Pharmacy Services - Appendices

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Appendix P-1

Technical Guidelines for Paper Claim Preparation
Form HFS 215, Drug Invoice

To assure the most efficient processing by the Department, please follow these guidelines in the preparation of paper claims for image processing:

- Use an original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photo-copying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions.

MediPlan Card is the identification card issued by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) All Kids Assist or Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration of Medicare coinsurance and deductibles.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Item Explanation and Instructions
HFS Use Only	**Document Control Number** – Leave Blank – This field will be completed by the Department of Healthcare and Family Services.
Required	**Provider Name** – Enter the pharmacy name exactly as it appears on the Provider Information Sheet.
Required	**Provider Number** – Enter the NPI of the Provider. Do not enter any additional spaces.
Optional	**Provider Reference** – Completion of this field is not required; however, you may enter the numerical and/or alphabetical characters (up to a maximum of 10) which are utilized in your accounting system for identification purposes. If this field is completed, the same entry will appear on Form 194-M-2, Remittance Advice, returned to you.
Required	**Provider Address** – Enter the location of the dispensing pharmacy.

Service Sections – Each service section contains the same fields and is designed to facilitate entry of complete billing data for one prescription.

Completion	Item Explanation and Instructions
Required	**Recipient Name** – Enter the participant's name exactly as it appears on the MediPlan Card. Separate the Components of the name (first, middle initial, last) in the proper sections of the name field. If Form HFS 1411, Temporary Medical Eligibility Card, was used by the participant as proof of medical eligibility, refer to the copy of the document which has been detached and retained by the pharmacy at the time the pharmacy item was dispensed. Enter the participant's name exactly as it appears on the HFS 1411.
Required	**Recipient Number** – Enter the nine-digit number assigned to the individual as copied from the Medical Eligibility Card. Use no punctuation or spaces. (Do not use the case identification number) The Form HFS 1411 issued by Cook County offices and by other larger local DHS offices will contain the participant number. Smaller local DHS offices will not always have this information available to them at the time the certificate is issued. If the Form HFS 1411 contains the participant number, the number must be entered as it appears on the certificate. The copy of the copy of the certificate should be retained in the participant's pharmacy file for future reference. If the Form HFS 1411 does not contain the recipient number, enter the participant name and birth date on the invoice and attach a copy of the certificate to the billing form on **first** submittal. The Department will review the invoice and determine the correct recipient number. (Any invoice with a certificate attached should be mailed to the Department in Form HFS 1414, Special Approval envelope, to expedite handling.)
Required	**Date of Birth** – Enter the month, day and year of birth of the participant as shown on the MediPlan Card or Certificate. Enter the two-digit month, the two-digit day and final two digits of the year. The completed field should be in the MMDDYY format.
Required	**Date of Service** – Enter the date the pharmacy item was dispensed to the participant. Use the MMDDYY format.
Required	**Prescribing Practitioner** – Enter the Prescriber's NPI number exactly as written. Do not add spaces.
Required	**Date of Birth** – Enter the month, day and year of birth of the participant as shown on the MediPlan Card or Certificate. Enter the two-digit month, the two-digit day and final two digits of the year. The completed field should be in the MMDDYY format.
Required	**Date of Service** – Enter the date the pharmacy item was dispensed to the participant. Use the MMDDYY format.
Required	**Prescribing Practitioner** – Enter the Prescriber's NPI number exactly as written. Do not add spaces.

Completion	Item Explanation and Instructions
Required	**Prescription Number** – Enter the prescription number assigned by the pharmacy. A maximum of eight numerical characters may be entered. Use no punctuation. The Rx number may be identical for those service sections related to the various ingredients of a compounded prescription.
Required	**Item Number** – Enter the eleven-digit National Drug Code number for the drug or supply being dispensed.
Required	**Metric Quantity** – Enter the quantity, in Arabic numerals **only** that corresponds to the metric units of the item dispensed. Description of units such as ccs, tabs, etc., are not to be entered. The maximum quantity of units, which may be billed for any single service, is 99,999 units. If an item has a decimal in the quantity, round up to the next whole number. For example, a metered dose inhaler with a quantity of 8.1 grams would be billed as a "9".
Conditionally Required	**TPL (Third Party Liability Code)** – The provider must determine if the assistance patient has access to a medical resource, other than Healthcare and Family Services that is available to meet all or part of a claim. The availability and applicability of the resource must be determined by examining the MediPlan Card and by questioning the patient. In those instances where a resource(s) is identified, a claim is to be filed and adjudicated by the liable third party prior to billing the Department. If the liable third party resource was identified on the patient's MediPlan Card, the TPL Code opposite the patient's name must be entered in the TPL box on the invoice. If the third party resource was not on the patient's MediPlan Card, the appropriate TPL resource code must be used. ***If no TPL applicable, leave this field blank.*** **Spenddown** – If the client has a Spenddown obligation, they will either be responsible for the total amount of the charge **or** will present the provider with a Form HFS 2432 (Split Billing Transmittal). When a Form 2432 is necessary, the Form HFS 215 should be completed as follow: 1. Enter 906 in the TPL Code Field. 2. From the Form HFS 2432, enter the amount from the **less participant liability amount** field in the TPL AMOUNT field on the Form HFS 215. This amount may be $0.00. 3. The TPL fields will need to be completed in each service section that has the same date of service as the Split Bill Day. The Spenddown liability will need to be divided and reported in the TPL AMOUNT field of each service section. Be sure to attach a copy of Form HFS 2432 when submitting the Form HFS 215.

Completion	Item Explanation and Instructions
Conditionally Required	**TPL Amount** – The amount received from the third party payer should be entered in the TPL amount field. When there are no resources and, therefore, no third party is being billed, both the TPL code and TPL amount fields should be left blank. Only after 30 days have elapsed since a third party claim was submitted and no adjudication of the claim has been made, may a pharmacy submit a claim to the Department of Healthcare and Family Services. If such a claim is submitted, entering the appropriate code, as shown on the MediPlan Card to identify the third party billed. The TPL Amount field is to be left blank.
Required	**Net Charge** – Do not deduct the TPL amount, if any, from the total charge made to the Department. The maximum amount per claim may not exceed $99,999.99. (Note that the dollar sign and a line distinguishing cents have been preprinted.
Required	**Date Rx Written** – Enter the date on the prescription was created.
Required	**New/Refill Indicator** – Enter the value that indicates whether the prescription is new (00) or which refill is being issued (01 through 99).
Required	**DAW (Dispense as Written) Code** – Enter the value that indicates whether the prescription was dispensed as written. See the following definitions: 0 – No DAW 1 – Physician DAW 2 – Patient DAW 3 – Pharmacy DAW 4 – No Generic Available 5 – Brand Dispensed as Generic 6 – Override 9 – Other
Required	**Day's Supply** – Enter the number of days, which the Metric Quantity is to cover.
Required	**Compound** – This code indicates whether or not the NDC item is part of a compound or not. The values are: 0 – Not specified 1 – Not a Compound 2 – Compound Ingredients are billed individually by each NDC item in the compound, same prescription number and compound code of "2."
Optional	**Delete** – If you make an error in any field that cannot be corrected, the entire service section must be eliminated. If this happens, enter a capital X in the delete box for the section. Then re-enter all information in the next service section.
Optional	**Repeat** – In the second through the seventh service sections, a field titled "Repeat" appears at the beginning of the service section. This field may be used, by entry of a capital X in the box, to eliminate the need to repeat the participant's name (first, initial, last), recipient number and date of birth.

Document Summary Information

Completion	Item Explanation and Instructions
Optional	**Drug name, Form and Strength or Size** – Providers may use this field to provide more information regarding the pharmacy item being billed. (Special characters such as % should not be entered in this element.) Note that this field may contain a maximum of fifty (50) characters including spaces. In the space to the left, title "**SERV SECT**" (Service Section), enter the appropriate Arabic numeral (1-7) corresponding to the service section in which the billing information appears.
Required	**Total Net Charge** – Complete this field by entering the total of the net charges billed in service sections 1 through 7.
Required	**Total Number of Service Sections** – Enter the total number of service sections completed correctly. (Remember include service sections marked "REPEAT." Do not include service sections marked "DELETE.")
Required	**Certification, Provider Signature and Date** – After reading the certification statement, the pharmacy owner; the pharmacist in charge, the dispensing pharmacist or an authorized representative of the pharmacy must sign the completed form. The individual must sign his or her own name. The signature must be handwritten in black ink (A stamped facsimile signature is not acceptable). Unsigned invoices will not be accepted by the Department and will be returned to the pharmacy, when possible. The date to be entered is the date the invoice is signed. This date entry may either be handwritten or typed.

Mailing Instructions

The Drug Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1415, Drug Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

Form HFS 1411, Temporary MediPlan Card
Any other document

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 as explained in Chapter 100.

Appendix P-2
Technical Guidelines for Paper Claim Preparation
Form HFS 3797, Medicare Crossover Invoice

To assure the most efficient processing by the Department, please follow these guidelines in the preparation of paper claims for image processing:

- Use an original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photo-copying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.
- **Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797.**

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.**

MediPlan Card – the identification card issued by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) All Kids Assist or Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration of Medicare coinsurance and deductibles.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Item	Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the following box 26 - Med. Equip/Supply – medical equipment and supply providers, pharmacies
Required	**1.**	**Recipient's Name** - Enter the participant's name (first, middle, last) exactly as it appears on the back of the MediPlan Card.
Required	**2.**	**Recipient's Birth date** - Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.
Not Required	4 A. B.	Was Condition Related to – Participant's Employment Accident
Required	**5.**	**Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number from the MediPlan Card. Do not use the Case Identification Number.
Required	**6.**	**Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).
Required	**7.**	**Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.
Conditionally Required	**9.**	**Other Health Insurance Information** – If the participant has an additional health benefit plan, enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.

Completion	Item	Explanation and Instructions
Required	**10A.**	**Date(s) of Service** – Enter the date(s) of service submitted to Medicare. Use the MMDDYY format in the "From" and "To" fields.
Not Required	10B.	P.O.S. (Place of Service) – Leave blank.
Not Required	10C.	T.O.S. (Type of Service) – Leave blank.
Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001.
Required	**10E.**	**Procedure Code** – Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F.**	**Amount Allowed** – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Required	**11.**	**For NDC Use Only** – Required when billing NDC Codes for pharmacy/physician claims.
Not Required	12.	For Modifier Use Only – Leave blank.
Not Required	13A.	Origin of Service – Leave blank.
Not Required	13B.	Modifier – Leave blank.
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier – Leave blank.
Not Required	16A.	Destination of Service – Leave blank.
Not Required	16B.	Modifier – Leave blank.
Optional	**17.**	**ICN #** – Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on the HFS 194-M-2, Remittance Advice, returned to the provider.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** – Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-10 Code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the ICD-10 Diagnosis Code without punctuation or spaces for the services rendered.

Completion	Item	Explanation and Instructions
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-10 Diagnosis Code without punctuation or spaces.
Required	**19.**	**Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.
Conditionally Required	**20.**	**Name and Address of Facility Where Services Rendered** – This entry is required when Place of Service (10B) is other than provider's office or participant's home. Enter the facility name and address where the service(s) was rendered. When the name and address of the facility where the services were rendered is the same as the biller's name and address as submitted in Field 22, enter the word "Same."
Required	**21.**	**Accept** Assignment – The provider must accept assignment of Medicare benefits for services provided to participants for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box if accepting assignment.
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code** – Enter the physician/supplier name exactly as it appears on the Provider Information Sheet to the right of the "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the provider's NPI.
Required	**24.**	**Payee Code** – Enter the single digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the prescribing practitioner.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – Enter the prescribing practitioner's NPI.
Not Required	**27.**	**Medicare Provider ID Number** – Leave blank.
Required	**28.**	**Taxonomy Code** – Enter 333600000X the ten-digit HIPAA Provider Taxonomy Code**.**
Conditionally Required	**29A.**	**TPL Code** – The TPL Code contained on the Participant's MediPlan Card is to be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the MediPlan Card, enter the appropriate TPL Code as listed in the Chapter 100. If none of the TPL codes are applicable to the source of payment, enter code "999." If more than one third party resource made a payment for a particular service, the additional TPL is to be shown in Fields 30A – 30D.

Completion	Item	Explanation and Instructions
Conditionally Required	**29B.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met..
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Completion	Item	Explanation and Instructions
Conditionally Required	**29D.**	**TPL Date** – A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL Status Code. Use the MMDDYY format. **Status Code Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Billing Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**30A.**	**TPL Code** – (See 29A above).
Conditionally Required	**30B.**	**TPL Status** – (See 29B above).
Conditionally Required	**30C.**	**TPL Amount** – (See 29C above).
Conditionally Required	**30D.**	**TPL Date** – (See 29D above).
Required	**31.**	**Provider Signature** - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider. The provider's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the provider's signature is to be entered in the MMDDYY format.

Mailing Instructions

The Medicare Crossover Invoice is a single page or two-part continuous feed form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the Department in the pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. Should envelopes be unavailable, the HFS 3797 (Medicare Crossover Invoice) can be mailed to:

Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix P-3

Explanation of Information on Provider Information Sheet

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix P-3a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** Code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification. **Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation 04 = Group Practice

Field	Explanation
Enrollment Specifics	**Enrollment Status** is a one-digit code and corresponding narrative, which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Exception Requested by Audits C = Citation to Discover Assets G = Garnishment S = Exception Requested by Provider Participation Unit T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** is the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has a HFS 1413 (Agreement for Participation) on file.
Certification/License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

Field	Explanation
Categories of Service	This area identifies special licensure information and the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 040 – Pharmacy Services 041 – Med Equip/Prosthetic Devices 048 – Medical Supplies Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.** **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes. Therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's database.

Appendix P-3a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 1/10/09
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 1/10/09
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
123456789002

PROVIDER NAME AND ADDRESS
ABC PHARMACY
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 091-SANGAMON
TELEPHONE NUMBER - -

PROVIDER TYPE: 060 – PHARMACY
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/01/06 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 054905051 ENDING 01/31/10
PHARMACY AFFIL: 03 – GROUP PRACTICE CLIA #:
LAST TRANSACTION ADD AS OF 01/14/09
NCPDP #:

D.E.A.#: AT5535882
RE-ENROLLMENT INDICATOR: E DATE: 11/15/07

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
040	PHARMACY SERVICES	11/01/06	041	MED EQUIP/PROSTHETIC DEVICES	11/01/06	
048	MEDICAL SUPPLIES	11/01/06				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ABC PHARMACY	1421 MY STREET	ANYTOWN	IL	62000	123456789-62000-01		11/01/06
	DBA:					TIN #: 01		

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
1112223338

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

Appendix P-4

Third Party Liability Billing Instructions

Following are instructions for providers who receive Error Code 41 - Submit Bill to Other Processor or Primary Payer.

If the provider does *not* have TPL information for a participant, the provider should ask the participant for their insurance information, or contact the third party to obtain billing information. Once the pharmacy has the billing information, the pharmacy should first bill the third party, and then bill the Department, reporting the third party payment information on the claim.

If the provider believes that the participant does not have other coverage on the date of service, the pharmacy should call the prior approval hotline at 1-800-252-8942.

If the pharmacy has TPL information for the participant for the date of service, and the pharmacy reports an OCC code other than 2, the claim will reject for Error Code 41 - Submit Bill to Other Processor or Primary Payer. Note that if a provider reports OCC 2 Other Coverage Exists – Payment Collected, and the amount reported in field 431 DV Other Payer Amount Paid is illogical relative to the charges reported in field 426 DQ Usual And Customary Charge, the claim will reject. The rejection message will state Verify TPL. If Correct Request PA. If the pharmacy receives this rejection, and the amount reported in field 431 DV Other Payer Amount Paid is accurate, the pharmacy should call the prior approval hotline at 1-800-252-8942.

Following are instructions for providers when an OCC code other than 2 is reported.

OCC - 3 = Other Coverage Exists - This Claim Not Covered

The pharmacy must determine the reason that the medication is not covered by the primary payer before billing the Department. Participants must follow the primary payer's coverage policies and formulary. If the primary payer requires a prior authorization, then the pharmacy must work with the prescriber to complete the necessary documentation to bill the claim to the primary payer. If the claim is for a non-formulary medication, the pharmacy may need to work with the prescriber to switch the prescription to a formulary medication. If the claim is for an injectable medication, the primary payer may require the beneficiary to use a specialty pharmacy mail-order program. In that case, the beneficiary must be referred to the specialty pharmacy program. Only medications that are not covered by the primary payer because of a benefit limitation and which are covered by the Department can be billed to the Department. In this case, the pharmacy should call the prior approval hotline at 1-800-252-8942.

OCC - 4 = Other Coverage Exists - Payment Not Collected

If the primary insurance did not make payment on the claim because the primary payer's benefit design is such that the participant is required to pay the total cost of the claim, e.g., the

participant is in the deductible period, the pharmacy should call the prior approval hotline at 1-800-252-8942.

Appendix P-5

Medications Subject to the 90 Day Supply Policy

Generic Name

Acebutolol HCL
Amiloride HCL
Amiloride/Hydrochlorothiazide
Amlodipine Besylate
Atenolol
Atenolol/Chlorthalidone
Benazepril HCL
Betaxolol HCL
Bisoprolol Fumarate
Bisoprolol Fumarate/HCTZ
Bumetanide
Captopril
Carvedilol
Chlorothiazide
Chlorpropamide
Clonidine HCL
Digoxin
Diltiazem HCL
Doxazosin Mesylate
Enalapril Maleate
Eplerenone
Felodipine
Folic Acid
Fosinopril Sodium
Furosemide
Glimepiride
Glipizide
Glipizide/Metformin HCL
Glyburide
Glyburide,Micronized
Glyburide/Metformin HCL
Guanabenz Acetate
Guanfacine HCL
Hydralazine HCL
Hydrochlorothiazide
Indapamide
Labetalol HCL
Liothyronine Sodium
Lisinopril
Losartan Potassium
Metformin HCL
Methyldopa
Methyldopa/Hydrochlorothiazide
Metolazone
Metoprolol Succinate
Metoprolol Tartrate
Minoxidil
Moexipril HCL
Nadolol
Nateglinide
Nicardipine HCL
Nifedipine
Perindopril Erbumine
Prazosin HCL
Propranolol HCL
Quinapril HCL
Ramipril
Reserpine
Sotalol HCL
Spironolact/Hydrochlorothiazide
Spironolactone
Terazosin HCL
Thyroid
Thyroid,Pork
Tolazamide
Tolbutamide
Torsemide
Trandolapril
Triamterene/Hydrochlorothiazide
Verapamil HCL