Appendix 10

Sample Paper Claim Form — Pharmaceutical Care

Form 98-1141 (8/98). Replaces 482-020
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

ICN (DO NOT WRITE IN THIS SPACE)

1. PROVIDER NAME AND ADDRESS
I.M. Provider
1 West Williams
Anytown, WI 55555

2. PROVIDER NUMBER
12345678

Wisconsin Medicaid

NON-COMPOUND DRUG CLAIM FORM

RECIPIENT INFORMATION

3. MEDICAID NUMBER	4. LAST NAME	5. FIRST NAME	6. SEX	7. DATE OF BIRTH
1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

	8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
1	AS7654321	12/20/00	12/20/00	00 00	00168 0199 15	30	15	$XX.XX
2	AS1234567	11/20/00	12/20/00	00 00	00781 1232 13	30	60	$XX.XX
3								$
4								$

	16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS
1	0	3942877	0	Timolol 0.25% eye drops	08
2	1	1279433	0	Enalapril 10 mg tablet	08
3					
4					

	21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME
1	V72.0	13	EX	MO	1C
2					
3					
4					

26. CERTIFICATION

I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE I.M. Provider DATE 01/01/01

27. PRIOR AUTHORIZATION NUMBER

28. O.C.

PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV-IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR'S OFFICE)

30. O.C. AMOUNT $XX.XX

31. PATIENT PAID $

32. NET BILLED $XX.XX

Appendix