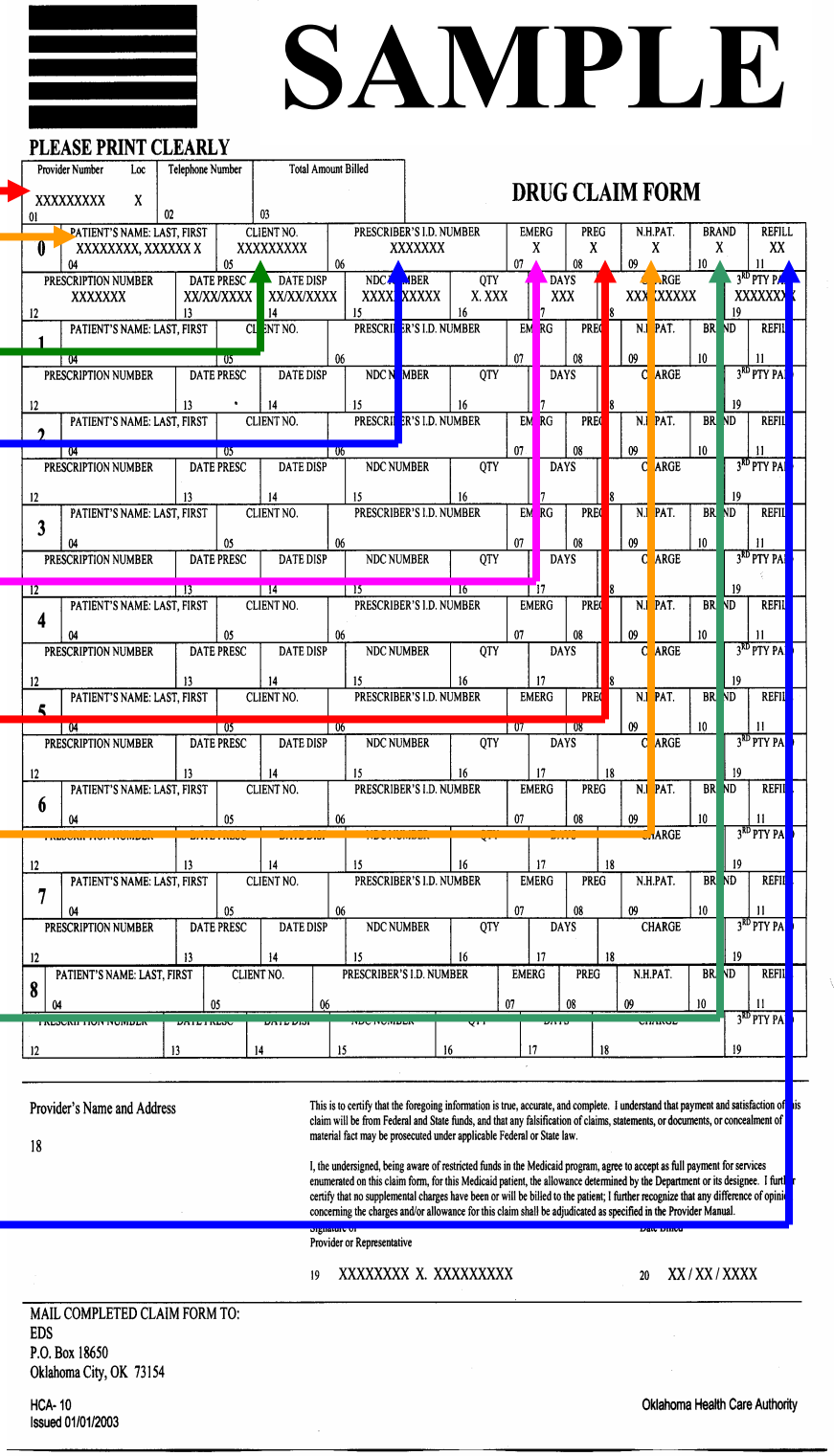
Pharmacy Drug Claim Form

Required Data Elements

1. Provider Number – must be 10 digits, last digit is the location code
4. Patient's Name – last, first, middle initial
5. Client ID Number – 9 characters
6. Prescriber ID Number – must be 7 digits
7. Emergency Indicator – Yes or No, if applicable
8. Pregnancy Indicator – Yes or No, if applicable
9. Nursing Home Indicator – Yes or No, if applicable
10. Brand BMN Indicator
    - 0 – No product selection indicated
    - 1 – Substitution not allowed by prescriber
11. Refill Indicator – two digits. Example: 00 = original dispensing, 01 to 99 = refill number



SAMPLE

PLEASE PRINT CLEARLY

DRUG CLAIM FORM

Provider Number	Loc	Telephone Number	Total Amount Billed
XXXXXXXXX 01	X	02	03

	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
0	XXXXXXXX, XXXXXX X 04	XXXXXXXXX 05	XXXXXXX 06	X 07	X 08	X 09	X 10	XX 11
1	04	05	06	07	08	09	10	11
2	04	05	06	07	08	09	10	11
3	04	05	06	07	08	09	10	11
4	04	05	06	07	08	09	10	11
5	04	05	06	07	08	09	10	11
6	04	05	06	07	08	09	10	11
7	04	05	06	07	08	09	10	11
8	04	05	06	07	08	09	10	11

PRESCRIPTION NUMBER	DATE PRESC	DATE DISP	NDC NUMBER	QTY	DAYS	CHARGE	3RD PTY PAY
XXXXXXX 12	XX/XX/XXXX 13	XX/XX/XXXX 14	XXXXXXXXXX 15	X. XXX 16	XXX 17	XXXXXXXXX 18	XXXXXXXX 19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19

Provider's Name and Address

18

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative — 19 XXXXXXXX X. XXXXXXXXX

Date Signed — 20 XX / XX / XXXX

MAIL COMPLETED CLAIM FORM TO:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

HCA- 10
Issued 01/01/2003

Oklahoma Health Care Authority

Created on 12/12/2002 1:19 PM

Pharmacy Drug Claim Form

Required Data Elements

12. Prescription Number – 7 characters

13. Date Prescribed – on or before receipt date, not a future date

14. Date Dispensed – on or before receipt date, cannot be future date

15. NDC Number – numeric, 11 digits

16. Metric Quantity – decimal and 3 zeros after value, up to 11 characters. Example: 99999999.999

17. Days Supply – up to 3 characters

18. Charge – numeric, up to 9 digits

19. TPL paid – numeric, eight digits, required if applicable

21. Signature of Provider or Representative

22. Date Billed/Date of Claim Submission

SAMPLE

PLEASE PRINT CLEARLY

DRUG CLAIM FORM

Provider Number	Loc	Telephone Number	Total Amount Billed
XXXXXXXXX 01	X	02	03

	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
0	XXXXXXXX, XXXXXX X 04	XXXXXXXXX 05	XXXXXXX 06	X 07	X 08	X 09	X 10	XX 11
1	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
2	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
3	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
4	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
5	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
6	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
7	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL
8	PATIENT'S NAME: LAST, FIRST	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H.PAT.	BRAND	REFILL

PRESCRIPTION NUMBER	DATE PRESC	DATE DISP	NDC NUMBER	QTY	DAYS	CHARGE	3RD PTY PAID
XXXXXXX 12	XX/XX/XXXX 13	XX/XX/XXXX 14	XXXXXXXXXXX 15	X.XXX 16	XXX 17	XXXXXXXXX 18	XXXXXXXX 19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
12	13	14	15	16	17	18	19
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Date Billed — 20 XX / XX / XXXX

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