
UCF 5.1 Billing Instructions

Line-by-line paper billing instructions
for Oregon Medicaid providers

Division of Medical
Assistance Programs

Oregon
Health
Authority

Overview

- This presentation is intended to provide information to help those to bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UCF 5.1 billing form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.
- We hope you find this tutorial helpful.

Claims processing

- Paper claims are data-entered into the claims system.
- Electronic claims (Web and Point of Sale) do not require specific claim forms and enter the system faster. Make sure you bill electronically whenever possible.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).

Before you bill

- Verify client eligibility on the date of service.
- Make sure you bill all prior resources first. Medicaid (DMAP) is the payer of last resort.
- Bill electronically if possible. You only need to bill on paper if you need to submit attachments with your claim, the claim is over a year old, and other certain instances.
- If you must bill on paper, use commercially available versions of the current UCF 5.1.

Paper billing tips

- When submitting handwritten claim forms:
 - Use blue or black ink; never use red ink.
 - Make sure your handwriting is legible. Zeroes should look different from the letter “O,” the number one (“1”) different from the letter “l,” etc.
 - Don’t use liquid paper/whiteout to make corrections.
- You can only bill two products on a single UCF 5.1 form.
 - If you need to bill more than two lines on a single claim, bill electronically. Then you don’t need to complete multiple paper claim forms.
- Check your printer alignment.

Form suppliers

- DMAP does not supply the UCF 5.1 form.
- You can order UCF 5.1 forms by contacting CommuniForm, LLC:
 - Order on the Web at www.communiform.com/ncpdp; or
 - Call 800-869-6508.
- If you don't want to purchase claim forms, you can use the Provider Web Portal for free!

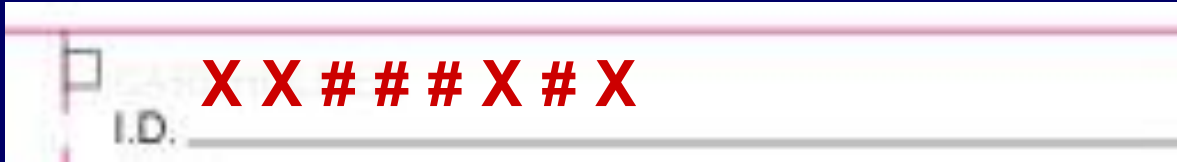
Claim header

INDIVIDUAL GROUP I.D. _____ I.D. _____
 NAME _____ PLAN NAME _____
 PATIENT NAME _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____
 PATIENT DATE OF BIRTH MM DD CCYY PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____
 PHARMACY NAME _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____
 ADDRESS _____ CITY _____ PHONE NO. () _____
 STATE & ZIP CODE _____ FAX NO. () _____
WORKERS COMP. INFORMATION
 EMPLOYER NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 CARRIER I.D. (6) _____ EMPLOYER PHONE NO. _____
 DATE OF INJURY MM DD CCYY CLAIM (7) REFERENCE I.D. _____
 I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.
 PATIENT / AUTHORIZED REPRESENTATIVE _____
FOR OFFICE USE ONLY
ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

Red = Required

Yellow = Required if applicable

Cardholder ID - Required



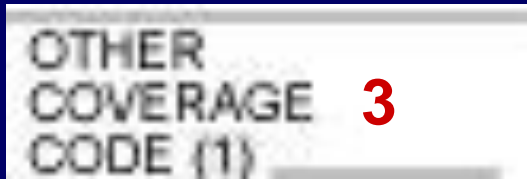
- Enter the client's eight-character Oregon Medicaid identification number.
- Enter the number exactly as it appears on the Medical Care Identification.

Patient Name- Required

PATIENT
NAME **Patient, Your**

- Enter the client's name exactly as it is printed on the Medical Care Identification.
- Use the client's last name first.
- Do not use nicknames.

Other Coverage Code – Required if applicable



- If the client has other medical coverage, enter the appropriate one-digit Other Coverage Code (at right).
- A code must be listed when the other insurance did not make a payment.
- A code is always required when the client has more than one other insurance carrier.

Accepted codes

- 0 = Not specified
- 1 = No other coverage identified
- 2 = Other coverage exists payment collected
- 3 = Other coverage exists this claim not covered
- 4 = Other coverage exists payment not collected
- 7 = Other coverage exists not in effect at time of service

Service Provider ID - Required

SERVICE PROVIDER I.D.	#####/##### ##
-----------------------	-------------------

- **Service Provider ID:**
 - In the first half of this field, enter the DMAP Provider ID.
 - In the second half this field, enter the 10-digit National Provider Identifier (NPI).
 - Separate the DMAP Provider ID from the NPI with a slash.

Worker's Comp. Information - Optional

WORKERS COMP. INFORMATION	
EMPLOYER NAME _____	I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below. PATIENT / AUTHORIZED REPRESENTATIVE _____
ADDRESS _____	
CITY _____	STATE _____ ZIP CODE _____
CARRIER I.D. (6) _____	EMPLOYER PHONE NO. _____
DATE OF INJURY MM DD CCYY _____	CLAIM (7) REFERENCE I.D. _____
ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE	

- Only complete this section when the claim is for services related to a Workers Compensation injury.

Claim detail

MM DD CCYY											
1											
PRESCRIPTION / SERV. REF. #		QUAL (8)	DATE WRITTEN			DATE OF SERVICE			FILL#	QTY DISPENSED (9)	DAYS SUPPLY
			MM	DD	CCYY	MM	DD	CCYY			
PRODUCT / SERVICE I.D.		QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED			PA TYPE (11)	PRESCRIBER I.D.		QUAL (12)	
DUR/FPS CODES (13)		BASIS COST (14)	PROVIDER I.D.		QUAL (15)	DIAGNOSIS CODE		QUAL (16)			
OTHER PAYER DATE		OTHER PAYER I.D.		QUAL (17)	OTHER PAYER REJECT CODES			USUAL & CUST. CHARGE			
MM DD CCYY											

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

Red = Required

Yellow = Required if applicable

Prescription/service reference # - Required



A screenshot of a form field with a light yellow background and a thin border. The text "PRESCRIPTION / SERV. REF. #" is printed in a small, dark font at the top of the field. Below this text, seven red hash symbols ("#####") are displayed, indicating a required 7-digit input.

- Enter the unique 7-digit number assigned by the pharmacy. Compound prescriptions must have a unique prescription number for each compound.
- In the Qualifier (QUAL) field, enter appropriate code:
 - Blank = Not specified
 - 1 = Rx billing
 - 2 = Service billing

Date Written - Required

DATE WRITTEN		
MM	DD	CCYY
MM	DD	CCYY

- Enter the date written on the prescription (MM/DD/YYYY).

Date of Service - Required

DATE OF SERVICE		
MM	DD	CCYY
MM	DD	CCYY

- Enter the date you provided the drug/product (MM/DD/YYYY).

Fill # - Required



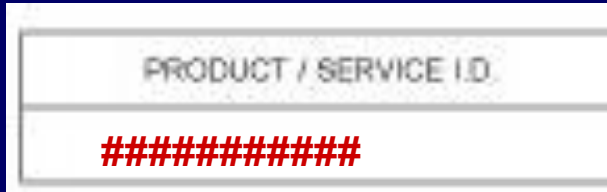
- Enter “0” for a new prescription, “1” for first refill, “2” for second refill, and so on.

Quantity Dispensed and Days Supply - Required

QTY DISPENSED (8)		DAYS SUPPLY
#	##	##

- Enter the quantity dispensed as a whole number. If you need to bill using decimals, bill electronically (point of sale or Provider Web Portal).
 - Do not include descriptive designations such as “ml,” “gm,” or “each.”
 - For additional information, refer to OAR 410-148-0320 Billing Quantities, Metric Quantities and Package Sizes.
- In the Days Supply field, estimate in days how long this quantity will last.

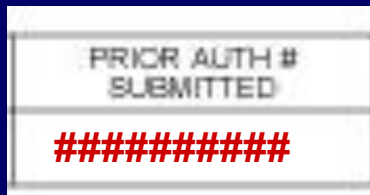
Product/Service ID - Required



PRODUCT / SERVICE I.D.
#####

- Enter the 11-digit National Drug Code (NDC) code for the drug/product being billed.
- If you cannot find an NDC number for an item that is prescribed and eligible for payment under this program, contact the Oregon Pharmacy Call Center.

Prior Authorization Number – Required if applicable



- For diabetic supplies in excess of DMAP's utilization guidelines, enter the 10-digit Prior Authorization number you received from DMAP.
 - Diabetic supply PA is authorized through DMAP Medical Management.
 - Claims for prescriptions and oral nutritional supplements do not require PA number.

Dispense as Written (DAW) – Required if applicable



- Enter “1” to indicate substitution not allowed by prescriber when the drug is a brand-name product and the proper documentation is on file with the pharmacy. PA is required.
 - To be “Dispensed as Written (DAW),” the prescription must have “Medically necessary,” “Brand medically necessary,” or “Brand necessary” written on it by the prescriber.
 - Initials or checked boxes are not acceptable.

Prescriber ID - Required



PRESCRIBER I.D.

#####

- Enter the 10-digit NPI for the physician who prescribed the drug. You can search for the provider's NPI at <https://nppes.cms.hhs.gov>.
- In the Qualifier (QUAL) field, enter "01" (NPI).

Diagnosis code – Required if applicable

DIAGNOSIS CODE	QUAL (19)
25003	01

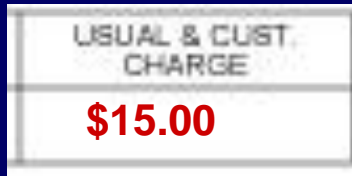
- Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number.
 - Carry the codes out to their highest degree of specificity (fourth or fifth digit).
 - The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.
 - Do not enter the decimal point or unnecessary characters.
 - In the Qualifier (QUAL) field, enter “01” (ICD-9).

Other Payer Reject Codes – Required if applicable

OTHER PAYER REJECT CODES
17

- If you entered an Other Coverage Code, enter the NCPDP Reject Codes you received from other payers.

Usual and Customary Charge - Required



- Enter the usual and customary charge for the drug/service.

Ingredient Cost Submitted – Required if applicable

\$45.00	INGREDIENT COST SUBMITTED
----------------	---------------------------------

- For compound drug claims, enter the ingredient costs.

Amount Due - Required

\$15.00	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
\$00.00	OTHER PAYER AMOUNT PAID
\$15.00	NET AMOUNT DUE

- **Gross Amount Due Submitted:** Enter the sum of all charges for the prescription.
- **Other Payer Amount Paid:** Enter the total amount paid by any other resource. Do not include DMAP copayments in this field. If the client has other insurance and this amount is zero, you must enter a code in the “Other Coverage” field.
- **Net Amount Due:** Subtract the Other Payer Amount Paid from the Gross Amount Due Submitted to get the total for this field.

Resources

Where to mail your claim	DMAP PO Box 14951 Salem, OR 97309-4951
Help with pharmacy billing	Oregon Pharmacy Call Center 888-202-2126
Provider Web Portal – Free paperless Web billing (for individual claims)	https://www.or-medicaid.gov
Electronic business practices (billing, payment and more)	www.oregon.gov/OHA/healthplan/ebp.shtml
Provider training	www.oregon.gov/OHA/healthplan/tools_provider/training.shtml

THANK YOU!