Appendix A:
Universal Claim Form (UCF) Instructions

All paper pharmacy claims must be submitted to Magellan Medicaid Administration on a Universal Claim Form (UCF), version 5.1. Mail claims to:

Magellan Medicaid Administration
Nevada Medicaid Paper Claims Processing Unit
P.O. Box C-85042
Richmond, VA 23261-5042

UCFs may be obtained from:

Moore Document Solutions
410 N. 44th Street, Suite 300
Phoenix, AZ 85008
(888) 665-2600 or (602) 220-0202

Instructions for Completing the Universal Claim Form, Version 5.1

1. Complete all applicable areas on the front of the form.
2. Verify recipient information is correct and that the recipient is eligible for benefits.
3. If this claim is for a workers compensation injury, complete the appropriate section on the front of the claim.
4. Patient signs certification on front side for prescription(s) received.
5. Enter Compound RX in the Product Service ID area and list each ingredient name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
6. Report the ICD-9 code and qualifier for the prescription (limit 1 per prescription).
7. Limit 1 set of DUR/PPS codes per claim.
8. Each area is numbered. Complete each area using the following codes:

(1) OTHER COVERAGE CODE

Code	Description
0	Not specified
1	No other coverage identified
2	Other coverage exists payment collected
3	Other coverage exists this claim not covered
4	Other coverage exists payment not collected
5	Managed care plan denial
6	Other coverage denied not a participating provider
7	Other coverage exists not in effect at time of service
8	Claim is billing for a copay

(2) PERSON CODE

This code assigned to a specific person within a family.

(3) PATIENT GENDER CODE

Code	Description
0	Not specified
1	Male
2	Female

(4) PATIENT RELATIONSHIP CODE

Code	Description
0	Not specified
1	Cardholder
2	Spouse
3	Child
4	Other

(5) SERVICE PROVIDER I.D. QUALIFIER (QUAL)

Code	Description
Blank	Not specified
01	National Provider Identifier (NPI)
02	Blue Cross
03	Blue Shield
04	Medicare
05	Medicaid
06	UPIN
07	NCPDP Provider ID
08	State license
09	Champus
10	Health Industry number (HIN)
11	Federal Tax ID
12	Drug Enforcement Administration (DEA)
13	State Issued
14	Plan Specific
99	Other

(6) CARRIER I.D.

Carrier code assigned in Worker's Compensation Program.

(7) CLAIM REFERENCE I.D.

Identifies the claim number assigned by Worker's Compensation Program.

(8) PRESCRIPTION / SERV. REF # QUALIFIER (QUAL)

Code	Description
Blank	Not specified
1	Rx billing
2	Service billing

(9) QTY DISPENSED

Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

(10) PRODUCT / SERVICE I.D. QUALIFIER (QUAL)

Code qualifying the value in Product/Service I.D. (407-07)

Code	Description
Blank	Not specified
01	Universal Product Code (UPC)
02	Health Related Item (HRI)
03	National Drug Code (NDC)
04	Universal Product Number (UPN)
05	Department of Defense (DOD)
06	Drug Use Review Professional Pharm. Services (DUR/PPS)
07	Common Procedure Terminology (CPT4)
08	Common Procedure Terminology (CPT5)
09	HCFA Common Procedural Coding System (HCPSCS)
10	Pharmacy Practice Activity Classification (PPAC)
11	National Pharmaceutical Product Interface Code (NAPPI)
12	International Article Numbering System (EAN)
13	Drug Identification Number (DIN)
99	Other

(11) PA TYPE

Code	Description
0	Not specified
1	Prior Authorization
2	Medical Certification
3	Early Periodic Screening Diagnosis Treatment (EPSDT)
4	Exemption from copay
5	Exemption from Rx limits
6	Family Planning Indicator
7	Aid to Families with dependent Children (AFDC)
8	Payer defined exemption

(12) PRESCRIBER I.D. QUALIFIER (QUAL)

Use service provider ID values.

(13) DUR/PPS CODES

Refer to the current NCPDP data dictionary for valid values.

Code	Description
A	Reason for Service
B	Professional Service Code
C	Result of Service

(14) BASIS COST

Code	Description
Blank	Not specified
00	Not Specified
01	Average Wholesale Price (AWP)
02	Local Wholesale
03	Direct
04	Estimated Acquisition Cost (EAC)
05	Acquisition
06	Maximum Allowable Cost (MAC)
07	Usual and Customary
09	Other

(15) PROVIDER I.D. QUALIFIER (QUAL)

Code	Description
Blank	Not specified
01	Drug Enforcement Administration (DEA)
02	State License
03	Social Security Number (SSN)
04	Name
05	National Provider Identifier (NPI)
06	Health Industry Number (HIN)
07	State issued
09	Other

(16) DIAGNOSIS CODE QUALIFER (QUAL)

Code	Description
Blank	Not specified
00	Not Specified
01	International Classification of Diseases (ICD9)
02	International Classification of Diseases (ICD10)
03	National Criteria Care Institute (NDCC)
04	Systemized Nomenclature of Human and Veterinary Medicine (SNDMED)
05	Common Dental Terminology (CDT)
06	Medi-Span Diagnosis Code
07	American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM/V)
99	Other

(17) OTHER PAYER ID QUALIFIER (QUAL)

Code	Description
Blank	Not specified
01	National Payer ID
02	Health Industry Number (HIN)
03	Bank Information Number (BIN)
04	National Association of Insurance Commissioners (NAIC)
09	Coupon
99	Other

(18) ADD INFORMATION ON COMPOUND PRESCRIPTIONS IF NECESSARY – LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM

Name	NDC	Quantity	Cost

I.D. _____ GROUP I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ ___ ____ (MM DD CCYY) PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
EMPLOYER NAME _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____
DATE OF INJURY ____ ___ ____ (MM DD CCYY) **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT/ AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE