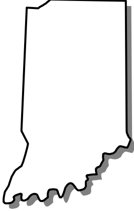


PROVIDER BULLETIN

BT200518 AUGUST 12, 2005

To: All Pharmacy and Prescribing Practitioners

Subject: Pharmacy Claims Processor Change

> *Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system. The information in this bulletin is directed at billing staff of pharmacy providers, as it addresses an upcoming change in the processor of pharmacy claims.*

Overview

Effective at 6 a.m. on Monday, September 26, 2005, Indiana Medicaid pharmacy claims processing will be transitioned from the current processor, ACS, to EDS. ACS will continue to provide clinically oriented services, such as pharmacy-related prior authorization. This bulletin gives providers the necessary information to ensure that there is no disruption in the submission of their claims during the claims processor transition. It also conveys revised and updated pharmacy-related contact information. *Only* matters directly related to or impacted by the forthcoming transition are referenced in this bulletin.

Instructions for Submission—Point of Sale Claims; Batch Claims; Paper Claims Media

Point of Sale Claims

ACS will continue to accept point of sale (POS) claims through 6 p.m. Eastern Standard Time (EST) Sunday, September 25, 2005. After 6 p.m., the entire pharmacy claims system will be down for a period of time not to exceed 12 consecutive hours. This scheduled down time is necessary to effect the transfer of file information from ACS to EDS. During this down time, pharmacy providers should use either the automated voice response (AVR) system, an OMNI device, or Web interChange to determine member eligibility. Prescriptions should continue to be filled and dispensed during the down time. Providers may either wait until POS service is restored before submitting the claim for payment or, alternatively, submit the claim via a paper claim form.

All electronic pharmacy claims should continue to be submitted in accordance with the National Council for Prescription Drug Programs (NCPDP) version 5.1 standard format. A copy of the 5.1 payer sheet is included with this bulletin as Attachment 1, and it is recommended that providers review

the changes noted in Table 1.1. Providers can download a complete version of the IHCP Payer sheet from the IHCP Web site at www.indianamedicaid.com and by clicking on Pharmacy Services.

Table 1.1 Changes to Data Requirements for Submission of NCPDP 5.1 Claims

NCPDP Field Number	NCPDP Field Name	ACS Value	EDS Value (Effective September 26, 2005)
101-A1	BIN Number	610084	610467-IN Medicaid
104-A4	Processor Control Number	DRRXPROD = Production DRRXACCP = Test	INCAIDPROD = Production INCAIDTEST = Test
307-C7	Patient Location	00 = Not Specified 03 = Nursing Home	00 = Not Specified 03 = Nursing Home 04 = Long Term/ Extended Care 11 = Hospice
402-D2	Prescription Number	Number Assigned by the Pharmacy	Prescription Number
406-D6	Compound Code	2 = Compound	1 = Not a Compound 2 = Compound
418-DI	Level of Service	3 = Emergency Supply	00 = Not Specified 03 = Emergency

Note: Providers should consult with their software vendor as soon as possible to determine if and when changes need to be made to the provider's billing software and/or procedures so that no disruption occurs during this transition. Failure by the provider to effect all such changes could lead to POS claims rejections.

Providers should direct questions about POS claims submission to the EDS Pharmacy Services Helpdesk by calling 1-800-577-1278 or (317) 655-3240 8 a.m. to 5 p.m. Monday thru Friday, excluding State holidays.

Batch Claims

ACS will continue to accept electronic batch pharmacy claims until 6 p.m. Eastern Standard Time (EST) September 25, 2005. After 6 p.m. EST no electronic batch claims will be accepted by the IHCP until 6 a.m. EST September 26, 2005. At that time, electronic batch pharmacy claims must be submitted to EDS using the NCPDP 1.1 batch format. Information pertaining to the NCPDP version 1.1 batch format is included in this bulletin as Attachment 1. Please note that if you are planning to submit electronic batch pharmacy claims to EDS, in accordance with HIPAA requirements you must first become established as a *trading partner* with the IHCP. In becoming a trading partner, you will obtain a secure ID and password. Providers can find instructions and more information about becoming a *trading partner* and obtaining IDs by visiting the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_ImplProc.asp h

Batch claim files are submitted using EDS's file exchange secure FTP Web connection. Additional information on file exchange can be found in the Batch Submission section of the Electronic Data

Interchange Communications Guide. This guide can be accessed at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/comm.pdf.

Questions regarding electronic batch pharmacy claims submission should be directed to the EDS EDI Solutions help desk at inxixtradingpartner@eds.com or by calling 1-877-877-5182.

Paper Claims Media (Medicaid Drug Claim Form, Compounded Prescription Claim Form)

While all pharmacy claim types may be billed electronically, providers choosing to bill pharmacy claims on paper claim forms must start to use the new updated claim forms attached to this bulletin on September 26, 2005. These forms, as well as detailed billing instructions, can also be found on the Indiana Medicaid Web site at www.indianamedicaid.com. ACS will continue to accept paper claims until September 12, 2005. Beginning on September 13, 2005, all paper claims must be submitted to EDS at only the following address:

EDS Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

ACS will forward paper claims for 30 days after September 12, 2005. Any claims received by ACS after that date will be returned to the submitting provider for proper routing.

Adjustments

The procedures and forms for submitting paid claim adjustments for pharmacy claims have not changed as a result of this transition, and remain as specified in Chapter 11 of the *IHCP Provider Manual*. ACS will continue to accept pharmacy claim adjustments until September 19, 2005. Beginning on September 20, 2005, all requests for adjustments of paid pharmacy claims must be directed to:

EDS Pharmacy Claims Adjustments
P.O. Box 7265
Indianapolis, IN 46207-7268

ACS will forward any adjustments received after September 19, 2005, for a period of 30 days. After 30 days, the adjustments will be returned to the submitting provider for proper routing.

Claim Reimbursement—Administrative Review and Appeal Procedures

The procedures that providers must follow if they are dissatisfied with the adjudication of a claim is specified in Chapter 10, Section 6, of the *IHCP Provider Manual*. After September 26, 2005, pharmacy providers must direct any requests for administrative review to:

EDS Pharmacy Claims Administrative Review
P.O. Box 7263
Indianapolis, IN 46207-7268

Again, ACS will forward any correspondence received after September 26, 2005, for a period of 30 days. After 30 days, the correspondence will be returned to the submitting provider for proper routing.

Other Pharmacy-Related Program Information

Preferred Drug List

The Preferred Drug List (PDL) is not changing related to this transition. All existing PDL limits and requirements remain in effect. A copy of the PDL can be viewed at www.indianapbm.com. Pharmacists and prescribing practitioners should contact ACS for any questions related to the PDL by calling 1-866-879-0106.

Pharmacy-Related Prior Authorization

ACS will continue to provide services for pharmacy-related prior authorization (PA). Prior authorization request forms have not changed and may be found at www.indianapbm.com. Providers should continue to direct all questions about and requests for pharmacy-related PA to ACS by calling 1-866-879-0106. Please refer to Chapter 9 of the *IHCP Provider Manual* for additional information pertaining to pharmacy-related prior authorization.

Helpdesk

EDS will maintain an in-house pharmacy services helpdesk for IHCP providers to call with any questions related to pharmacy claims processing, payment, billing procedures, or member eligibility. The EDS Pharmacy Services Helpdesk can be reached by calling 1-800-577-1278 or (317) 655-3240 from 8 a.m. to 5 p.m. Monday through Friday, excluding State holidays.

Pharmacy-Related Contact Information

Table 1.2 is an updated and comprehensive list of pharmacy-related contact information. Providers should note that this contact information becomes valid and applicable after the transition.

Table 1.2 – Pharmacy Contact Information

Pharmacy Contact Information (Effective September 26, 2005)		
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	**EDS Pharmacy Services Helpdesk for POS claims processing** 317-655-3240 or 1-800-577-1278 or INXIXPharmacy@EDS.com	**PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center** 1-866-879-0106 or Fax: 1-866-780-2198
Indiana DUR Board INXIXDURQuestions@acs-inc.com	**Indiana Administrative Review/Pharmacy Claims** EDS Pharmacy Claims Administrative Review P.O. Box 7263 Indianapolis, IN 46207-7268	**EDI Solutions Helpdesk for Electronic Batch Claims** 1-877-877-5182 or inxixtradingpartner@eds.com
EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7268	**EDS Pharmacy Claims** P.O. Box 7268 Indianapolis, IN 46207-7268	**To make refunds to IHCP for pharmacy claims send check to:** **EDS Pharmacy Refunds** P.O. Box 2302 Dept 130 Indianapolis, IN 46206-2303

Questions

Providers should direct questions about this bulletin to the EDS Pharmacy Services Helpdesk by calling 1-800-577-1278 or (317) 655-3240 from 8 a.m. to 5 p.m. Monday through Friday, excluding State holidays.

Attachment 1: NCPDP Version 1.1 and 5.1 Transactions Payer Sheets

Billing/Rebill Claim Request (B1/B3)

Transaction Header Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
101-A1	BIN Number	9(6)	N	610467 – IN Medicaid	Mandatory
102-A2	Version/Release Number	x(2)	A	51 – Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	B1 – Billing B3 – Rebill	Mandatory
104-A4	Processor Control Number	x(10)	A	INCAIDPROD – production INCAIDTEST- test	Mandatory
109-A9	Transaction Count	x(1)	A	1 – One occurrence 2 – Two occurrences 3 – Three occurrences 4 – Four occurrences Max of one allowed for compound transactions	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	05 – Medicaid	Mandatory
201-B1	Service Provider ID	x(15)	A	10-character billing pharmacy provider ID number assigned by IHCP (nine-digit provider number plus one alpha character location code)	Mandatory
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
110-AK	Software Vendor/Certification ID	x(10)	A		Mandatory

Patient Segment: Required					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	01 – Patient	Mandatory when segment is present
310-CA	Patient First Name	x(12)	A	Patient first name	Required
311-CB	Patient Last Name	x(15)	A	Patient last name	Required
307-C7	Patient Location	9(2)	N	00 – Not specified 03 – Nursing home 04 – Long term / extended care 11 – Hospice	Required when known 04 is to be used for a member who resides in an ICF/MR
335-2C	Pregnancy Indicator	x(1)	A	2 – Pregnant	Required when known

Insurance Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	04 – Insurance	Mandatory
302-C2	Cardholder ID	x(20)	A	12-digit Indiana Medicaid member ID number	Mandatory
301-C1	Group ID	x(15)	A	For MCO encounter claims: 10-character MCO ID (nine-digit MCO ID plus one alpha character region code) For fee for service claims: INCAID100	Required

Claim Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	07 – Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	1 – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory
436-E1	Product/Service ID Qualifier	x(2)	A	00 – Not specified 03 – National Drug Code (NDC)	Mandatory Compound: Use 00 to designate multi-ingredient product.
407-D7	Product/Service ID	x(19)	A	NDC (Drug Code) 11 characters	Mandatory Compound: Use 0 to designate multi-ingredient product.
442-E7	Quantity Dispensed	9(7).9(3)	D	Maximum of 9999999.999	Required Enter the 10 digit metric decimal quantity of the drug dispensed. Compound: Enter the quantity of entire multi-ingredient product.
403-D3	Fill Number	9(2)	N	00 – Original dispensing 01–99 – Refill number	Required
405-D5	Days Supply	9(3)	N	Estimated number of days the prescription will last	Required
406-D6	Compound Code	9(1)	N	1 – Not a compound 2 – Compound	Required Compound: Use 2

Claim Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
408-D8	Dispense as Written Code (DAW)/Product Selection Code	x(1)	A	0 – No product selection indicated 5 – Substitution allowed-brand drug dispensed as a generic 6 – Override 8 – Substitution allowed-generic drug not available in marketplace	Code indicating whether or not the prescriber's instructions regarding substitution were followed. DAW 6 is required when prescriber has written *Brand Medically Necessary* on the prescription. This may also require PA. Other values sent treated as 0
414-DE	Date Prescription Written	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required
420-DK	Submission Clarification Code	9(2)	N	08 – Process compound for approved ingredients	Situational

Claim Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
308-C8	Other Coverage Code	9(2)	N	02 – Other coverage exists – payment collected 03 – Other coverage exists – claim not covered 04 – Other coverage exists – payment not collected 05 – Managed care plan denial 06 – Other coverage denied – not participating provider 07 – Other coverage exists – not in effect on DOS 08 – Claim is billing for copay	Situational
418-DI	Level of Service	9(2)	N	00 – Not specified 03 – Emergency	Required when known

Prescriber Segment: Required					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	03 – Prescriber	Mandatory
466-EZ	Prescriber ID Qualifier	x(2)	A	08 – State license	Required
411-DB	Prescriber ID	x(15)	A	Eight-digit prescriber license number	Required: Refer to the *IHCP Provider Manual* instructions about the Indiana Prescriber License Number

COB/Other Payments Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	05 – Coordination of benefits/other payments	Mandatory when segment is present
337-4C	Coordination of Benefits/Other Payments Count	9(1)	N	1 - 9 Max of 9 allowed	Mandatory when segment is present. NCPDP recommends limiting the number of payers to three in the COB segment.
338-5C	Other Payer Coverage Type	x(2)	A	Blank -Not specified 01 – Primary 02 – Secondary 03 – Tertiary 99 – Composite	Mandatory when segment is present (Repeating)
443-E8	Other Payer Date	9(8)		CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Required when known (Repeating)
341-HB	Other Payer Amount Paid Count	9(1)	N	1 – 9 Max of 9 allowed	Required when known
342-HC	Other Payer Amount Paid Qualifier	x(2)	A	Blank – Not specified 07 – Drug benefit 08 – Sum of all reimbursement 99 – Other	Required when known (Repeating)
431-DV	Other Payer Amount Paid	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	Required when there is payment from another source (Repeating)

DUR/PPS Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	8 - DUR/PPS	Mandatory when segment is present
473-7E	DUR/PPS Code Counter	9(1)	N	1	Required when known Max of one allowed
439-E4	Reason for Service Code	x(2)	A	DD – Drug/Drug Interaction ER – Early Refill HD – High Dose LD – Low Dose LR – Late Refill MC – Drug/Disease (Reported) PA – Drug/Age PG – Drug/Pregnancy TD – Therapeutic	Required when known In the case of multiple *Reason for Service* Codes, only the last code will be processed
440-E5	Professional Service Code	x(2)	A	00 – No intervention M0 – Prescriber consulted P0 – Patient consulted R0 – Pharmacist consulted other source	Required when known Example: If the pharmacist spoke with the patient as a result of a conflict code being transmitted on a prescription, the field would reflect P0.

DUR/PPS Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
441-E6	Result of Service Code	x(2)	A	1A – Filled as is, false positive 1B – Filled prescription as is 1C – Filled, with different dose 1D – Filled, with different directions 1E – Filled, with different drug 1F – Filled, with different quantity 1G – Filled, with prescriber approval 2A – Prescription not filled 2B – Not filled, directions clarified	Required when known

Pricing Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	11 – Pricing	Mandatory
426-DQ	Usual and Customary Charge	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	Required Total amount billed
430-DU	Gross Amount Due	9(9)v99b or 9(9)v99-	D	s$$$$$$cc s9(6)v99	Required when submitting claim with Other Coverage Code 8 in field 308-C8 (billing for TPL copay only)

Compound Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	10 – Compound	Mandatory when segment is present Field 406-D6 in the Claim Segment must be = 2
450-EF	Compound Dosage Form Description Code	x(2)	A	Blank – Not Specified 01 – Capsule 02 – Ointment 03 – Cream 04 – Suppository 05 – Powder 06 – Emulsion 07 – Liquid 10 – Tablet 11 – Solution 12 – Suspension 13 – Lotion 14 – Shampoo 15 – Elixir 16 – Syrup 17 – Lozenge 18 – Enema	Mandatory when segment is present
451-EG	Compound Dispensing Unit Form Indicator	9(1)	N	1 – Each 2 – Grams 3 – Milliliters	Mandatory when segment is present

Compound Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
452-EH	Compound Route of Administration	9(2)	N	0 – Not Specified 1 – Buccal 2 – Dental 3 – Inhalation 4 – Injection 5 – Intraperitoneal 6 – Irrigation 7 – Mouth/Throat 8 – Mucous Membrane 9 – Nasal 10 – Ophthalmic 11 – Oral 12 – Other/Miscellaneous 13 – Otic 14 – Perfusion 15 – Rectal 16 – Sublingual 17 – Topical 18 – Transdermal 19 – Translingual 20 – Urethral 21 – Vaginal 22 – Enteral	Mandatory when segment is present
447-EC	Compound Ingredient Component Count	9(2)	N	01 – 40	Mandatory when segment is present
488-RE	Compound Product ID Qualifier	x(2)	A	03 – NDC Code	Mandatory when segment is present (Repeating)
489-TE	Compound Product ID	X(19)	A	NDC (Drug Code) 11 characters	Mandatory when segment is present (Repeating)
448-ED	Compound Ingredient Quantity	9(7).9(3)	D	Compound Ingredient Quantity 9999999.999	Mandatory when segment is present (Repeating)

Clinical Segment: Optional					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	13 – Clinical	Mandatory when segment present
491-VE	Diagnosis Code Count	9(1)	N	1 Max of 1 allowed	Required when known
492-WE	Diagnosis Code Qualifier	x(2)	A	01 – International Classification of Diseases (ICD-9)	Required when known
424-DO	Diagnosis Code	x(15)	A	Three to seven digit alpha/numeric code. One occurrence allowed.	Required when known

B2 Claim Reversal

Transaction Header Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
101-A1	BIN Number	9(6)	N	610467 – IN Medicaid	Mandatory
102-A2	Version/Release Number	x(2)	A	51– Version 5.1	Mandatory
103-A3	Transaction Code	x(2)	A	B2 – Reversal	Mandatory
104-A4	Processor Control Number	x(10)	A	INCAIDPROD – production INCAIDTEST – test	Mandatory
109-A9	Transaction Count	x(1)	A	1 – One occurrence 2 – Two occurrences 3 – Three occurrences 4 – Four occurrences	Mandatory
202-B2	Service Provider ID Qualifier	x(2)	A	05 – Medicaid	Mandatory
201-B1	Service Provider ID	x(15)	A	Ten character billing pharmacy provider ID number assigned by IHCP (nine-digit provider number plus one alpha character location code)	Mandatory

Transaction Header Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
401-D1	Date of Service	9(8)	N	CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
110-AK	Software Vendor/Certification ID	x(10)	A	Spaces	Mandatory

Claim Segment: Mandatory					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
111-AM	Segment Identification	x(2)	A	07 – Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	x(1)	A	1 – Rx billing	Mandatory
402-D2	Prescription/Service Reference Number	9(7)	N	Prescription number	Mandatory
436-E1	Product/Service ID Qualifier	x(2)	A	03 – NDC Code	Mandatory
407-D7	Product/Service ID	x(19)	A	NDC (Drug Code) 11 characters	Mandatory

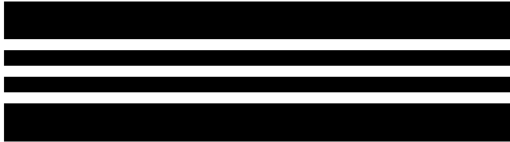
NCPDP Version 1.1 Batch Transaction

Header Record Definition: Mandatory					
(Only one Version 1.1 Transaction Header Record per batch transmission file)					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
880-K4	Text Indicator	X(1)	A	Start of Text (STX) – X02	Mandatory
701	Segment Identifier	X(2)	A	00 – File header	Mandatory
880-K6	Transmission Type	X(1)	A	T – Transaction R – Response E – Error	Mandatory
880-K1	Sender ID	X(24)	A	The four-byte sender ID assigned by the IHCP (Trading Partner ID)	Mandatory
806-5C	Batch Number	9(7)	N	Assigned by the sender and must match the Transaction Trailer Batch Number field	Mandatory
880-K2	Creation Date	9(8)	N	Date Filled Format – CCYYMMDD CC – Century YY – Year MM – Month DD – Day	Mandatory
880-K3	Creation Time	9(4)	N	Time Filled Format – HHMM HH – Hour MM – Minute	Mandatory
702	File Type	X(1)	A	P – Production T – Test	Mandatory
102-A2	Version/Release Number	X(2)	A	11 – Version 1.1	Mandatory
880-K7	Receiver ID	X(24)	A	Indiana Medicaid BIN # – 610467	Mandatory
880-K4	Text Indicator	X(1)	A	End of text (ETX) – X03	Mandatory

Detail Data Record Definition: Required					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
880-K4	Text Indicator	X(1)	A	Start of text (STX) – X02	Mandatory
701	Segment Identifier	X(2)	A	G1 – Detail data record	Mandatory
880-K5	Transaction Reference Number	X(10)	A	The Transaction Reference Number is assigned by the pharmacy and is used to explicitly tie a response back to the original claim	Mandatory
	NCPDP Version 5.1 Data Record			The data record to be transmitted in this batch standard will follow the *NCPDP Telecommunication Standard Version 5.1*. Length will vary	Mandatory Use the *IHCP Version 5.1 Payer Sheet* for the *Detail Data Record* instructions
880-K4	Text Indicator	X(1)	A	End of text (ETX) – X03	Mandatory

Batch Transaction Trailer Definition: Required					
(Only one Version 1.1 Transaction Trailer Record per batch transmission file)					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
880-K4	Text Indicator	X(1)	A	Start of text (STX) – X02	Mandatory
701	Segment Identifier	X(2)	A	99 – File trailer	Mandatory
806-5C	Batch Number	9(7)	N	Assigned by the sender and must match the Transaction Header Batch Number field.	Mandatory
751	Record Count	9(10)	N	Count of Version 1.1 Batch records (one Version 1.1 Batch Transaction Header, one to many Version 1.1 Batch Transaction Detail Data Records, and one Version 1.1 Batch Transaction Trailer) The record count field includes the total number of Version 1.1 records in the batch, including the header and trailer records. The maximum number of records in a file is 9,999,999,999 including one Transaction Header and one Transaction Trailer.	Mandatory

Batch Transaction Trailer Definition: Required					
(Only one Version 1.1 Transaction Trailer Record per batch transmission file)					
Field	**Field Name**	**Field Format**	**Type**	**Value**	**Comments**
504-F4	Message	X(35)	A	The message field can be used to further explain the reasons why the entire batch is in error or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data.	Situational
880-K4	Text Indicator	X(1)	A	End of text (ETX) - X03	Mandatory



PLEASE PRINT CLEARLY	Indiana Family and Social Services Administration

Indiana Medicaid
COMPOUNDED PRESCRIPTION CLAIM FORM

MEMBER NAME: LAST, FIRST 1	RID NO. 2	PRESCRIBER'S LICENSE NUMBER 3	EMERGENCY 4	PREG 5	PATIENT LOCATION CODE 6

DAW CODE 7	REFILL NUMBER 8	PRESCRIPTION NUMBER 9	DATE PRESCRIBED 10	DATE DISPENSED 11	TOTAL QUANTITY DISPENSED 12	DAYS SUPPLY 13

USUAL & CUSTOMARY CHARGE 14	ROUTE OF ADMINISTRATION CODE 15	SUBMISSION CLARIFICATION CODE 16	OTHER COVERAGE CODE 17	TPL AMOUNT PAID 18	OTHER AMOUNT CLAIMED SUBMITTED 19	GROSS AMOUNT DUE 20

LINE NUMBER	21 NDC NUMBER	22 DESCRIPTION OF INGREDIENT	23 INGREDIENT QUANTITY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

PROVIDER'S NAME AND ADDRESS

24

PROVIDER NUMBER

25

PROVIDER TYPE

☐ PHARMACY

☐ PHYSICIAN

☐ DENTIST

☐ OTHER

26

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable Federal or State laws.

I, the undersigned, being aware of restricted funds in the Medicaid Program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative ☐ 27

Date Filed 28

MAIL COMPLETED CLAIM FORM TO:
EDS Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

Indiana Family and Social Services Administration

PLEASE PRINT CLEARLY

The claim information below is an example for illustrative purposes only.

Indiana Medicaid

DRUG CLAIM FORM

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
EXAMPLE: Smith, Betty	01099955	NO	NO	0

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANTITY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)
100000000099	0654321	0	6	30.000	30	27.99

DATE PRESCRIBED (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)
08/17/2004	01/24/2005	999991-9999-01	0.00	00	0.00	

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
1				

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANITTY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)

DATE PRESCRIBED (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
2				

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANTITY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)

DATE PRESC (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
3				

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANTITY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)

DATE PRESCRIBED (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
4				

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANTITY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)

DATE PRESCRIBED (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)

MEMBER NAME: LAST, FIRST (01)	PRESCRIBER'S LICENSE NUMBER (02)	EMERGENCY (03)	PREGNANT (04)	PATIENT LOCATION CODE (05)
5				

RID NO. (06)	PRESCRIPTION NUMBER (07)	DAW CODE (08)	REFILL NUMBER (09)	QUANTITY DISPENSED (10)	DAYS SUPPLY (11)	USUAL & CUSTOMARY CHARGE (12)

DATE PRESCRIBED (13)	DATE DISPENSED (14)	NDC NUMBER (15)	TPL AMOUNT PAID (16)	OTHER COVERAGE CODE (17)	OTHER AMOUNT CLAIMED SUBMITTED (18)	GROSS AMOUNT DUE (19)

PROVIDER'S NAME AND ADDRESS

☐

20

PROVIDER TYPE

- ☐ PHARMACY
- ☐ PHYSICIAN
- ☐ DENTIST
- ☐ OTHER

21

PROVIDER MEDICAID NUMBER

22

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable federal or state laws.

I, the undersigned, being aware of restricted funds in the IHCP Program, agree to accept as full payment for services enumerated on this claim form, for this IHCP patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

SIGNATURE OF PROVIDER OR REPRESENTATIVE

☐ 23

DATE FILED

24

MAIL COMPLETED CLAIM FORM TO:

EDS Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268