N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

PHARMACY CLAIM

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

CLAIMS MUST BE RECEIVED WITHIN ONE YEAR AFTER DISPENSING DATE IN ORDER TO BE PAID

1a. **National Provider Identifier (NPI) No.:** _____

1b. Tax ID No.: _____

2a. Pharmacy: _____

2b. Address: _____
Street

_____ _____ _____
City State Zip

3. Telephone: _____ 4. Billing Date: _____

5. Patient's Name per Eligibility: _____ _____ D.O.B: _____
Last Name First Name

6. Patient's Address: _____
City

_____ _____
State Zip

7. Client No.: _____ Authorization No.: _____

8. Other Third Party Coverage: _____

Claims Address: _____

Telephone No.: _____

9. LEGEND PRESCRIPTION DRUGS (See definition in Part 9 instructions on reverse of form.)

(A) PRESCRIPTION NUMBER	(B) NAME OF DRUG	(C) NDC NO.	(D) STRENGTH	(E) QUANTITY or Package Size	(F) DATE FILLED	(G) EST DAYS' SUPPLY	(H) COST	(I) Brand or Generic	(J) DAW Code

10. PHARMACY/OTC ITEMS (See definition in Part 10 instructions on reverse of form.) Durable medical equipment, medical supplies, and formula with HCPCS codes must be billed on the HCFA 1500 claim form.

(A) PRESCRIPTION OR REFERENCE NO.	(B) NAME OF DRUG/ ITEM	(C) STRENGTH	(D) QUANTITY or Package Size	(E) DATE SOLD	(F) EST DAY'S SUPPLY	(G) CHARGE	LEAVE BLANK

I certify that this information is accurate, and I agree to the Terms and Conditions on the reverse.

X _____
Dispensing Pharmacist's Signature
Must have original signature

11.(a) Total cost of the drugs in Section 9 $ _____

(b) Dispensing fee: Brand _____ X _____ Rx: $ _____

Dispensing fee: Generic _____ X _____ Rx: $ _____

[See Instructions 11(b) on reverse of form]

(c) Total charge for pharmacy OTC items in Section 10: $ _____
(State of North Carolina is tax exempt- do not include tax)

(d) Grand Total $ _____

INSTRUCTIONS FOR DSB-0511 Preparation: For each client, submit one claim monthly that contains all charges for a single calendar month. In items 1-8, enter the information requested. The directions for information required in items 1-8 in the DSB instructions. See the link below.

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) The prescription (or file) number assigned by the individual pharmacy.
9(B) 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) The National Drug Code (NDC) number assigned to the product actually dispensed.
9(D) The concentration of drug per unit volume or per unit weight.
9(E) The quantity or package size of drug dispensed, e.g., number of tabs, caps, ml, cc, oz.
9(F) The date the prescription order was actually filled.
9(G) The estimated number of days the dispensed quantity of drug should last if used in accordance with the prescriber's directions.
9(H) 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) Please indicate B for Brand or G for Generic drug.
9(J) Please indicate 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) The prescription (or file) number assigned, if any, assigned by the individual pharmacy.
10(B) 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) The concentration of drug or item per unit volume or per unit weight.
10(D) The quantity or package size of drug dispensed, e.g., number of tabs, caps, ml, cc, oz.; or items.
10(E) The date the order was actually filled.
10(F) 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) The dispensing pharmacist's usual charge for the drug or item.

Item 11 (a) Enter total cost of the drugs in Section 9.
(b) In the first blank, enter the lower of: 1) the allowable Medicaid dispensing fee in effect at the time the prescription drug is dispensed, or 2) the usual and customary dispensing fee charged to the general public for the same service. In the second blank, enter the total number of prescriptions dispensed in Section 9. Multiply, and enter the result in the third blank. Do this for both brand name and generic drugs. The current dispensing fees can go as high as $7.00.
(c) Enter total usual charge for pharmacy OTC items in Section 10.
(d) Enter total of a, b, and c.

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.

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-instructions.pdf