Colorado Medical Assistance Program

Colorado Pharmacy Claim Form (PCF-2)

I. Client Information

Client's Medicaid ID Number: _____ Group ID: COMEDICAID 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: 01

III. Prescriber Information

Prescriber's Last Name: _____ Prescriber's Phone Number: ___-___-____

Prescriber's ID: _____ Prescriber's ID Qualifier: 01

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: _____

Unit of Measure: _____ Prescription Origin Code: _____

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.

This form should be printed, completed by hand, or typed and mailed to Prime Therapeutics State Government Solutions, LLC

Please mail completed form(s) to:

Prime Therapeutics State Government Solutions, LLC, Attn: GV - 4102, P.O. Box 64811, St. Paul, MN 55164-0811

Revised 9/27/2024

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 ***

FIELD	VALUE	COMMENT
Client's Mcaid ID #	Client's 7-character Medical Assistance Program ID	Required
Group ID	COMEDICAID	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 Qualifier	01=NPI-National Provider Identifier	Default value on claim form
Prescriber's Last Name	Last Name of Prescriber	Required
Prescriber's Phone #	Prescriber's Phone #	Required
Prescriber's ID	Prescriber's NPI	Required
Prescriber's ID Qualifier	01=National Provider Identifier	Default value on claim form
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
Prescription Origin Code	1=Written 2=Telephone 3=Electronic 4=Facsimile 5=Pharmacy	Required
Days Supply	# of Days Prescription is Prescribed	Required
DAW Codes	0=No Generic Available or Generic Medication 1=Physician Requested	Required when the valid values are appropriate for submission of the claim
PA Type Code	0=Not Specified	
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 "0"
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
Unit of Measure	Ea=each GM=grams ML=milliliters	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 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 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	02=ICD10 Code	
Diagnosis Code	ICD10 Code on Prescription	Required if this information can be used in place of prior authorization request

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

FIELD	VALUE	COMMENT
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.		
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