Arkansas Medicaid
Pharmacy Prior Authorization Program
500 President Clinton Avenue
Suite 400
Little Rock, AR 72201

Arkansas Medicaid

Claim Form Billing Instructions

CMS-1500 Claim Form

This guide provides information about participation requirements for services submitted to Arkansas Medicaid and is designed to be used as a reference tool to identify and provide a description of fields listed on the CMS-1500 claim form. To view a sample of this form click **here**.

Arkansas Medicaid Participation Requirements for Pharmacies Administering Influenza Virus Vaccine and Pneumococcal Polysaccharide Vaccine

1. Pharmacy must be a currently enrolled Arkansas Medicaid Provider
2. Pharmacy provider file must reflect a specialty code of PV (Pharmacy administered Vaccines). (Requirement for the PV specialty is proof of Medicare enrollment.)
3. For individuals ages **19 and older**, the Arkansas Medicaid Program will reimburse the pharmacy the cost of administering, by injection or intranasal use, two types of vaccines:
    a. Influenza virus vaccine (see Table 1)
    b. Pneumococcal polysaccharide vaccine (see Table 1)
4. The influenza virus vaccine is limited to one per state fiscal year (July through June.) The pneumococcal polysaccharide vaccine is limited to one every ten years.
5. Medicaid will reimburse the Medicare deductible and/or coinsurance for all beneficiaries receiving both Medicare and Medicaid benefits.
6. Pharmacies may use the **CMS-1500 claim form** when billing Medicaid for these vaccines.
7. Claims may be submitted electronically or the provider may log onto their **Medicaid Provider Portal**.
8. Claims may be submitted electronically if the pharmacy's vendor software can code and transmit an 837P X12 claim.

Completed CMS-1500 claim forms should be sent to:

Attn: Claims
P.O. Box 8034
Little Rock, AR 72203

For provider inquiries regarding pharmacy vaccine administration reimbursement, call:

The DXC Provider Assistance Center

In-State Toll Free: (800) 457-4454

Local and Out-of-State: (501) 376-2211

Arkansas Medicaid Pharmacy Reimbursable Vaccines

Table 1: CPT or HCPCS Procedure Codes for Influenza virus and Pneumococcal Polysaccharide Vaccines

90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use (ages 19 to 64 years)
90656	Influenza virus vaccine, trivalent, split virus, preservative-free (ages 19 years and older)
90658	Influenza virus vaccine, split virus, for intramuscular use (ages 19 years and older)
90660	Influenza virus vaccine, live virus, for intranasal use (ages 19 years and older)
90662	Influenza virus vaccine, split virus, preservative-free, enhanced immunogenicity via increased antigen content, for intramuscular use (ages 65 years or older)
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use, (ages 19 to 49 years)
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use (ages 18-49 years old)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative-free, for intramuscular use (ages 19 years and older)
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use (ages 19 years and older)
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use (ages 19-99 years old)
G9141	Influenza A (H1N1) immunization (administration only) (ages 0 years and older)

Instructions for CMS-1500 Claim Form

The following table contains information that will aid in the completion of the **CMS-1500 claim form**. The table follows the claim form by field name and number, giving a brief description of the information to be entered, and whether providing information in that field is required, optional, or conditional of the individual beneficiary's situation.

Carefully follow these instructions to help the Arkansas Medicaid Enterprise efficiently process claims. Accuracy, completeness, and clarity are essential. Claims **cannot** be processed if necessary information is omitted.

Note: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

Table 2: CMS-1500 Claim Form Field List

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
Field Name and Number	**Instructions for Completion**
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.

	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.

10. IS PATIENT'S CONDITION RELATED TO:

a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.

Table 2: CMS-1500 Claim Form Field List

10d. CLAIM CODES	The “Claim Codes” identify additional information about the beneficiary’s condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.

Table 2: CMS-1500 Claim Form Field List

Field Name and Number	Instructions for Completion
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
Field Name and Number	**Instructions for Completion**

Table 2: CMS-1500 Claim Form Field List

Field	Name	Instructions
15.	OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Pharmacy services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	(blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b.	NPI	Not required.
A.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
B.	ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.

Table 2: CMS-1500 Claim Form Field List

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) for dates of service before 10-1-2014 or Tenth Revision (ICD-10-CM) diagnosis coding for dates of service on or after 10-1-2014. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
24A.	DATE(S) OF SERVICE The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence. 3.

Table 2: CMS-1500 Claim Form Field List

Field	Instructions
B. PLACE OF SERVICE	99 for Pharmacy Providers.
C. EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Not applicable to Pharmacy claims.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in the Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.

Table 2: CMS-1500 Claim Form Field List

Field	Name	Instructions
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid or Arkids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
	a. (blank)	Not required.
	b. (blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
	a. (blank)	Not required.
	b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.