1 CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

Fasten Here

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Provider Name, Address

PHARMACY CLAIM FORM

2 ID QUALIFIER | 3 PROVIDER ID

4 ZIP CODE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

Provider Phone Number:

ELITE PICA ← TYPEWRITER ALIGNMENT → ELITE PICA

PATIENT INFORMATION
5 PATIENT NAME (LAST, FIRST, MI) | 6 MEDI-CAL IDENTIFICATION NO (CD HIV EG CI KT) | 7 SEX | 8 DATE OF BIRTH (MM DD YYYY) | 9 PATIENT LOCATION | 10 MEDICARE STATUS

1

11 PRESCRIPTION NO | 12 FILL NUMBER | 13 DATE OF SERVICE (MM DD YYYY) | 14 METRIC QUANTITY (WHOLE UNITS . DECIMAL) | 15 CODE 1 MET? (Y) | 16 EMERGENCY FILL? (Y) | 17 DAYS SUPPLY

18 BASIS OF COST DETERMINATION | 19 PROD ID QUAL | 20 PRODUCT ID | 21 ID QUAL | 22 PRESCRIBER ID

23 PRIMARY ICD-CM | 24 SECONDARY ICD-CM | 25 CHARGE | 26 OTHER COVERAGE PAID | 27 OTH COV CODE

28 PATIENT'S SHARE | 29 TAR CONTROL NO | 30 COMP CODE | 31 DELETE (Y)

2

32 PRESCRIPTION NO | 33 FILL NUMBER | 34 DATE OF SERVICE (MM DD YYYY) | 35 METRIC QUANTITY (WHOLE UNITS . DECIMAL) | 36 CODE 1 MET? (Y) | 37 EMERGENCY FILL? (Y) | 38 DAYS SUPPLY

39 BASIS OF COST DETERMINATION | 40 PROD ID QUAL | 41 PRODUCT ID | 42 ID QUAL | 43 PRESCRIBER ID

44 PRIMARY ICD-CM | 45 SECONDARY ICD-CM | 46 CHARGE | 47 OTHER COVERAGE PAID | 48 OTH COV CODE

49 PATIENT'S SHARE | 50 TAR CONTROL NO | 51 COMP CODE | 52 DELETE (Y)

3

53 PRESCRIPTION NO | 54 FILL NUMBER | 55 DATE OF SERVICE (MM DD YYYY) | 56 METRIC QUANTITY (WHOLE UNITS . DECIMAL) | 57 CODE 1 MET? (Y) | 58 EMERGENCY FILL? (Y) | 59 DAYS SUPPLY

60 BASIS OF COST DETERMINATION | 61 PROD ID QUAL | 62 PRODUCT ID | 63 ID QUAL | 64 PRESCRIBER ID

65 PRIMARY ICD-CM | 66 SECONDARY ICD-CM | 67 CHARGE | 68 OTHER COVERAGE PAID | 69 OTH COV CODE

70 PATIENT'S SHARE | 71 TAR CONTROL NO | 72 COMP CODE | 73 DELETE (Y)

SPECIFIC DETAILS/REMARKS:

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

X
81 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

74 MEDICAL RECORD NO | 75 BILL LIM EX | 76 ATTACHMENTS

77 DATE BILLED (MM DD YYYY) | 78 DISCHARGE DATE (MM DD YYYY) | F.I. USE ONLY 79 80

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

IMPORTANT

The services listed on this form have been personally provided to the patient by the provider or under the provider's direction by another person eligible under the Medi-Cal program to provide such services, and such person(s) are designated on this form. The services were, to the best of provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and / or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and / or state laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to California Department of Health Care Services; Medi-Cal Fraud Unit, California Department of Justice; Medi-Cal Audits Project, Office of State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.

Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.