

# Colorado Medical Assistance Program

## Colorado Pharmacy Claim Form (PCF-2)

### I. Client Information

Client's Medicaid ID Number: \_\_\_\_\_ Group ID: Colorado Colorado Relationship Code: 1  
 Client's Name (Last/First/Middle Initial): \_\_\_\_\_, \_\_\_\_\_  
 Client's Street Address: \_\_\_\_\_ Client's City: \_\_\_\_\_ Client's Zip Code: \_\_\_\_\_  
 Other Coverage Code: \_\_\_\_\_ Client's DOB (MM/DD/YYYY):  / /

### II. Pharmacy Information

Service Provider ID: \_\_\_\_\_ Service Provider ID Qualifier: \_\_\_\_\_

### III. Prescriber Information

Prescriber's Last Name: \_\_\_\_\_ Prescriber's Phone Number:  - -  
 Prescriber's ID: \_\_\_\_\_ Prescriber's ID Qualifier: \_\_\_\_\_

### IV. Claim Information (Claim must be for the same client as listed above)

Prescription Number: \_\_\_\_\_ Fill Number: \_\_\_\_\_ Days Supply: \_\_\_\_\_  
 Date Written:  / / Date Filled:  / / Prescription # Qualifier: \_\_\_\_\_  
 DAW Code: \_\_\_\_\_ PA Type Code: \_\_\_\_\_ Quantity Prescribed: \_\_\_\_\_  
 Product ID: \_\_\_\_\_ Product ID Qualifier: \_\_\_\_\_ Quantity Dispensed: \_\_\_\_\_  
 Submitted Ingredient Cost: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Gross Amount Due: \_\_\_\_\_

### V. Other Payer Information

Other Payer Coverage Type: \_\_\_\_\_ Other Payer Date:  / /  
 Other Payer Amount Paid: \_\_\_\_\_ Other Payer Amount Paid Qualifier: \_\_\_\_\_  
 Other Payer Reject Code: \_\_\_\_\_ Other Payer Patient Responsibility Amount: \_\_\_\_\_  
 Other Payer Patient Responsibility Amount Qualifier: \_\_\_\_\_  
 Compound Claim: \_\_\_\_\_ Diagnosis Code Qualifier:   Diagnosis Code: \_\_\_\_\_  
 RX Override: \_\_\_\_\_ RX Override: \_\_\_\_\_ RX Override: \_\_\_\_\_

### VI. Complete this Section for Compound Prescriptions Only

#### Limit 1 Compound Prescription Per Claim Form

Ingredient Name	NDC	Quantity	Ingredient Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: \_\_\_\_\_ Date:  / /

This is to certify that the foregoing information is true, accurate, and complete. This is to certify that I understand that payment of this claim will be from Federal and State funds and that my falsification or concealment of material fact may be prosecuted under Federal and State laws.

FIELD	VALUE	COMMENT
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*This form should be printed, completed by hand, or typed and mailed to ACS:*

Please mail completed form(s) to:  
 Paper Claims Submissions, P.O. Box 30, Denver, CO 80201-0030

## Instructions for Completing the Pharmacy Claim Form (PCF-2)

Below are the completion instructions for the Colorado Pharmacy Claim Form (PCF-2) for Pharmacy Providers. The form is one-sided and requires an authorized signature. Providers must follow the instructions below and may only submit one (prescription) per claim. The claim may be a multi-line compound claim. If there is more than a single payer a D.0 electronic transaction must be submitted.

\*\*\* Please note: The format for entering a date is different than the date format in the POS system \*\*\*

Client's Mcaid ID #	Client's 7-character Medical Assistance Program ID	Required
Group ID	Colorado	Default value on claim form
Relationship Code	1=Cardholder	Default value on claim form
Client's Name	Last, First, MI	Required
Other Cov Code	0=Not specified 1=No other cov identified 2=Other cov exists-Pymt collected 3=Other cov exists-Claim not covered 4=Other cov exists-Pymt not collected	Required when submitting a claim for client w/ other cov
Client's DOB	MM/DD/YYYY	Required

Svc Prov ID	NPI=National Provider Identifier	Required
Svc Prov ID Qual	01=NPI-National Provider Identifier	Required

Prescriber's Last Name	Last Name of Prescriber	Required
Prescriber's Phone #	Prescriber's Phone #	Required
Prescriber's ID	Prescriber's NPI, CO State License or DEA #	Required
Prescriber's ID Qualifier	01=National Provider Identifier 12=Drug Enforcement Administration 08=CO State License # (DEA#)	Required
Prescription #	Prescription # Assigned by Pharmacy	Required
Date Written	MM/DD/YYYY	Required
Date Filled	MM/DD/YYYY	Required
Fill #	00=Original Fill 01-99=# of Refills	Required
Prescription # Qualifier	0=Blank 1=Rx Billing	Required
Days Supply	# of Days Prescription is Prescribed	Required
DAW Codes	0=No Generic Available or Generic 1=Physician Requested Medication	Required when the valid values are appropriate for submission of the claim
PA Type Code	0=Not Specified 4=Pregnant or 60 Days Postpartum	Required when the client is pregnant or 60 days postpartum
Quantity Prescribed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Quantity Dispensed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Product ID	NDC #	Required-If claim is for a compound prescription, enter "COMPOUND RX"
Product ID Qualifier	00=If Claim is a Compound Claim 03=National Drug Code (NDC)	Required-If claim is for a compound prescription, enter "00"
Submitted Ingredient Cost		Required-Enter total ingredient costs even if claim is for a compound prescription
Total Charge		Required-Pharmacy's Usual and Customary Charge
Gross Amount Due		Required

Other Payer Cov Type	01=Primary	Required if Other Cov Code equals 2, 3, or 4
Other Payer Date	MM/DD/YYYY	Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid		Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid Qualifier	02=Shipping 06=Cognitive Service 03=Postage 07=Drug Benefit 04=Administrative 09=Compound Preparation Cost 05=Incentive 10=Sales Tax	Required if Other Cov Code equals 2, 3, or 4
Other Payer Reject Code	Value from Prior Payer	Required if Other Cov Code equals 3
Other Payer Patient Responsibility \$	Value from Prior Payer	Required if Other Cov Code equals 4
Other Payer Patient Responsibility \$ Qualifier	01=Amount Applied to Periodic Deductible 05=Amount of Copay 06=Patient Pay Amount (only if Prior Payer was still in NCPDP version 5.1) 07=Amount of Coinsurance	Required if Other Cov Code equals 4
Compound Claim	Blank 1=Not a Compound Claim 0=Not Specified 2=Claim is a Compound Claim	Required when claim is for a compound prescription
Diagnosis Code Qualifier	01=ICD9 Code on Prescription 02=ICD10 (adoption date to be announced)	
Diagnosis Code	ICD9 Code on Prescription ICD10 (adoption date to be announced)	Required if this information can be used in place of prior auth
RX Override	8=Process Compound Claim for Approved Ingredients * In the future, Colorado plans to utilize other Rx Override fields.	Conditional-Needed to process claim for approved ingredients when claim is for a compound prescription

If the claim is a compound claim, complete the bottom section of the claim form to indicate each ingredient name, NDC quantity, and cost. Remember that there is a limit of one prescription per claim form.

FIELD	VALUE	COMMENT
Ingredient Name	Ingredient Name	Required when the claim is for a compound prescription
NDC	NDC Number of the Ingredient	Required when the claim is for a compound prescription
Quantity	Metric Decimal Quantity Dispensed	Required when the claim is for a compound prescription
Ingredient Cost Submitted		Required when the claim is for a compound prescription