAID
63 OTH COV CODE
64 PATIENT'S SHARE
65 TAR CONTROL NO
66 COMP CODE
67 DELETE: Y

4

68 PRESCRIPTION NO
69 DATE OF SERVICE: MM DD YYYY
70 METRIC QUANTITY: WHOLE UNITS . DECIMAL
71 CODE 1 MET?: Y
72 DAYS SUPPLY
73 BASIS OF COST DETERMINATION
74 PROD ID QUAL
75 PRODUCT ID
76 ID QUAL
77 PRESCRIBER ID
78 PRIMARY ICD-CM
79 SECONDARY ICD-CM
80 CHARGE
81 OTHER COVERAGE PAID
82 OTH COV CODE
83 PATIENT'S SHARE
84 TAR CONTROL NO
85 COMP CODE
86 DELETE: Y

SPECIFIC DETAILS/REMARKS:
Medicare and OHC Crossover Claim with Attachment

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 Smith, Pharm D.*
94 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

87 MEDICAL RECORD NO
88 BILL LIM EX
89 ATTACHMENTS: X
90 DATE BILLED: **11 30 2007**
91 DISCHARGE DATE: MM DD YYYY
F.I. USE ONLY 92 93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

30-1 RV7 03/07

Figure 3a. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Drugs with Other Health Coverage.

ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA 99999-5555

11/07/07

Medicare Remittance Notice
NORIDIAN

BENEFICIARY NAME HIC NO./EX NO. CONTROL NUMBER	SERVICE FROM TO	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCT	COINSUR	PAYMENT	INTEREST
JOHN DOE 90000000A95001	100507 100507	1	30	99999999996	39900	27555		000	5511	22044	
CLAIM TOTALS					39900	27555		000	5511	22044	000

Figure 3b. Medicare Remittance Notice (MRN) Simplified Example
Note: Shows Medicare $220.44 payment plus OHC $50 payment.

medi cr ph ex
12

DO NOT STAPLE IN BAR AREA

[redacted]

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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8

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: 0123456789
4 ZIP CODE: 999995555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI): DOE JOHN
6 MEDI-CAL IDENTIFICATION NO: 90000000A95001
7 SEX: M
8 DATE OF BIRTH: 04 01 1938
9 PATIENT LOCATION
10 MEDICARE STATUS

1
11 PRESCRIPTION NO: 1234567
12 DATE OF SERVICE: 10 05 2007
13 METRIC QUANTITY: WHOLE UNITS 150 . 000 SECIMAL
14 CODE 1 MET?: Y
15 DAYS SUPPLY: 30
16 BASIS OF COST DETERMINATION: 00
17 PROD ID QUAL: 03
18 PRODUCT ID: 99999999996
19 ID QUAL: 01
20 PRESCRIBER ID: 1234567890
21 PRIMARY ICD-CM: V427
22 SECONDARY ICD-CM:
23 CHARGE: 27555
24 OTHER COVERAGE PAID: 22044
25 OTH COV CODE:
26 PATIENT'S SHARE:
27 TAR CONTROL NO:
28 COMP CODE: 1
29 DELETE: Y

2
30 PRESCRIPTION NO:
31 DATE OF SERVICE: MM DD YYYY
32 METRIC QUANTITY: WHOLE UNITS . SECIMAL
33 CODE 1 MET?: Y
34 DAYS SUPPLY:
35 BASIS OF COST DETERMINATION:
36 PROD ID QUAL:
37 PRODUCT ID:
38 ID QUAL:
39 PRESCRIBER ID:
40 PRIMARY ICD-CM:
41 SECONDARY ICD-CM:
42 CHARGE:
43 OTHER COVERAGE PAID:
44 OTH COV CODE:
45 PATIENT'S SHARE:
46 TAR CONTROL NO:
47 COMP CODE:
48 DELETE: Y

3
49 PRESCRIPTION NO:
50 DATE OF SERVICE: MM DD YYYY
51 METRIC QUANTITY: WHOLE UNITS . SECIMAL
52 CODE 1 MET?: Y
53 DAYS SUPPLY:
54 BASIS OF COST DETERMINATION:
55 PROD ID QUAL:
56 PRODUCT ID:
57 ID QUAL:
58 PRESCRIBER ID:
59 PRIMARY ICD-CM:
60 SECONDARY ICD-CM:
61 CHARGE:
62 OTHER COVERAGE PAID:
63 OTH COV CODE:
64 PATIENT'S SHARE:
65 TAR CONTROL NO:
66 COMP CODE:
67 DELETE: Y

4
68 PRESCRIPTION NO:
69 DATE OF SERVICE: MM DD YYYY
70 METRIC QUANTITY: WHOLE UNITS . SECIMAL
71 CODE 1 MET?: Y
72 DAYS SUPPLY:
73 BASIS OF COST DETERMINATION:
74 PROD ID QUAL:
75 PRODUCT ID:
76 ID QUAL:
77 PRESCRIBER ID:
78 PRIMARY ICD-CM:
79 SECONDARY ICD-CM:
80 CHARGE:
81 OTHER COVERAGE PAID:
82 OTH COV CODE:
83 PATIENT'S SHARE:
84 TAR CONTROL NO:
85 COMP CODE:
86 DELETE: Y

SPECIFIC DETAILS/REMARKS:
Medicare and OHC Crossover Claim with Attachment

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 Smith, Pharm D.*
94 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

87 MEDICAL RECORD NO:
88 BILL LIM EX:
89 ATTACHMENTS: X
90 DATE BILLED: 11 30 2007
91 DISCHARGE DATE: MM DD YYYY
F.I. USE ONLY 92 93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

30-1 RV7 03/07

Figure 4a. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Drugs.

ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA 99999-5555

11/07/07

Medicare Remittance Notice
NORIDIAN

BENEFICIARY NAME	SERVICE	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCT	COINSUR	PAYMENT	INTEREST
HIC NO./EX NO. CONTROL NUMBER	FROM TO										
JOHN DOE	100507 100507	1	30	99999999996	39900	27555		000	5511	22044	
90000000A95001											
CLAIM TOTALS					39900	27555		000	5511	22044	000

Figure 4b. Medicare Remittance Notice (MRN) Simplified Example.

DO NOT STAPLE IN BAR AREA

[redacted]

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

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2

Provider Name, Address, Phone

COMPOUND DRUG PHARMACY CLAIM FORM

PROFESSIONAL PHARMACY
1234 MAIN STREET
ANYTOWN, CA

2 ID QUALIFIER: 01
3 PROVIDER ID: 0123456789
4 ZIP CODE: 938255555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI): SMITH, JOHN
6 MEDI-CAL IDENTIFICATION: 90000000A95001 (CONFIDENTIAL)
7 SEX: M
8 DATE OF BIRTH: 05 01 1946
9 DATE OF ISSUE: 06 05 2006
10 PRESCRIPTION NO: 345678
11 DATE OF SERVICE: 06 29 2007
12 TOTAL METRIC QUANTITY: WHOLE UNITS . 240
13 CODE 1 MET?: Y
14 DAYS SUPPLY: 30
15 PATIENT LOCATION:
16 MEDICARE STATUS:
17 ID QUAL: 01
18 PRESCRIBER ID: ABC654321
19 PRIMARY ICD-CM: 496
20 SECONDARY ICD-CM:
21 DOSG FORM DESC CODE: 05
22 DISP UNIT FORM IND: 2
23 ROUTE OF ADMIN: 3
24 TOTAL CHARGE: 7488
25 OTHER COVERAGE PAID: 6490
26 OTH COV CODE: 9
27 PATIENT'S SHARE:
28 INCENTIVE AMOUNT:
29 TAR CONTROL NO:

	30 PROD ID QUAL	31 INGREDIENT PRODUCT ID	32 INGREDIENT QUANTITY	33 INGREDIENT CHARGE	34 BASIS OF COST
1	03	62991100604	WHOLE UNITS . 180	1260	00
2	03	62991108506	WHOLE UNITS . 060	600	00
3			WHOLE UNITS . DECIMAL		
4			WHOLE UNITS . DECIMAL		
5			WHOLE UNITS . DECIMAL		
6			WHOLE UNITS . DECIMAL		
7			WHOLE UNITS . DECIMAL		
8			WHOLE UNITS . DECIMAL		
9			WHOLE UNITS . DECIMAL		
10			WHOLE UNITS . DECIMAL		
11			WHOLE UNITS . DECIMAL		
12			WHOLE UNITS . DECIMAL		
13			WHOLE UNITS . DECIMAL		
14			WHOLE UNITS . DECIMAL		
15			WHOLE UNITS . DECIMAL		
16			WHOLE UNITS . DECIMAL		
17			WHOLE UNITS . DECIMAL		
18			WHOLE UNITS . DECIMAL		
19			WHOLE UNITS . DECIMAL		
20			WHOLE UNITS . DECIMAL		
21			WHOLE UNITS . DECIMAL		
22			WHOLE UNITS . DECIMAL		
23			WHOLE UNITS . DECIMAL		
24			WHOLE UNITS . DECIMAL		
25			WHOLE UNITS . DECIMAL		

35 MEDICAL RECORD NO: 1234XY5678
36 BILL LIM EX:
37 DATE BILLED: 11 30 2007
38 HOSP DISCHARGE DATE: MM DD YYYY
39 INGREDIENT TOTAL CHARGE: 1860

SPECIFIC DETAILS/REMARKS:

MEDICARE AND OHC CROSSOVER CLAIM WITH ATTACHMENT

40 PROC FOR APPROVED INGREDIENTS:
41 CONTAINER COUNT:
F.I. USE ONLY: 42 43 44

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 45 *JANE DOE, PHARM D.*
Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. Revision Date: 03/07 Form Number 30-4

Figure 5a. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Compound Drugs with Other Health Coverage.

PROFESSIONAL PHARMACY
1234 MAIN STREET
ANYTOWN, CA 93825-5555

07/10/07

MEDICARE REMITTANCE NOTICE
NORIDIAN

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED/ INGREDIENT CHARGE	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN SMITH	06 29 07	06 29 07	1	30	62991100604	12.60						
99999999999999	06 29 07	06 29 07	11	30	62991108506	6.00						
					Dispensing Fee	57.00						
CLAIM TOTALS						75.60	74.88		0.00	14.98	59.90	0.00

Figure 5b. Medicare Remittance Notice (MRN) Simplified Example.
Note: Claim shows Medicare $59.90 payment plus OHC $5 payment

medi cr ph ex
16

MEDICARE CROSSOVER CLAIM WITH ATTACHMENT

DO NOT STAPLE IN BAR AREA

1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

Fasten Here

2

COMPOUND DRUG PHARMACY CLAIM FORM

Provider Name, Address, Phone

ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA

2 ID QUALIFIER: 01
3 PROVIDER ID: 0123456789
4 ZIP CODE: 938255555

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI): SMITH, JANE
6 MEDI-CAL IDENTIFICATION: 90000000A95001 (CONFIDENTIAL)
7 SEX: F
8 DATE OF BIRTH: 04 08 1946
9 DATE OF ISSUE: 06 01 2006
10 PRESCRIPTION NO: 234567
11 DATE OF SERVICE: 06 27 2007
12 TOTAL METRIC QUANTITY: WHOLE UNITS . 240
13 CODE 1 MET?: Y
14 DAYS SUPPLY: 30
15 PATIENT LOCATION:
16 MEDICARE STATUS:
17 ID QUAL: 01
18 PRESCRIBER ID: 1234567890
19 PRIMARY ICD-CM: 496
20 SECONDARY ICD-CM:
21 DOSG FORM DESC CODE: 05
22 DISP UNIT FORM IND: 2
23 ROUTE OF ADMIN: 3
24 TOTAL CHARGE: 7488
25 OTHER COVERAGE PAID: 5990
26 OTH COV CODE: 9
27 PATIENT'S SHARE:
28 INCENTIVE AMOUNT:
29 TAR CONTROL NO:

	30 PROD ID QUAL	31 INGREDIENT PRODUCT ID	32 INGREDIENT QUANTITY	33 INGREDIENT CHARGE	34 BASIS OF COST
1	03	62991100604	WHOLE UNITS . 180	1260	00
2	03	62991108506	WHOLE UNITS . 060	600	00
3			WHOLE UNITS . DECIMAL		
4			WHOLE UNITS . DECIMAL		
5			WHOLE UNITS . DECIMAL		
6			WHOLE UNITS . DECIMAL		
7			WHOLE UNITS . DECIMAL		
8			WHOLE UNITS . DECIMAL		
9			WHOLE UNITS . DECIMAL		
10			WHOLE UNITS . DECIMAL		
11			WHOLE UNITS . DECIMAL		
12			WHOLE UNITS . DECIMAL		
13			WHOLE UNITS . DECIMAL		
14			WHOLE UNITS . DECIMAL		
15			WHOLE UNITS . DECIMAL		
16			WHOLE UNITS . DECIMAL		
17			WHOLE UNITS . DECIMAL		
18			WHOLE UNITS . DECIMAL		
19			WHOLE UNITS . DECIMAL		
20			WHOLE UNITS . DECIMAL		
21			WHOLE UNITS . DECIMAL		
22			WHOLE UNITS . DECIMAL		
23			WHOLE UNITS . DECIMAL		
24			WHOLE UNITS . DECIMAL		
25			WHOLE UNITS . DECIMAL		

35 MEDICAL RECORD NO: X0123456YU
36 BILL LIM EX:
37 DATE BILLED: 11 30 2007
38 HOSP DISCHARGE DATE: MM DD YYYY
39 INGREDIENT TOTAL CHARGE: 1860

SPECIFIC DETAILS/REMARKS:

40 PROC FOR APPROVED INGREDIENTS:
41 CONTAINER COUNT:
F.I. USE ONLY: 42 43 44

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 45 JANE DOE, PHARM D.
Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. Revision Date: 03/07 Form Number 30-4

Figure 6a. Figures 6a and 6b. Billing Medi-Cal for Part B Services Billed to a Part B Carrier: NCPDP Retail Pharmacy Compound Drugs.

ABC PHARMACY
1234 MAIN STREET
ANYTOWN, CA 95823-5555

07/02/07

MEDICARE REMITTANCE NOTICE
NORIDIAN

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIFIER	AMOUNT BILLED/ INGREDIENT CHARGE	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JANE SMITH	06 27 07	06 27 07	1	30	62991100604	12.60						
90000000A95001	06 27 07	06 27 07	1	30	62991108506	6.00						
					Dispensing Fee	57.00						
CLAIM TOTALS						75.60	74.88		0.00	14.98	59.90	0.00

Figure 6b. Medicare Remittance Notice (MRN) Simplified Example.