Hawaii State Medicaid Fee For Service Program
204 Claim Form Instructions (10/02)

1. **Identification Number:** Enter the member's identification number.
2. **Member's Name:** Enter the member's name: first and last name.
3. **Date of Birth:** Enter the member's date of birth: mm/dd/yyyy.
4. **Pharmacy NABP:** Enter the pharmacy NABP.
5. **Pharmacy Name:** Enter the name of the pharmacy.
6. **Physician's Name:** Enter the name of the physician.
7. **Physician's DEA #/ Provider Medicaid ID #:** Enter either the physician's DEA number or the Provider's Medicaid ID number.
8. **Pharmacy Address:** Enter the address of the pharmacy, including city and zip code.
9. **Other Drug or Liability Coverage:** If the member does not have other drug or liability coverage, check **No** otherwise, **Yes** and enter the name of the other coverage.
10. **Date of Accident:** Enter the date of the accident or injury.
11. **Is the illness or injury:** Check whether the injury was work related, third party, an automobile accident, or another type of accident.
12. **ICF-MR/ICF/SNF:** Check whether or not ICF-MR/ICF/SNF.
13. **RX Number:** Enter the prescription number.
14. **Metric Qty:** Enter the metric quantity of the prescription; include the decimal amount where applicable.
15. **Days Supply:** Enter the number of days supplied for this prescription.
16. **NDC:** Enter the NDC number, #####-####-##.
17. **Diag. Code:** Enter the diagnosis code for the claim, ###.#.
18. **Date:** Enter the date of service, MM/DD/YYYY.
19. **New/Refill:** Check whether this is a new prescription or a refill.
20. **Drug Name:** Enter the name of the drug prescribed.
21. **DAW Code:** Enter the dispense as written code, such as 0,1,5, or 7.
22. **Prior Authorization No:** Enter the prior authorization number, ##########.
23. **Reason for Refill Too Soon Override:** Enter the reason for overriding a refill too soon: Lost/Stolen, Vacation, Additional Therapy Authorized, Change in Dose, Readmission to LTC facility
24. **Compd:** If this is a compound, check the box.
25. **Submitted Charge:** Enter the amount of the charge submitted.
26. **Paid by TPL Amount:** Enter the amount paid by a third party. Attach a copy of the Explanation of Benefits.
27. **Total:** Enter the total amount for this drug: Submitted Charge minus the amount paid by TPL if applicable.

*Note: Please **boldly label** on the top of paper claim if any of the following apply:*

Early Refill
Vacation
Home Infusion
TPL
Spend down
Elig problem
Coupon
Dx Code
MD Specialty
Mandatory Brand