I.D.		I.D	PLAN		
NAME		OTHER			
PATIENT NAME		COVERAGE CODE (1)	PERSON CODE (2)		
DATIENT			PATIENT (4) RELATIONS		
DATE OF BIRTH	MM DD CCYY	GENDER CODE	RELATIONS	HIP CODE	
NAME				QUAL (5)	FOR OFFICE
ADDRESS		SERVICE PROVIDER I.D.			FOR OFFICE USE ONLY
CITY		PHONE NO. (	5	-	
	DE	FAX NO. \		-	
EMPLOYER	P. INFORMATION	I have hereby read	the Certification Statement or	n the reverse side. I hereby o	certify to and accept the
NAME		below.	so certify that I have received	1 or 2 (please circle numb	er) prescription(s) listed
ADDRESS		AUTHORIZED REPR	ESENTATIVE		
CITY		STATE	ZIP CODE		
CARRIER I.D. (6)		EMPLOYER PHONE NO		10.001	ENTION RECIPIENT PLEASE READ
DATE OF	CLAIM	(7)		S	CERTIFICATION
INJURYM	DD CCYY REFERE	ÉNCE I.D.			REVERSE SIDE
1				1	INGREDIENT COST SUBMITTED
	EDV DEE # IQUAL DATE WRITTEN	DATE OF SERVICE FILL#		DAYS	DISPENSING FEE SUBMITTED
PRESCRIPTION / S	ERV. HEF. # (8) MM DD CCYY		QTY DISPENSED (9)	SUPPLY	INCENTIVE AMOUNT SUBMITTED
PRODUCT	SERVICE I.D. QUAL DAW (10) CODE	PRIOR AUTH # PA TYPE SUBMITTED (11)	PRESCRIBER I.D.	QUAL (12)	OTHER AMOUNT SUBMITTED
					SALES TAX SUBMITTED
DUR/PPS CODE	BASIS PROVIDER I.D.		QUAL		GROSS AMOUNT DUE SUBMITTED
(13)	BASIS COST PROVIDER I.D.	(15) DIAGNOSIS (	(16)		PATIENT PAID AMOUNT
N 0					OTHER PAYER
OTHER PAYER DAT		THER PAYER REJECT CODES	USUAL & CUST. CHARGE		AMOUNT
	K				AMOUNT DUE
					INGREDIENT
2				2	COST SUBMITTED
PRESCRIPTION / S	ERV REF # QUAL DATE WRITTEN	DATE OF SERVICE FILL#	QTY DISPENSED (9)	DAYS	DISPENSING FEE SUBMITTED
	(8) MM DD CCYY	MM DD CCYY	arr bior criticite (b)	SUPPLY	INCENTIVE AMOUNT SUBMITTED
					OTHER
PRODUCT	SERVICE I.D. QUAL DAW CODE	PRIOR AUTH # PA TYPE SUBMITTED (11)	PRESCRIBER I.D.	QUAL (12)	SUBMITTED
					SUBMITTED
DUR/PPS CODE	S BASIS COST PROVIDER I.D.	QUAL DIAGNOSIS			GROSS AMOUNT DUE SUBMITTED
(13)	(14) PROVIDER I.D.	(15) DIAGNOSIS (	(16)		PATIENT PAID
					OTHER PAYER
OTHER PAYER DAT	E OTHER PAYER I.D. QUAL (17) C	THER PAYER REJECT CODES	USUAL & CUST. CHARGE		AMOUNT PAID
					AMOUNT DUE
10 - 14 - 1870 -	and the state		Ka (8)	1	101

## NCPDP Universal Claim Form Sample

## Instructions For Completing NCPDP Universal Claim Form (UCF)

<u>Field No.</u> N/A N/A N/A N/A	<u>Field Name</u> I.D. GROUP I.D. NAME PLAN NAME	<u>Entry</u> Required Not required Not required Not required	Description Enter the recipient's 13 digit Medicaid ID.
N/A Field 1	PATIENT NAME OTHER COVERAGE CODE	Required Not required	<ul> <li>Enter the Recipient's full name: First, Last.</li> <li>Complete 'OTHER COVERAGE CODE' using the values noted below:</li> <li>0 = Not specified</li> <li>1 = No other coverage identified</li> <li>2 = Other coverage exists – payment collected</li> <li>3 = Other coverage exists – this claim not covered</li> <li>4 = Other coverage exists – payment not collected</li> <li>5 = Managed care plan denial</li> <li>6 = Other coverage denied – not a participating provider</li> <li>7 = Other coverage exists – not in effect at time of service</li> <li>8 = Claim is billing for a co-pay</li> </ul>
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
Field 4	PATIENT RELATIONSHIP CODE	Required	2 = Female Must be completed using a value of ' <b>1</b> ', 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 ' <b>05'</b> identifying Medicaid.
N/A	СІТҮ	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

<u>Field No.</u> Field 6 N/A N/A Field 7	<u>Field Name</u> CARRIER ID EMPLOYER PHONE NO DATE OF INJURY CLAIM/REFERENCE ID	<u>Entry</u> Not required Not required Not required Not required	<u>Description</u> Employer Carrier ID Employer Phone Number Workers Comp. Date of Injury Workers Comp Claim/Reference ID
SECTION 1	FIRST CLAIM	_	
N/A	PRESCRIPTION/SERVICE	Dequired	Enter the prescription number
IN/A	REFERENCE #	Required	Enter the prescription number
Field 8	QUAL.	Required	Must be completed using a value of ' <b>1'</b> 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 <b>'03'</b> identifying National Drug Code (NDC).
N/A	DAW CODE	Required, if applicable	<ul> <li>Enter valid Dispense as Written (DAW) code:</li> <li>0 = No Product Selection Indicated</li> <li>1 = Substitution Not Allowed by Prescriber</li> <li>2 = Substitution Allowed - Patient Requested Product Dispensed</li> <li>3 = Substitution Allowed - Pharmacist Selected Product Dispensed</li> <li>4 = Substitution Allowed - Generic Drug Not in Stock</li> <li>5 = Substitution Allowed - Brand Drug Dispensed as a Generic</li> <li>6 = Override, used to indicate MAC pricing applies.</li> <li>7 = Substitution Not Allowed - Brand Drug Mandated by Law</li> <li>8 = Substitution Allowed - Generic Drug Not Available in Marketplace</li> <li>9 = Other</li> </ul>
N/A	PRIOR AUTH # SUBMITTED	Not required	

Field No.	Field Name	<u>Entry</u>	Description
Field 11	ΡΑ ΤΥΡΕ	Not required	Prior Authorization Type code must be completed using the following values noted below:
			<ul> <li>0 = Not specified</li> <li>1 = Prior Authorization</li> <li>2 = Medical Certification</li> <li>3 = EPSDT (Early Periodic Screening Diagnosis Treatment)</li> <li>4 = Exemption from co-pay</li> <li>5 = indicates exemption from service limits*</li> <li>6 = indicates family planning drugs*</li> <li>7 = Temporary Assistance for Needy Families (TANF)</li> <li>8 = indicates co-pay exemption due to pregnancy*</li> </ul>
N/A	PRESCRIBER ID	Required	Enter the 7-digit Medicaid prescriber provider number.
Field 12	QUAL.	Required	Must be completed using a value of <b>'05'</b> 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 ' <b>01',</b> 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 ' <b>99</b> ', 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	<u>Entry</u>	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.