

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

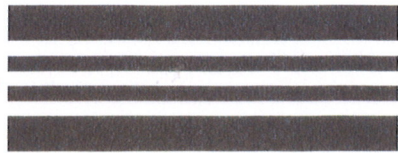
- MEDICAL – PPM145
- DENTAL – PPD989

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 Control Number	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



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)

ID QUALIFIER PROVIDER ID
PPM145 Clinic Tax Id and Suffix (if applicable)
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 PATIENT NAME (LAST, FIRST, MI) Last Name, First Name
MEDI-CAL IDENTIFICATION NO 319002xxxxxxxxxx
SEX F/M DATE OF BIRTH MM/DD/CCYY
PATIENT LOCATION MEDICARE STATUS

11 PRESCRIPTION NO 563964 12 DATE OF SERVICE 11 25 2014 13 METRIC QUANTITY 24 14 CODE 1 MET? 15 DAYS SUPPLY 12 16 BASIS OF COST DETERMINATION
17 PROD ID QUAL 18 PRODUCT ID 00781261305 19 ID QUAL 20 PRESCRIBER ID 1538152350 21 PRIMARY ICD-CM 22 SECONDARY ICD-CM
23 CHARGE 6.29 24 OTHER COVERAGE PAID 0 25 OTH COV CODE 26 PATIENT'S SHARE 0 27 TAR CONTROL NO 11 24 2014 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

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

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 92 F.I. USE ONLY 93

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