

Medicaid Title XIX Pharmacy Invoice

Check One Box:
 72 Hour Emergency Supply
 Retro Eligibility
 TPN

State of Mississippi
 Division of Medicaid
 P.O. Box 23076
 Jackson, MS 39225

PROVIDER INFORMATION

¹ Provider Name	² NPI	³ Medicaid Number	⁴ Phone # Fax #
⁵ Street Address	⁶ City	⁷ State	⁸ Zip Code
⁹ Medicaid ID		Medicare #	

BENEFICIARY INFORMATION

¹⁰ Last Name	¹¹ First Initial	¹² DOB
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1	¹³ Rx Number	¹⁴ Prescriber NPI	¹⁵ Prescriber Medicaid#	¹⁶ Date of Service
	<input type="checkbox"/> New <input type="checkbox"/> Refill	¹⁸ Drug Name	¹⁹ Days Supply	²⁰ Quantity
	²² National Drug Code	²³	²⁴ TPL Amt	²⁵ U&C Price
2	¹³ Rx Number	¹⁴ Prescriber NPI	¹⁵ Prescriber Medicaid#	¹⁶ Date of Service
	<input type="checkbox"/> New <input type="checkbox"/> Refill	¹⁸ Drug Name	¹⁹ Days Supply	²⁰ Quantity
	²² National Drug Code	²³	²⁴ TPL Amt	²⁵ U&C Price
3	¹³ Rx Number	¹⁴ Prescriber NPI	¹⁵ Prescriber Medicaid#	¹⁶ Date of Service
	<input type="checkbox"/> New <input type="checkbox"/> Refill	¹⁸ Drug Name	¹⁹ Days Supply	²⁰ Quantity
	²² National Drug Code	²³	²⁴ TPL Amt	²⁵ U&C Price
4	¹³ Rx Number	¹⁴ Prescriber NPI	¹⁵ Prescriber Medicaid#	¹⁶ Date of Service
	<input type="checkbox"/> New <input type="checkbox"/> Refill	¹⁸ Drug Name	¹⁹ Days Supply	²⁰ Quantity
	²² National Drug Code	²³	²⁴ TPL Amt	²⁵ U&C Price
5	¹³ Rx Number	¹⁴ Prescriber NPI	¹⁵ Prescriber Medicaid#	¹⁶ Date of Service
	<input type="checkbox"/> New <input type="checkbox"/> Refill	¹⁸ Drug Name	¹⁹ Days Supply	²⁰ Quantity
	²² National Drug Code	²³	²⁴ TPL Amt	²⁵ U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ **27. Date:** _____

28. Pharmacist's Name Printed: _____

CLAIM FORM INSTRUCTIONS FOR PHARMACY SERVICES

- Item 1. Enter the provider's name.
- Item 2. Enter the provider's NPI (National Provider Indicator).
- Item 3. ("Optional") Enter the provider's 8 digit Medicaid Provider Number.
- Item 4. Enter the provider's 10 digit phone and fax numbers.
- Item 5. Enter the provider's street address (mailing address).
- Item 6. Enter the provider's city.
- Item 7. Enter the provider's state.
- Item 8. Enter the provider's zip code.
- Item 9. Enter the beneficiary's Medicaid and Medicare Identification Numbers.
- Item 10. Enter the beneficiary's full last name as it appears on the Medicaid Card.
- Item 11. Enter the beneficiary's first name initial.
- Item 12. Enter the beneficiary's date of birth (MM/DD/YYYY).
- Item 13. Enter the pharmacy prescription number.
- Item 14. Enter the prescriber's NPI number.
- Item 15. ("Optional") Enter the prescriber's Medicaid provider number.
- Item 16. Enter the date the prescription was filled (MM/DD/YYYY).
- Item 17. Check appropriate box to indicate if prescription is new or a refill.
- Item 18. Enter the name of the drug.
- Item 19. Enter the estimated number of days supply for the drug billed.
- Item 20. Enter the quantity dispensed.
- Item 21. Enter the appropriate dispensing fee code. A= IV drugs C= hyperalimentation
- Item 22. Enter the 11 digit National Drug Code (NDC) for the drug dispensed.
- Item 23. Space is intentionally left blank. Do not write in this box.
- Item 24. Enter the total third party insurance payment received.
- Item 25. Enter the usual and customary charge.
- Item 26. The pharmacy form must be signed by the submitting pharmacist.
- Item 27. Enter the date that the claim form was completed (MM/DD/YYYY).
- Item 28. Print the submitting pharmacist's name.

"The Mississippi Medicaid program operates under the provisions of Title VI of the Civil Rights Act of 1964. Under the provisions of this Act, any provider of services receiving Federal funds must comply with the intent of this Act and this means there shall be no discrimination because of race, color, or national origin. This Title also provides for a strict compliance and complaint procedure.

The provider of services agrees to maintain such records as are necessary to disclose the services rendered and upon request to make these records available to the Mississippi Medicaid Agency, or its representatives, in substantiation of any and all claims."