PHARMACY CLAIM INSTRUCTIONS

PURPOSE

Used by pharmacies that have signed a working agreement (DSB-4020: Pharmacy Agreement) with the Division of Services for the Blind (DSB) to provide pharmaceutical services to eligible individuals of the agency. These drugs include those authorized for diagnostic, palliative, or therapeutic purposes.

Prescription drugs must be billed at the Acquisition Cost plus a professional dispensing fee set by Department of Health Human Services (DHHS). It will be the responsibility of the Program Benefit/ Payment Section of the DHHS to ensure that the First Data Bank Price Alerts Blue Book costs are correct.

It is the responsibility of the Nursing Eye Care Consultant for the Medical Eye Care (MEC) Program and the DSB Vocational Rehabilitation (VR) Counselor approving the bill to be sure that the professional fee has not been charged more than one time per calendar month per prescription drug per eligible individual.

PREPARED BY

Pharmacy

INSTRUCTIONS

Preparation: For each eligible individual, submit one claim monthly that contains all charges for a single calendar month.

1a. National Provider Identifier (NPI) No.: Enter the pharmacy's National Provider Identifier number

1b. Tax ID No.: Enter the pharmacy tax identification number

2a. Pharmacy: Enter the pharmacy's full name

2b. Address: Enter the pharmacy address to include: street/Post office box, city, state and five-digit zip code

3. Telephone: Enter the pharmacy's 10-digit telephone number

4. Billing Date: Enter the two-digit month, two-digit day, and four-digit date the bill is being mailed to DSB

5. Patient's Name per Eligibility: Enter the individual's full name to include last name, first name

D. O. B: Enter the two-digit month, two-digit day, and four-digit year for the birth date

6. Patient's Address: Enter the patient's address to include city, state, and five-digit zip code

7. Client No.: Enter the last four-digits of the individual's social security number

Authorization No.: Enter the DSB authorization number for the medication(s)

8. Other Third Party Coverage: Enter any other third party coverage, the full address of the other third party insurance, and the 10-digit telephone number.

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In spaces 9(A) through 9(J), enter the information about prescription drugs as described below (NOTE: A prescription legend drug is defined as one that bears the statement "CAUTION: Federal Law Prohibits Dispensing without Prescription" on the label of the manufacturer's original package. Assigning a prescription number to a non-prescription drug does not make it a prescription drug, even if a prescription has been issued. Exception: All pharmacist-compounded prescription orders are considered to be prescription drugs.):

9(A) PRESCRIPTION NUMBER: The prescription (or file) number assigned by the individual pharmacy.

9(B) NAME OF DRUG: The brand name (proprietary name) of the drug actually dispensed, or the generic name (non-proprietary name) of the non-branded drug actually dispensed.

9(C) NDC NO.: The National Drug Code (NDC) number assigned to the product actually dispensed.

9(D) STRENGTH: The concentration of drug per unit volume or per unit weight.

9(E) QUANTITY or Package Size: The quantity of drug dispensed, e.g., number of tabs, caps, ml, cc, oz. or items.

9(F) DATE FILLED: The date the prescription order was actually filled.

9(G) EST DAY'S SUPPLY: The estimated number of days the dispensed quantity of drug should last if used in accordance with the prescriber's directions.

9(H) COST: The cost of the drug. The amount you enter here will be compared to the maximum cost allowed by the Medicaid Program. If you intend to bill your usual charge to the public, you must deduct the dispensing fee here. The dispensing fee is billed in item 11(B). [NOTE: drugs covered by the Maximum Allowable Cost Program (MAC) will be reimbursed at MAC rates unless (1) a prescriber override has been made, and (2) the letters "OA" have been entered in the last two digits of the NDC number to indicate the override.]

9(I) B/G: Please indicate B for Brand or G for Generic drug

9(J) DAW Code: Indicate a valid DAW Code. 0-No Dispense as written, 1-Physician writes Dispense as Written, 5-Brand dispensed priced as Generic, 7-Substitution Not allowed; Brand mandated by Law, 8-Generic not available.

In spaces 10(A) through 10(H), enter the information about pharmacy/OTC items as described below:

10(A) PRESCRIPTION OR REFERNCE NO: The prescription (or file) number assigned, if any, assigned by the individual pharmacy.

10(B) NAME OF DRUG/ITEM: The brand name (proprietary name) of the drug or item actually dispensed, or the generic name (non-proprietary name) of the non-branded drug or item actually dispensed.

10(C) STRENGTH: The concentration of drug or item per unit volume or per unit weight.

10(D) QUANTITY or Package Size: The quantity of drug dispensed, e.g., number of tabs, caps, ml, cc, oz.; or items.

10(E) DATE SOLD: The date the order was actually filled.

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10(F) EST DAY'S SUPPLY: The estimated number of days the dispensed quantity of drug or item should last if used in accordance with the prescriber's directions.

10(G) CHARGE: The dispensing pharmacist's **usual charge** for the drug or item.

Item 11(a) Total cost of the drugs in Section 9: Enter total cost of the drugs in Section 9. Enter the total cost of all drugs in Section 9.

Item 11(b) Dispensing fee: Brand and Generic:

Item 11(c) Total charge for pharmacy Over the Counter (OTC) items in Section 10: Enter total **usual charge** for pharmacy OTC items in Section 10.

Item 11(d) Grand Total: Enter total of a, b, and c.

DISTRIBUTION

Original: Division of Services for the Blind local district office at the address listed on top of the authorization.

Disposition: Copies of this form retained by state agencies may be destroyed in accordance with the *Records Disposition Schedule* published by the N.C. Division of Archives and History.

PHARMACY CLAIM INSTRUCTIONS

TERMS AND CONDITIONS

CLAIM NOT VALID UNLESS SIGNED ON THE REVERSE BY DISPENSING PHARMACIST

1. I understand that the programs of the Division of Services for the Blind pay the Medicaid rate of reimbursement for prescription drugs and other items (the rate in effect at the time a claim is received) and that this includes reimbursement for MAC drugs.

2. I understand that payment is available only for service which has been **authorized** by a program and that claims must be received by the Division within one year after the dispensing date in order to be paid.

3. I understand that payment is available only for services not covered by another third party payer and that Medicaid must be billed for any service that can be paid by Medicaid.

4. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, and statements or documents, or concealment of a material fact, may be prosecuted under the applicable Federal and State laws.

5. I understand that payment is subject to the availability of funds.

6. I will accept payment by the Division of Services for the Blind as payment in full for services rendered.

WEBSITE: http://info.dhhs.state.nc.us/olm/forms/dsb/dsb-0511-ia.pdf