Instructions For Completing Drug Adjustment Form (GAINWELL TECHNOLOGIES 211)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE VENDOR OR AUTHORIZED REPRESENTATIVE.

Field No.	Field Name	Entry	Description
1	**ADJUSTMENT/VOID/ OVR**	Required	**ADJUSTMENT/VOID/OVR:** Check the appropriate box for Adjustment, Void, or DUR Override.
2	**RECIPIENT IDENTIFICATION NUMBER**	Required	**ADJUSTMENT/VOID:** Enter recipient's 13-digit Medicaid ID number exactly as it appeared on the original claim form.
3	**QUANTITY**	Required	**ADJUSTMENT:** Enter the correct information or exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form.
4	**Rx PRICE**	Required	**ADJUSTMENT**: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID**: Enter the information exactly as it appeared on the original claim form.
5	**PRESCRIBING PROVIDER NPI**	Required	**ADJUSTMENT/VOID:** Enter the 10-digit National Provider Identifier for the prescribing practitioner**.**
6	**Rx DATE**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. **VOID:** Enter the information exactly as it appeared on the original claim form**.**
7	**= # DAYS SPLY**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form**.**
8	**Rx NO.**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form**.**
9	**PROVIDER NAME**	Not required	**ADJUSTMENT/VOID:** Enter the name exactly as it appeared on the original claim form.
10	**PROVIDER NO.**	Required	**ADJUSTMENT/VOID:** Enter the pharmacy provider number exactly as it appeared on the original claim form.

Field No.	Field Name	Entry	Description
11	**LEVEL OF SERV**	Not required	**ADJUSTMENT/VOID:** Enter NCPDP value of“03” if the service was provided on an emergency basis and no co-pay was collected.
12	**PATIENT LOCATION**	Not required	**ADJUSTMENT/VOID:** Enter NCPDP Patient Location Code value of “04”if the service was for an LTC recipient and no co-pay was collected**.**
13	**DATE Rx FILLED**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. **VOID:** Enter the information exactly as it appeared on the original claim form**.**
14	**PROVIDER NPI**	Required	**ADJUSTMENT/VOID:** Enter the pharmacy’s National Provider Identifier number exactly as it appeared on the original claim form.
15	**REFILL CODE**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form**.** Note: Where “0” = New Rx, “1,2, 3, 4, 5” = Refill of prescription
16	**DIAGNOSIS CODE**	Required, if applicable	**ADJUSTMENT/VOID:** Enter valid Diagnosis Code if applicable.
17	**ELIG CLAR**	Not required	**ADJUSTMENT/VOID:** Enter NCPDP value if applicable.
18	**MANUFACTURER NO**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form.
19	**PRODUCT NO.**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form.
20	**PKG NO.**	Required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected.

Field No.	Field Name	Entry	Description
			VOID: Enter the information exactly as it appeared on the original claim form.
21	**MAC OVERRIDE**	Required, if applicable	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form.
22	**ADMINSTERING PROVIDER NPI**	Required if applicable	**ADJUSTMENT:** Enter the 10-digit National Provider Identifier of the provider who administered the pharmaceutical. **VOID:** Enter the 10-digit National Provider Identifier of the provider who administered the pharmaceutical.
23	**ADMINISTERING PROVIDER QUALIFIER**	Required if applicable.	**ADJUSTMENT:** Enter the 2-digit qualifier code of the provider who administered the pharmaceutical. **VOID:** Enter the 2-digit qualifier code of the provider who administered the pharmaceutical.
24	**DRUG COVERAGE OTHER THAN TITLE XIX (TPL BOX)**	Not required	**ADJUSTMENT:** Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. **VOID:** Enter the information exactly as it appeared on the original claim form.
25	**TPL CARRIER CODE (TPL BOX)**	Not required	**ADJUSTMENT/VOID:** Enter valid Louisiana Carrier Code if applicable.
26	**PATIENT NAME**	Required	**ADJUSTMENT/VOID:** Enter the name exactly as it appeared on the original claim form.
	THIS BLOCK IS FOR PROVIDERS TO USE FOR DUR OVERRIDES		
27	**REASON FOR SERVICE**	Not required	**(DUR CONFLICT) OVERRIDE: Enter the Reason for Service Code associated with the Error to be overridden. (Example: ER for Early Refill).**
28	**PROFESSIONAL SERVICE CODE**	Not required	**(DUR INTERVENTION) OVERRIDE: Enter the Professional Service Code that describes the intervention activity performed by the pharmacist. (Example: MO for Prescriber Consulted).**
29	**RESULT OF SERVICE**	Not required	**(DUR OUTCOME) OVERRIDE: Enter the Result of Service Code describing the disposition of the prescription. (1G for Filled with Prescriber Approval).**

Field No.	Field Name	Entry	Description
		BOTTOM OF FORM	
30	**CONTROL NUMBER**	Required	Enter the 13-digit correct control number (CCN) exactly as it appears on your Remittance Advice).
31	**DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID**	Required	Enter the exact date of the Remittance Advice using (8) digits, i.e.,
32	**REASONS FOR ADJUSTMENT**	Required, if applicable	Place an "X" in the appropriate box and describe the reason for the adjustment, where the values are: **'01' = Third Party Liability Recovery** **'02' = Provider Corrections** **'03' = Fiscal Agent Error** **'90' = State Office Use Only – Recovery** **'99' = Other – please explain.**
33	**REASONS FOR VOID**	Required if applicable	Place an "X" in the appropriate box describing the reason for the void, where the values are: **'10' = Claim Paid for Wrong Recipient** **'11' = Claim Paid to Wrong Provider** **'99' = Other – please explain**
34	**SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE**	Required	**ADJUSTMENT/VOID**: Enter the complete and legal signature of vendor or his/her authorized representative.
35	**DATE**	Required	**ADJUSTMENT/VOID**: Enter the date this form was completed using (8) digits. i.e., MM/DD/YYYY format.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE DRUG ADJUSTMENT FORM, PLEASE CONTACT THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT GAINWELL TECHNOLOGIES (225) 216-6381 OR (800) 648-0790.

MAIL TO:
GAINWELL TECHNOLOGIES/LA MEDICAID
P.O. BOX 91019
BATON ROUGE, LA 70821
(800) 648-0790

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL ASSISTANCE PROGRAM
DRUG ADJUSTMENT FORM

(1) ADJ | VOID | OVR

(2) RECIPIENT IDENTIFICATION NUMBER

TPL

DRUG COVERAGE OTHER THAN TITLE XIX
(24) $ _____ AMOUNT

TPL CARRIER CODE **(25)**

1. _____
2. _____
3. _____

(3) QUANTITY

(4) Rx PRICE

(5) PRESCRIBING PROVIDER NPI

(6) Rx DATE (MM/DD/YYYY)

(7) = #DAYS SPLY

(8) Rx NUMBER

(9) PROVIDER NAME

PATIENT NAME **(26)**

_____
Last Name (first five characters)

_____
First Name (first character)

(10) PROVIDER MEDICAID NO.

(11) Level of Serv

(12) Patient Location

(13) DATE Rx FILLED(MM/DD/YYYY)

(14) PROVIDER NPI

(15) 0 = NEW Rx
1-5 = REFILL
REFILL CODE

(16) DIAGNOSIS CODE

(17) ELIG CLAR

(18) MANUFACTURER NO.

(19) PRODUCT NO.

(20) PKG NO

(21) MAC Override

(22) ADMINISTERING PROVIDER NPI

(23) ADMINISTERING PROVIDER QUALIFIER

DUR
(27) REASON FOR SERVICE (DUR CONFLICT)
(28) PROFESSIONAL SERVICE CODE (DUR INTERVENTION)
(29) RESULT OF SERVICE (DUR OUTCOME)

(30) CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

(31) DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAM WAS PAID (MM/DD/YYYY)

(32) REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY – RECOVERY
- ☐ 99 OTHER – PLEASE EXPLAIN

(33) REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER – PLEASE EXPLAIN

I HAVE READ, UNDERSTAND, AND ACKNOWLEDGE THE CERTIFICATION STATEMENT ON THE REVERSE SIDE OF THIS ADJUSTMENT FORM. I HEREBY AGREE TO AND ACCEPT THE TERMS THEREOF.

(34) _____
SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE

(35) _____
DATE (MM/DD/YYYY)

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06/23