

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

Pharmacy Claim Form (30-1) Completion

The *Pharmacy Claim Form* (30-1) is used by pharmacies to bill Medi-Cal for prescriptions.

Durable Medical Equipment (DME), disposable and incontinence medical supplies, and blood products for provider types other than straight Medi-Cal beneficiaries and for Medi-Cal beneficiaries that have 91 or 97 prefix Service Authorization Requests (SARs), must be billed using the *CMS-1500* claim. See the *CMS-1500 Completion* section of this manual for information.

If billing for a compounded drug prescription, complete the *Compound Drug Pharmacy Claim Form* (30-4). Refer to the *Compound Drug Pharmacy Claim Form* (30-4) *Completion* section of this manual for instructions on how to bill for compounded drug prescriptions.

Most claims for non-compounded drugs and pharmacy-only medical supplies (diabetic testing supplies, inhalant assistance devices, peak flow meters, Family PACT [Planning, Access, Care and Treatment] supplies and enteral formula) may be submitted through the National Council for Prescription Drug Programs (NCPDP) Batch Standard, Version 1.2. For batch submission information, refer to the *CMC* section in the Part 1 manual.

Claims for compounded and non-compounded pharmaceutical products also may be submitted online through the Point of Service (POS) network. Claims submitted online will be immediately adjudicated, including program requirements, Drug Use Review (DUR), eligibility and Share of Cost (SOC) liability. Pharmacies may access the POS network using vendor-supplied hardware and software. For more information, call the Telephone Service Center (TSC) at 1-800-541-5555.

For information about billing via Computer Media Claims (CMC) or POS, refer to the *CMC* and *Point of Service* (POS) sections in the Part 1 provider manual.

Pharmacy providers with Internet access also may submit single compound and non-compound pharmacy claims using the Real-Time Internet Pharmacy (RTIP) claim submission system. To submit RTIP claim transactions on the Medi-Cal website, submitters must complete the *Medi-Cal Point of Service* (POS) *Network/Internet Agreement* and send to the FI at the following address:

Attn: POS/Internet Help Desk
Xerox State Healthcare, LLC
820 Stillwater Road
West Sacramento, CA 95605-1630

RTIP submitters also must complete the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* and send to the FI at the following address:

Attn: CMC Unit
Xerox State Healthcare, LLC
P.O. Box 15508
Sacramento, CA 95852-1508

Crossover pharmacy claims that do not cross over automatically via NCPDP must be billed on the *Pharmacy Claim Form* (30-1). These claims cannot be billed via CMC, POS or RTIP. For more information and billing examples, refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services Billing Examples* section of this manual.

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

8 Fasten Here

PHARMACY CLAIM FORM

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

Provider Name, Address

3A

2 ID QUALIFIER	3 PROVIDER ID
4 ZIP CODE	

Provide Phone Number:

ELITE	PICA	← TYPEWRITER ALIGNMENT →	ELITE	PICA
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5 PATIENT INFORMATION PATIENT-NAME (LAST, FIRST, MI)	6 MEDICAL IDENTIFICATION NO	7 SEX	8 DATE OF BIRTH	9 PATIENT LOCATION	10 MEDICARE STATUS
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11 PRESCRIPTION NO	12 DATE OF SERVICE	13 METRIC QUANTITY	14 CODE 1 MET?	15 DAYS SUPPLY	16 BASIS OF COST DETERMINATION
17 PROD ID QUAL	18 PRODUCT ID	19 ID QUAL	20 PRESCRIBER ID	21 PRIMARY ICD-CM	22 SECONDARY ICD-CM
23 CHARGE	24 OTHER COVERAGE PAID	25 OTH COV CODE	26 PATIENT'S SHARE	27 TAR CONTROL NO	28 COMP CODE
				29 DELETE	

20 PRESCRIPTION NO	21 DATE OF SERVICE	22 METRIC QUANTITY	23 CODE 1 MET?	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	

30 PRESCRIPTION NO	31 DATE OF SERVICE	32 METRIC QUANTITY	33 CODE 1 MET?	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	

40 PRESCRIPTION NO	41 DATE OF SERVICE	42 METRIC QUANTITY	43 CODE 1 MET?	44 DAYS SUPPLY	45 BASIS OF COST DETERMINATION
46 PROD ID QUAL	47 PRODUCT ID	48 ID QUAL	49 PRESCRIBER ID	50 PRIMARY ICD-CM	51 SECONDARY ICD-CM
52 CHARGE	53 OTHER COVERAGE PAID	54 OTH COV CODE	55 PATIENT'S SHARE	56 TAR CONTROL NO	57 COMP CODE
				58 DELETE	

SPECIFIC DETAILS/REMARKS:

95

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.

94

X _____
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 LHM EX	89 ATTACHMENTS
90 DATE BILLED	91 DISCHARGE DATE	F.I. USE ONLY
92	93	

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

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Figure 1. Medi-Cal Required Fields (Sample Pharmacy Claim Form [30-1]).

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *Pharmacy Claim Form (30-1)* on the previous page. All items must be completed unless otherwise noted in these instructions.

For general paper claim billing instructions, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Item Description

1. **CLAIM CONTROL NUMBER.** For DHCS FI use only. Do not mark in this area. A unique 13-digit number, assigned by the FI to track each claim, will be entered here when the claim is received by the FI.
2. **ID QUALIFIER.** Identifies the NCPDP D.0 standard provider ID type. Place a 05 for Pharmacy Provider.
3. **PROVIDER ID.** Enter your provider number. Do not submit claims using a Medicare provider number or State license number.

Billing Services

Providers using a billing service should notify the service to amend its records so the correct provider number for the date of service will appear on the claim.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 3a. | PROVIDER NAME, ADDRESS, PHONE NUMBER. Enter your name, address and telephone number. Confirm that this information is correct before submitting claim forms. |
| 4. | ZIP CODE. Enter the pharmacy's nine-digit ZIP code. |
- Note:** The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.

<u>Item</u>	<u>Description</u>
Newborn Infant	<p>5. PATIENT NAME. Enter the patient's last name, first name, and middle initial, if known. Avoid nicknames or aliases.</p> <p>When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name, sex and year of birth in the appropriate spaces. Enter the complete date of birth (MMDDYYYY) and write "Newborn infant using mother's card" in the <i>Specific Details/Remarks</i> area.</p> <p>If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl). If newborn infants from a multiple birth are being billed in addition to the mother, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A).</p> <p>Services to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.</p> <p>6. MEDI-CAL IDENTIFICATION NUMBER. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).</p> <p>7. SEX. Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the BIC. (For newborns, see <i>Item 4.</i>)</p>

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 8. | DATE OF BIRTH. Obtain this number from the recipient's BIC. Although the form utilizes MMDDYYYY format, enter the date in MMDCCYY format, where "MM" is the two-digit month, "DD" is the two-digit day, "CC" is the two-digit century and "YY" is the two-digit year. For example, a birth date of March 8, 1945 should be entered as "03081945." Birth dates may not be in the future. You must enter this information in order for your claim to process successfully. |
| 9. | PATIENT LOCATION. If the recipient is residing in a Nursing Facility (NF) Level A or B or Nursing Facility Level B (Subacute Care), enter the appropriate code in this field:

C – Nursing Facility (NF) Level A
4 – Nursing Facility (NF) Level B
F – Nursing Facility (NF) Level B (Adult Subacute)
F – Subacute Care Facility
G – Intermediate Care Facility–Developmentally Disabled (NF-A/DD)
H – Intermediate Care Facility–Developmentally Disabled, Habilitative (NF-A/DD-H)
I – Intermediate Care Facility–Developmentally Disabled, Nursing (NF-A/DD-N)
M – Nursing Facility Level B (Pediatric Subacute) |

If the recipient is not residing in any of these facilities, leave *Item 9* blank.

Item Description

10. **MEDICARE STATUS.** Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:

<u>Code</u>	<u>Explanation</u>
0	Under 65, does not have Medicare coverage
* 1	Benefits exhausted
* 2	Utilization committee denial or physician non-certification
* 3	No prior hospital stay
* 4	Facility denial
* 5	Non-eligible provider
* 6	Non-eligible recipient
* 7	Medicare benefits denied or cut short by Medicare intermediary
8	Non-covered services
* 9	PSRO denial
* L	Medi/Medi Charpentier: Benefit limitations
* R	Medi/Medi Charpentier: Rates
* T	Medi/Medi Charpentier: Both rates and benefit limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section in this manual for additional information.

11. **PRESCRIPTION NUMBER.** Enter your prescription number in this space for reference on the *Remittance Advice Details* (check warrant and voucher). A maximum of eight digits may be used.

<u>Item</u>	<u>Description</u>
13.	METRIC QUANTITY (continued).
Use Correct Measurement Unit	The correct measurement unit is listed beside each item in the Contract Drugs List sections. This is the measurement unit you should use for billing. For items requiring a <i>Treatment Authorization Request</i> (TAR), the approved TAR will specify the exact number of units to be used in the quantity field of the claim form.
Package Size Specific Codes	<p>The items in the Contract Drugs List sections of this manual are sometimes package-size specific. That is, a different is assigned to different package sizes of the same drug or medical supply.</p> <p>In such cases, use the code that corresponds to a trade package actually made by the manufacturer whose product is dispensed. If the manufacturer does not make a trade package containing the quantity dispensed, use the code that corresponds to the package size that was used in filling the prescription. For instance, if 60 grams of an ointment are dispensed out of a 454 Gm jar, the code for the 454 Gm jar should be used.</p>
Prepacks	The units (Gm's, ml's or each) that are to be used when billing the program are specified in the item's listing. The units specified must be used in all cases. The quantity entered for prepacks should always be in the number of units specified in the Contract Drugs List sections.
14.	CODE 1 (RESTRICTIONS) MET? A "Y" means that the Code 1 restriction listed under the drug in the Contract Drugs List sections has been met.
15.	DAYS SUPPLY. Enter the estimated number of days that the drug dispensed will last.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 16. | BASIS OF COST DETERMINATION. This field indicates the method by which the ingredient cost was calculated. Enter "08" (Other) if the cost basis is Disproportionate share/Public Health Service or the drug is purchased under the 340B Drug Discount Program. Otherwise enter "00" (Not specified). |
| 17. | PRODUCT ID QUALIFIER. This field identifies the type of product ID submitted. Place a "03" for National Drug Code (NDC). |
| 18. | PRODUCT ID. When billing for drugs, enter the NDC, Universal Product Number (UPN) or Health Related Items (HRI) code of the drug billed. |

Zero Fill NDC Numbers

All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. For a complete 11-digit number, the first segment must have five digits, the second segment four digits and the third segment two digits. Add leading zeros wherever they are needed to complete a segment with the correct number of digits. For example:

<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002-0022-02)	00002002202

	<u>Item</u>	<u>Description</u>
Drug Manufacturer and Product Codes	18.	<p>PRODUCT ID (continued).</p> <p>If the item being billed is a drug, check the list found in the <i>Drugs: Contract Drugs List Part 5 – Authorized Drug Manufacturer Labeler Codes</i> section of this manual. The products of manufacturers not listed in this section are not covered by Medi-Cal without authorization.</p>
Medical Supplies		<p>Disposable medical and incontinence supplies may not be billed on the 30-1. Medical supplies that may be billed as “pharmacy only” benefits according to National Council for Prescription Drug Programs (NCPDP) claim transaction standards include diabetic supplies, peak flow meters, inhalers, contraceptive products and enteral nutritional formulae.</p>
	19.	<p>ID QUALIFIER. Identifies the NCPDP D.0 standard provider ID type.</p>
	20.	<p>PRESCRIBER ID. Enter the provider number of the prescriber or, if applicable, the provider number of the certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor or pharmacist who functions pursuant to a policy, procedure, or protocol as required by <i>Business and Professions Code</i> statutes. Do not use the Drug Enforcement Administration Narcotic Registry Number. This information must be entered for your claim to successfully process.</p>

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 21. | <p>PRIMARY ICD-CM. Optional. If available, enter all letters and/or numbers of the <i>International Classification of Diseases – 9th Revision – Clinical Modification</i> (ICD-9-CM) code for the primary diagnosis, including the fourth and fifth digits, if present. Do not enter the decimal point.</p> <p>Important: For claims that will be received by the FI on or after September 22, 2014, enter ICD indicator “9” as an additional digit before the ICD CM diagnosis code. The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code but no ICD indicator may be denied.</p> |
| 22. | <p>SECONDARY ICD-CM. Optional. The primary diagnosis code should be placed in the first occurrence and the secondary should be placed in the second occurrence.</p> |
| 23. | <p>CHARGE. Enter the dollar and cents amount for this item. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). If the item is taxable, include the applicable state and county sales tax for each claim line total. For DMAC NCPDP hard copy pharmacy crossovers, enter the Medicare Allowed Amount.</p> |
| 24. | <p>OTHER COVERAGE PAID. Enter the full dollar amount of payment received from Other Health Coverage carriers. Do not enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For DMAC NCPDP hard copy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, then enter the combined total.</p> |
| 25. | <p>OTHER COVERAGE CODE. A valid Other Coverage Code is required. Enter one of the following values:</p> |

<u>Code</u>	<u>Explanation</u>
0	Not Specified or No Other Coverage Exists
2	Other Coverage Exists, Payment Not Collected
7	Other Coverage Exists, Claim was not covered or other coverage was not in effect at time of service
9	Other Coverage Exists, Payment Collected

Item Description

26. **PATIENT'S SHARE (OF COST).** Enter the full dollar amount of the patient's Share of Cost for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For more information, see the *Share of Cost (SOC): 30-1 for Pharmacy* section in this manual.

27. **TAR CONTROL NUMBER.** If authorization is required, enter the 10-digit TAR Control Number (TCN) followed by the Pricing Indicator (PI) from the *Adjudication Response (AR)* on each applicable claim line. It is not necessary to attach a copy of the *Adjudication Response* to the claim. Recipient, quantity, drug and date of service on the claim must agree with the information on the *Adjudication Response*.

28. **COMPOUND CODE.** Enter the appropriate code in this box.

<u>Code</u>	<u>Description</u>
0	Not specified
1	Not a compound
2	Compound

Note: Compound pharmacy claims should be billed on the *Compound Pharmacy Claim Form (30-4)* or electronically through the POS network or Real-Time Internet Pharmacy (RTIP) claim submission system.

Item Description

29. **DELETE.** If an error has been made, enter an “X” in this space to delete the entire line. Enter the correct billing information on another line. When a *Delete* box is marked “X”, the information on the line will be “ignored” by the system and will not be entered as a claim line.
- 30 – 86. **ADDITIONAL CLAIM LINES.** Lines 2, 3 and 4 are used for additional items for the same patient during the same month of service.
87. **MEDICAL RECORD NUMBER.** This is an optional field that will help you to easily identify a recipient on RTDs. Enter the patient’s medical record number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever you enter here will appear on the RTD. Refer to the *Resubmission Turnaround Document (RTD) Completion* section in this manual for more information.

If the pharmacy does not assign unique record-keeping numbers to each recipient, it is recommended that the recipient’s name be entered in this field.

- | Item | Description |
|---------|--|
| 88. | BILLING LIMIT EXCEPTIONS. If there is an exception to the six-month billing limitation, enter the appropriate reason code number and include the required documentation. (See the <i>Pharmacy Claim Form [30-1] Submission and Timeliness Instructions</i> section of this manual.) |
| 89. | ATTACHMENTS. Enter an “X” if attachments are included with the claim (for example, catalog pages, invoices, etc.). <u>Leave blank if not applicable.</u> |
| | Reminder: If this box is not marked, attachments may not be seen by the claim examiner, which may cause the claim to be denied. |
| 90. | DATE BILLED. Enter the date this statement is being submitted to the DHCS FI for processing. Use numbers as described in <i>Item 12</i> (Date of Service). |
| 91. | DISCHARGE DATE. Leave blank. This will be used for the date the patient was discharged from the hospital. |
| 92, 93. | FI USE ONLY. Leave blank. |
| 94. | SIGNATURE OF PROVIDER AND DATE. The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only. |
| | An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file with the FI. |

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 95. | SPECIFIC DETAILS/REMARKS. Use this blank space to clarify or detail any line item. <u>Indicate the line item number being referenced.</u> If additional space is needed, insert a capital "X" or "Y" in Box 89 (<i>Attachments</i>) and clip or staple your attachment to the top right-hand corner of the claim. |

The *Specific Details/Remarks* area is also used to provide information on Share of Cost, Crossovers or Charpentier Rebilling. See the *Pharmacy Claim Form (30-1): Special Billing Instructions* section, the *Share of Cost: (30-1) for Pharmacy* section or the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section of this manual for more information.

Emergency Certification Statement

Claims that require documentation, such as an Emergency Certification Statement, cannot be billed through the POS network or CMC format. The Emergency Certification Statement must be attached to the claim and include:

- The nature of the emergency, including relevant clinical information about the patient's condition
- Why the emergency services rendered were considered to be immediately necessary
- The signature of the physician, podiatrist, dentist or pharmacist who had direct knowledge of the emergency

The statement must be comprehensive enough to support a finding that an emergency existed. A mere statement that an emergency existed is not sufficient.

An Emergency Certification Statement may not be used in place of a *Treatment Authorization Request (TAR)* for diabetic supplies that require authorization when the maximum quantity has been reached. For further information, see the *List of Contracted Diabetic Test Strips and Lancets* spreadsheet.

Note: Emergency claims cannot be billed using the CMC format or through the POS network.