

Medi-Cal Rx Provider Pharmacy Claim Inquiry

Instructions: The *Medi-Cal Rx Provider Pharmacy Claim Inquiry* form (CIF) is used by pharmacy providers to resolve pharmacy claim payments or denials as identified on the pharmacy provider’s *Remittance Advice* (RA). Read the enclosed instructions carefully prior to completing and signing the CIF. All required fields must be completed to process the CIF.

Pharmacy providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located in the *Explanation of Provider Pharmacy Claim Inquiry Form* section. Incomplete forms will not be processed and will be returned to the pharmacy provider.

*** Indicates Required Field**

Pharmacy Provider Information

- * Pharmacy Provider Name: _____
- * Service Address: _____
- * City: _____ * State: _____ * ZIP Code: _____
- * National Provider Identifier (NPI) Number: _____

Pharmacy Claim Information

Claim Type: 01 – Pharmacy

- * Member Name: _____
- * Member Medi-Cal ID Number: _____
- * Complete all applicable fields for each claim line (up to five claims per form).

Claim 1

Prescription Number: _____ Date of Service (DOS): _____

NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____

Reconsideration	Void	Share of Cost (SOC)	Tracer	Crossover
Underpayment	Overpayment	Number of Attachments: _____		

Claim 2

Prescription Number: _____ Date of Service (DOS): _____

NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____

Reconsideration	Void	Share of Cost (SOC)	Tracer	Crossover
Underpayment	Overpayment	Number of Attachments: _____		

Claim 3

Prescription Number: _____ Date of Service (DOS): _____

NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____

Reconsideration Void Share of Cost (SOC) Tracer Crossover
 Underpayment Overpayment Number of Attachments: _____

Claim 4

Prescription Number: _____ Date of Service (DOS): _____

NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____

Reconsideration Void Share of Cost (SOC) Tracer Crossover
 Underpayment Overpayment Number of Attachments: _____

Claim 5

Prescription Number: _____ Date of Service (DOS): _____

NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____

Reconsideration Void Share of Cost (SOC) Tracer Crossover
 Underpayment Overpayment Number of Attachments: _____

* Total Attachments (*required when attachments are included*): _____

* Remarks, such as: Corrections or additional information necessary to resubmit a denied pharmacy claim or request an adjustment for an underpayment or overpayment. What went wrong with the pharmacy claim? What has the biller/pharmacy provider done to correct the pharmacy claim? What do you want Medi-Cal Rx to do with the pharmacy claim? If listing multiple pharmacy claims on the CIF, specify to which pharmacy claim each remark applies.

Pharmacy Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services (DHCS) for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the pharmacy provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the pharmacy provider or the authorized representative binds the pharmacy provider to statements and conditions contained in this form.

* **Print Name:** _____

* **Signature of Pharmacy Provider or Authorized Representative** (*Original Signature Required; Use **Blue Ink***):

_____ * **Date:** _____

Form Submission

Print, sign, date, and mail this completed form to the address below. For assistance in completing this form, call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610

Explanation of Provider Pharmacy Claim Inquiry Form

The CIF is used to resolve claim payments or denials as identified on the RA. There are seven main reasons to submit a CIF:

1. **Reconsideration:** A claim has been denied, and a pharmacy provider has information that would correct the reason for denial.
2. **Void:** Reverse payment on a claim.
3. **Share of Cost (SOC):** A claim has been paid at a different amount and a pharmacy provider requests a reimbursement for SOC.
4. **Tracer:** No record of payment or denial of a previously submitted claim exists on the RA and a provider wants to trace the status of a claim.
5. **Crossover:** Refer to the *Medicare Part B COB Claims* section in the *Medi-Cal Rx Provider Manual* for more information.
6. **Underpayment:** A claim has been underpaid, and a pharmacy provider requests an adjustment.
7. **Overpayment:** A claim has been overpaid, and a pharmacy provider requests an adjustment.

Refer to the *Medi-Cal Rx Provider Pharmacy Claim Inquiry Form (CIF) (DHCS 6570)* section in the *Medi-Cal Rx Provider Manual* for additional information regarding types of inquiries, timeliness of submission, special billing instructions, exceptions to using a CIF, acceptable attachments, completion reminders, response to the CIF, and completion tips. The *Medi-Cal Rx Provider Manual* is located on the [Medi-Cal Rx Web Portal](https://medi-calrx.dhcs.ca.gov/home/) (<https://medi-calrx.dhcs.ca.gov/home/>).

Explanation of Form Fields

Pharmacy Provider Information

- **Pharmacy Provider Name:** Enter the pharmacy provider's name.
- **Service Address, City, State, ZIP Code:** Enter the pharmacy provider's service address.
- **National Provider Identifier (NPI) Number:** Enter the pharmacy provider's NPI number.

Pharmacy Claim Information

- **Claim Type:** Defaulted to Pharmacy. Visit <https://www.medi-cal.ca.gov/> for information about inquiries for other claim types (for example, Long Term Care, Inpatient, Outpatient, Medical, etc.).
- **Member Name:** Enter the member's first and last name.
- **Member Medi-Cal ID Number:** Enter the member's ID number that appears on the RA showing adjudication of that claim.
- **Prescription Number:** Enter the prescription number.
- **Date of Service:** Enter the date in a MM/DD/YYYY format.
- **NDC or Medical Supply Billing Code:** Enter the NDC or 11-digit NDC-like medical supply billing code. When submitting an inquiry for a compound drug claim, enter zero ("0") in place of listing the NDCs and include each ingredient NDC with the attachment(s).
- **Amount Billed:** Enter the dollar amount originally billed.
- **Reconsideration:** Select this box for a denied claim reconsideration request.

- **Void:** Select this box for a void request.
- **Share of Cost (SOC) Reimbursement:** Select this box for an SOC reimbursement request.
- **Tracer:** Select this box for a tracer request.
- **Crossover:** Select this box for a Medicare Part B Crossover adjustment request.
- **Underpayment:** Select this box for an underpayment adjustment request.
- **Overpayment:** Select this box for an overpayment adjustment request.
- **Number of Attachments:** Select this box if including attachments related to the request and enter the number of attachments submitted for each request.
 - **Note:** All claim inquiries should have attachments except when requesting a tracer.
- **Total Attachments:** Enter the total number of attachments for all requests included on the form.
- **Remarks:** Enter comments specific to each claim on the CIF. If listing multiple pharmacy claims on the CIF, include the claim number for each remark.

Pharmacy Provider Certification

- **Print Name:** Enter the name of the person signing the form.
- **Signature of Pharmacy Provider or Authorized Representative:** Include the signature of the pharmacy provider or the pharmacy provider's authorized representative. An original signature is required; use **blue** ink.
- **Date:** Provide the date on which the form is signed.