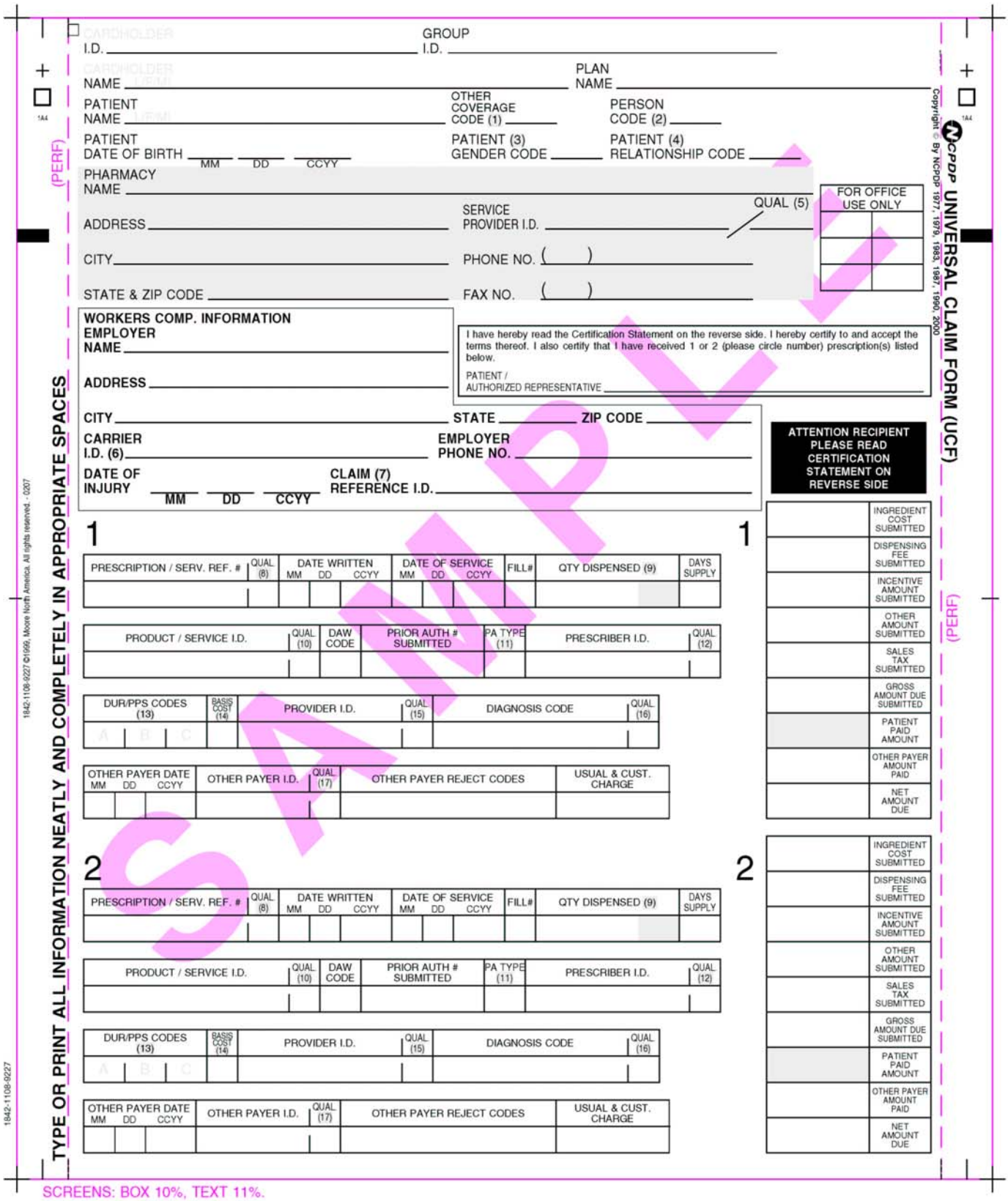
NCPDP Universal Claim Form Sample



SCREENS: BOX 10%, TEXT 11%.

Instructions For Completing NCPDP Universal Claim Form (UCF)

Field No.	Field Name	Entry	Description
N/A	**I.D.**	Required	Enter the recipient's 13 digit Medicaid ID.
N/A	**GROUP I.D.**	Not required	
N/A	**NAME**	Not required	
N/A	**PLAN NAME**	Not required	
N/A	**PATIENT NAME**	Required	Enter the Recipient's full name: First, Last.
Field 1	**OTHER COVERAGE CODE**	Not required	Complete 'OTHER COVERAGE CODE' using the values noted below: 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 co-pay
Field 2	**PERSON CODE**	Not required	The code assigned to a specific person within a family must be entered in this field.
N/A	**PATIENT DATE OF BIRTH**	Not required	Enter the Recipient's Date of Birth in MM/DD/CCYY format.
Field 3	**PATIENT GENDER**	Not required	Complete using the values noted below: 0 = Not specified 1 = Male 2 = Female
Field 4	**PATIENT RELATIONSHIP CODE**	Required	Must be completed using a value of '**1'**, identifying a cardholder.
N/A	**PHARMACY NAME**	Not required	Enter the pharmacy name.
N/A	**ADDRESS**	Not required	Enter the Address of the pharmacy.
N/A	**SERVICE PROVIDER ID**	Required	Enter the 7-digit Medicaid Provider ID
Field 5	**SERVICE PROVIDER ID QUALIFIER**	Required	Must be completed using a value of '**05'** identifying Medicaid.
N/A	**CITY**	Not required	Enter the City name for the address of the Pharmacy
N/A	**PHONE NO.**	Not required	Enter the phone number for the Pharmacy: (999) 999-9999.
N/A	**STATE & ZIP CODE**	Not required	Enter the State code and Zip Code of the address of the Pharmacy.
N/A	**FAX NO.**	Not required	
Workers Comp.	**EMPLOYER NAME**	Not required	
N/A	**ADDRESS**	Not required	Employer Address
N/A	**CITY**	Not required	Employer City
N/A	**STATE**	Not required	Employer State
N/A	**ZIP CODE**	Not required	Employer Zip Code

Field No.	Field Name	Entry	Description
Field 6	**CARRIER ID**	Not required	Employer Carrier ID
N/A	**EMPLOYER PHONE NO**	Not required	Employer Phone Number
N/A	**DATE OF INJURY**	Not required	Workers Comp. Date of Injury
Field 7	**CLAIM/REFERENCE ID**	Not required	Workers Comp Claim/Reference ID
SECTION 1	**FIRST CLAIM**		
N/A	**PRESCRIPTION/SERVICE REFERENCE #**	Required	Enter the prescription number
Field 8	**QUAL.**	Required	Must be completed using a value of '**1'** identifying an Rx billing.
N/A	**DATE WRITTEN**	Required	Enter the date the prescription was written by the prescriber in MMDDCCYY format.
N/A	**DATE OF SERVICE**	Required	Enter the date the prescription was filled in MMDDCCYY format.
N/A	**FILL #**	Required	Enter 0 if new prescription; 1 for first refill, 2 for second refill, etc.
Field 9	**QTY DISPENSED**	Required	Quantity dispensed expressed in metric decimal units (*shaded areas for decimal values*).
N/A	**DAYS SUPPLY**	Required	Enter the Days Supply.
N/A	**PRODUCT/SERVICE ID**	Required	Enter the NDC for the drug filled
Field 10	**QUAL.**	Required	Must be completed using a value of **'03'** identifying National Drug Code (NDC).
N/A	**DAW CODE**	Required, if applicable	Enter valid Dispense as Written (DAW) code: 0 = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed - Patient Requested Product Dispensed 3 = Substitution Allowed - Pharmacist Selected Product Dispensed 4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug Dispensed as a Generic **6 = Override, used to indicate MAC pricing applies.** 7 = Substitution Not Allowed - Brand Drug Mandated by Law 8 = Substitution Allowed - Generic Drug Not Available in Marketplace 9 = Other
N/A	**PRIOR AUTH # SUBMITTED**	Not required	

Field No.	Field Name	Entry	Description
Field 11	**PA TYPE**	Not required	Prior Authorization Type code must be completed using the following values noted below: 0 = Not specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from co-pay **5 = indicates exemption from service limits*** 6 = indicates family planning drugs* 7 = Temporary Assistance for Needy Families (TANF) **8 = indicates co-pay exemption due to pregnancy***
N/A	**PRESCRIBER ID**	Required	Enter the 7-digit Medicaid prescriber provider number.
Field 12	**QUAL.**	Required	Must be completed using a value of **'05'** indicating Medicaid.
Field 13	**DUR/PROFESSIONAL SERVICE CODES**	Required, if applicable	Reason for Service, Professional Service Code and Result of Service Codes. For values refer to current NCPDP data dictionary. Block 1 (Reason for Service) Block 2 (Professional Service) Block 3 (Result of Service) Examples: Block 1 – ER (Early Refill) Block 2 – M0 (Prescriber Consulted) Block 3 – 1G (Filled, with prescriber approval)
Field 14	**BASIS OF COST DETERMINATION**	Not required	
N/A	**PROVIDER ID**	Not required	
Field 15	**PROVIDER ID QUALIFIER**	Not required	
N/A	**DIAGNOSIS CODE**	Required, if applicable	May be required for payment of specific drugs. See the POS Users' Manual for situations where Diagnosis Code is required.
Field 16	**DIAGNOSIS CODE QUALIFIER**	Required, if applicable	Must be completed using a value of '**01',** identifying an International Classification of Diseases (ICD9) code.
N/A	**OTHER PAYER DATE**	Required if TPL is reported.	Date other payer made payment on the pharmacy service.
N/A	**OTHER PAYER ID**	Required if TPL is reported.	Enter the Louisiana Medicaid Carrier ID
Field 17	**QUAL.**	Required	Must be completed using a value of '**99**', identifying 'Other' for a Medicaid Carrier ID.
N/A	**OTHER PAYER REJECT CODES**	Required if TPL has been billed.	Enter the primary NCPDP reject Code associated with the Other Payer denial of the claim for payment.

Field No.	Field Name	Entry	Description
N/A	**USUAL & CUST. CHARGE**	Required	Enter the billed charges for the claim (Usual and Customary Charge).
N/A	**INGREDIENT COST SUBMITTED**	Not required	
N/A	**DISPENSING FEE SUBMITTED**	Not required	Standard Medicaid payable dispensing fee will be used to calculate payment.
N/A	**INCENTIVE AMOUNT SUBMITTED**	Not required	
N/A	**OTHER AMOUNT SUBMITTED**	Not required	
N/A	**SALES TAX SUBMITTED**	Not required	
N/A	**GROSS AMOUNT DUE SUBMITTED**	Not required	Claim will be paid using Usual and Customary Charge
N/A	**PATIENT PAID AMOUNT**	Not required	Enter the amount of co-payment collected from the Recipient.
N/A	**OTHER PAYER AMOUNT PAID**	Required, if TPL amount was received.	Enter the amount paid by the Other Payer.
N/A	**NET AMOUNT DUE**	Not required	
SECTION 2	**SECOND CLAIM**		Complete this section same as above when second prescription is billed for the same Recipient.
N/A	**PATIENT/AUTHORIZED REPRESENTATIVE**	Required	Signature of patient or authorized representative required.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE NCPDP UNIVERSAL CLAIM FORM (UCF), PLEASE CONTACT THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT UNISYS OR CALL 800-648-0790 or (225) 237-3381.