MAGELLAN MEDICAID ADMINISTRATION

Michigan Department of Community Health (MDCH) Claim Form

Please print using blue or black ink. Grayed boxes are for official use only.

(1) I.D. _____ (2) PATIENT NAME: _____

(3) PERSON CODE 01 (4) PATIENT DATE OF BIRTH _____ / _____ / _____ MM DD CCYY (5) PATIENT GENDER CODE (1 for Male OR 2 for Female) _____ (6) PATIENT RELATIONSHIP CODE 1

(7) PATIENT ADDRESS _____ (8) CITY _____ (9) STATE & ZIP CODE _____

(10) PHARMACY NAME _____

(11) ADDRESS _____ (14) SERVICE PROVIDER I.D. _____

(12) CITY _____ (15) PHONE NO. _____ - _____ - _____

(13) STATE & ZIP CODE _____ (16) FAX NO. _____ - _____ - _____

(17) QUAL
01

ATTENTION: PLEASE READ THIS CERTIFICATION STATEMENT BEFORE SIGNING.

(18) I certify that the patient information entered on this form is correct, that the patient named is eligible for the benefits, and that I have received the medication described. I also authorize release of all information pertaining to this claim.

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 _____

1

(19) PRESCRIPTION/ SERV. REF. #	(20) QUAL	(21) DATE WRITTEN MM	DD	CCYY	(22) DATE OF SERVICE MM	DD	CCYY	(23) FILL #	(24) QTY DISPENSED	(25) DAYS SUPPLY	(26) UNIT OF MEASURE	(33) USUAL & CUST. CHARGE
	1											

(27) PRODUCT / SERVICE I.D.	(28) QUAL	(29) PRESCRIBER I.D.	(30) QUAL	(31) PROVIDER I.D.	(32) QUAL
	03		**01**		**01**

2

(19) PRESCRIPTION/ SERV. REF. #	(20) QUAL	(21) DATE WRITTEN MM	DD	CCYY	(22) DATE OF SERVICE MM	DD	CCYY	(23) FILL #	(24) QTY DISPENSED	(25) DAYS SUPPLY	(26) UNIT OF MEASURE	(33) USUAL & CUST. CHARGE
	1											

(27) PRODUCT / SERVICE I.D.	(28) QUAL	(29) PRESCRIBER I.D.	(30) QUAL	(31) PROVIDER I.D.	(32) QUAL
	03		**01**		**01**

Please call the **Magellan Medicaid Administration Beneficiary Help Line** toll-free at **1-877-681-7540** if you have questions about this form (*Monday through Friday 8:00 a.m. – 5:00 p.m. EST).*

Mail this form, with receipts, to **Paper Claims Processing Unit ▪ P.O. Box 85042 ▪ Richmond, VA 23261**