MY HEALTH LA INITIATIVE – MEDICAL AND DENTAL PHARMACY CLAIM FORM

USE MEDI-CAL 30-1 FORM – (ORIGINAL CLAIM (Pink or Orange ONLY) – NO Black /White COPIES)

FOR CLINICS TO SUBMIT CLAIMS, USE ONE OF FOLLOWING PROGRAM CODES

- MEDICAL – PPM145
- DENTAL – PPD989

Pharmacy claims must include all of the following elements, except those indicated as optional:

MEDI-CAL BOX #/Title	Put the following data for the MHLA Pharmacy Program:	Comment
1. Claim ControlNumber	Clinic's Name and Address	Mandatory
2 .ID Qualifier	Program Code PPD989 or PPM145	Mandatory
3. Provider ID	Clinic's Tax ID (and suffix if applicable)	Mandatory
Provider Name, Address	Pharmacist Name for Medical Dentist Name for Dental	Mandatory
Provider Phone Number	Clinic's Phone number and Contact Name	Mandatory
5. Patient Name	Last Name, First Name of Patient	Mandatory
6. Medi-Cal ID No	MHLA Identification Number (One E App 17 PID) for Medical SSN for Dental	Mandatory
7. Sex	M= Male, F=Female	Mandatory
8. Date of Birth	Format: Month/Day/Year	Mandatory
11.Prescription Number	Internal Number assigned by Clinic	Mandatory
12.Date of Service	Filling/Dispensing or Date of Refill	Mandatory
13. Metric Quantity	Number of pills, gm, or ml dispensed to patient	Mandatory
15. Days Supply	Number of days that patient has been instructed to take the drug	Mandatory
18.Product ID	NDC – National Drug Code	Mandatory
20. Prescriber ID	NPI for Physician/Dentist who prescribed drug	Mandatory
21. Primary ICD-CM	Authorization # - 10 digit number assigned by County – Given by Pharmacy Division at DHS.	Mandatory if drug Preauthorized by County, otherwise leave blank.
23. Line Charge	Amount that it costs the clinic for the drug. Should be .01 or greater.	Mandatory
Specific Details	Put description of drug	Mandatory
87. Medical Record #	Patient Account Number assigned by clinic. If no number assigned, default to 1234	Mandatory
90. Date Billed	Date claim is generated	Optional
91. Discharge Date	Total amount of all line items submitted.	Mandatory
94. Signature of Provider	Signature of Pharmacist, Dentist or put Signature on File	Mandatory

Note: Line items occur 4 times. Information requested under boxes 11 – 23 applies to all 4 line items.

DO NOT STAPLE IN BAR AREA

[redacted]

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

Clinic Name and Address

Fasten Here

Provider Name, Address

PHARMACY CLAIM FORM

Pharmacist Name (for Med)
Dentist Name (for Dental)

2 ID QUALIFIER | 3 PROVIDER ID
PPM145 Clinic Tax Id and Suffix (if applicable)

4 ZIP CODE
PPD989 (use for Dental Pharmacy)

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

Provider Phone Number:
Clinic's Phone # for Contact

ELITE PICA

TYPEWRITER ALIGNMENT

ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI): Last Name, First Name
6 MEDI-CAL IDENTIFICATION NO: 319002xxxxxxxxxx
7 SEX: F/M
8 DATE OF BIRTH: MM/DD/CCYY
9 PATIENT LOCATION
10 MEDICARE STATUS

1

11 PRESCRIPTION NO	12 DATE OF SERVICE	13 METRIC QUANTITY	14 CODE 1 MET?	15 DAYS SUPPLY	16 BASIS OF COST DETERMINATION
563964	11 25 2014	24		12	

17 PROD ID QUAL	18 PRODUCT ID	19 ID QUAL	20 PRESCRIBER ID	21 PRIMARY ICD-CM	22 SECONDARY ICD-CM
	00781261305		1538152350		

23 CHARGE	24 OTHER COVERAGE PAID	25 OTH COV CODE	26 PATIENT'S SHARE	27 TAR CONTROL NO	28 COMP CODE	29 DELETE
6.29	0		0	11 24 2014		

2

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

3

49 PRESCRIPTION NO	50 DATE OF SERVICE	51 METRIC QUANTITY	52 CODE 1 MET?	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

4

68 PRESCRIPTION NO	69 DATE OF SERVICE	70 METRIC QUANTITY	71 CODE 1 MET?	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

SPECIFIC DETAILS/REMARKS:

00781261305
AMOXICILLIN 500MG CAP

SAMPLE

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.

Signature On File

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: 1234567
88 BILL LIM EX
89 ATTACHMENTS
90 DATE BILLED: 12 10 2014
91 DISCHARGE DATE: 6.29
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 04/12

3