CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME L/F/MI IOWA MEDICAID POS PLAN NAME _____

PATIENT NAME L/F/MI Instructions OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH SEE BELOW * and MM DD CCYY * * PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( )

STATE & ZIP CODE _____ FAX NO. ( )

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____

DATE OF INJURY MM DD CCYY _____ **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

* Refill must be numeric only 00, 01-99

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
				*		

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
	**				

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

INGREDIENT COST SUBMITTED
DISPENSING FEE SUBMITTED
INCENTIVE AMOUNT SUBMITTED
OTHER AMOUNT SUBMITTED
SALES TAX SUBMITTED
GROSS AMOUNT DUE SUBMITTED
PATIENT PAID AMOUNT
OTHER PAYER AMOUNT PAID
NET AMOUNT DUE

** = use Basis Cost = 09 "other" to indicate unit dose drug.

2

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

INGREDIENT COST SUBMITTED
DISPENSING FEE SUBMITTED
INCENTIVE AMOUNT SUBMITTED
OTHER AMOUNT SUBMITTED
SALES TAX SUBMITTED
GROSS AMOUNT DUE SUBMITTED
PATIENT PAID AMOUNT
OTHER PAYER AMOUNT PAID
NET AMOUNT DUE

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified
1=No other coverage identified
2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered
4=Other coverage exists-payment not collected
5=Managed care plan denial
6=Other coverage denied-not a participating provider
7=Other coverage exists-not in effect at time of service
8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified
1=Male
2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified
1=Cardholder
2=Spouse
3=Child
4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified
01=National Provider Identifier (NPI)
02=Blue Cross
03=Blue Shield
04=Medicare
05=Medicaid
06=UPIN
07=NCPDP Provider ID
08=State License
09=Champus
10=Health Industry Number (HIN)
11=Federal Tax ID
12=Drug Enforcement Administration (DEA)
13=State Issued
14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified
1=Rx billing
2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified
00=Not Specified
01=Universal Product Code (UPC)
02=Health Related Item (HRI)
03=National Drug Code (NDC)
04=Universal Product Number (UPN)
05=Department of Defense (DOD)
06=Drug Use Review/Professional Pharm. Service (DUR/PPS)
07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)
09=HCFA Common Procedural Coding System (HCPCS)
10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI)
12=International Article Numbering System (EAN)
13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified
1=Prior authorization
2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment)
4=Exemption from copay
5=Exemption from Rx limits
6=Family Planning Indicator
7=Aid to Families with Dependent Children (AFDC)
8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service
B=Professional Service Code
C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified
00=Not Specified
01=AWP (Average Wholesale Price)
02=Local Wholesaler
03=Direct
04=EAC (Estimated Acquisition Cost)
05=Acquisition
06=MAC (Maximum Allowable Cost)
07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified
01=Drug Enforcement Administration (DEA)
02=State License
03=Social Security Number (SSN)
04=Name
05=National Provider Identifier (NPI)
06=Health Industry Number (HIN)
07=State Issued
99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified
00=Not Specified
01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10)
03=National Criteria Care Institute (NDCC)
04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT)
06=Medi-Span Diagnosis Code
07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified
01=National Payer ID
02=Health Industry Number (HIN)
03=Bank Information Number (BIN)
04=National Association of Insurance Commissioners (NAIC)
09=Coupon
99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost