FORM INSTRUCTIONS
DHS Form 204 CLAIM FORM (Rev. 03/07)
Prescription Drug Form

PURPOSE:
Fee For Service program manual paper claim for prescription drug claim

FORM INSTRUCTIONS:
1. **Identification Number:** Enter the recipient's identification number.
2. **Recipient's Name:** Enter the recipient's name: first and last name.
3. **Date of Birth:** Enter the recipient's date of birth: mm/dd/yyyy.
4. **Pharmacy's National Provider Identifier (NPI):** Enter the pharmacy's NPI.
5. **Pharmacy's Name:** Enter the name of the pharmacy.
6. **Pharmacy's Address:** Enter the address of the pharmacy, including city and zip code.
7. **Prescriber's NPI:** Enter the prescriber's NPI.
8. **Prescriber's Drug Enforcement Agency (DEA) number (for C II – V drugs):** Enter prescriber's DEA number.
9. **Prescriber's Name:** Enter the name of the prescriber.
10. **Other Drug or Liability Coverage:** If the recipient does not have other drug or liability coverage, check **No** otherwise, **Yes** and enter the name of the other coverage.
11. **Date of Accident:** Enter the date of the accident or injury.
12. **Is the illness or injury:** Check whether the injury was work related, third party, an automobile accident, or another type of accident.
13. **ICF-MR/ICF/SNF:** Check whether or not ICF-MR/ICF/SNF.
14. **RX Number:** Enter the prescription number.
15. **Metric Quantity:** Enter the metric quantity of the prescription; include the decimal amount where applicable.
16. **Billing Unit:** Check the appropriate National Council for Prescription Drug Program's (NCPDP) billing unit for this prescription: Gm = gram; ML = milliliters; Each = all other forms.
17. **Days Supply:** Enter the number of days supplied for this prescription.
18. **NDC:** Enter the NDC number, ##### **-** #### **-** ##.
19. **Diagnosis Code:** Enter the diagnosis code for the claim, ### **.** #.
20. **Date:** Enter the date of service, MM/DD/YYYY.
21. **New/Refill:** Check whether this is a new prescription or a refill.
22. **Drug Name/Strength:** Enter the name of the drug prescribed and the strength.
23. **DAW Code:** Enter the 'dispense as written' (DAW) code, such as 0, 1, 5, 7 or 9.
24. **Prior Authorization Number:** Enter the prior authorization number, ###########.
25. **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 long term care (LTC) facility
26. **Compound:** If this is a compound, check the box.
27. **Submitted Charge:** Enter the amount of the charge submitted.
28. **Paid by Third Party Liability (TPL) Amount:** Enter the amount paid by a third party. Attach a copy of the Explanation of Benefits (EOB).
29. **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 (Third Party Liability)
Spend Down,
Eligibility Problem,
Coupon,
Diagnosis Code,
MD Specialty OR
Mandatory Brand.

FILING INSTRUCTIONS:
Retain a copy and submit the original by mail to:

ACS
Hawaii State Medicaid Fee For Service Program
Attention: Claims
P.O. Box 967
Henderson, NC 27536-0967.