Arkansas Department of Human Services
Division of Medical Services

Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us

TO: **Arkansas Medicaid Health Care Providers - Pharmacy**

DATE: **September 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal #74**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	9-1-04	201.000	9-1-05
204.000 – 205.000	9-1-04	204.000 – 205.000	9-1-05
211.000	9-1-04	211.000	9-1-05
213.100	9-1-04	213.100	9-1-05
219.000 – 221.000	Dates vary	219.000 – 221.000	9-1-05
251.101	10-13-03	251.101	9-1-05
252.000 – 254.000	10-13-03	252.000 – 254.000	9-1-05
261.000 – 262.100	10-13-03	261.000 – 262.100	9-1-05
262.300 – 262.310	10-13-03	262.300 – 262.310	9-1-05

Explanation of Updates

Section 201.000 is included to clarify that subsequent license renewal must be forwarded to the Provider Enrollment Unit within 30 days of issuance and failure to do so may result in termination from the Arkansas Medicaid Program.

Sections 204.000, 205.000, 211.000, 213.100, 214.000, 219.000, 220.000, 251.101, 252.000, 253.000, and 261.000 have been included to make minor wording changes. The word recipient or recipients has been changed to beneficiary or beneficiaries.

Section 221.000 is included to indicate a department name change. Effective July 1, 2005, the Department of Human Services has changed to the Department of Health and Human Services.

Section 253.000 is included to make a correction. The Prescription Clarification Code is **08** instead of 03.

Sections 261.000, 262.000 and 262.300 are included to remove obsolete information.

Section 262.100 is included to make a correction to a procedure code. Procedure code **90658** replaces procedure code 90659. This information was inadvertently omitted.

Section 262.310 is included to remove information in field 29 of the CMS-1500 claim instructions regarding co-payments imposed by private insurance. The beneficiary is no longer responsible for insurance co-payments.

The following Official Notices can be deleted since they are not applicable to the Pharmacy manual: DMS-2004-W-2, DMS-2004-W-1, and DMS-2003-W-1.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

201.000 Arkansas Medicaid Participation Requirements for Pharmacy Providers 9-1-05

Providers of pharmacy services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. The pharmacy must complete a provider application, a Medicaid contract and a Request for Taxpayer Identification Number and Certification with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (W-9).**

B. The pharmacy must have a current retail pharmacy permit issued by the applicable State Board of Pharmacy. A current copy of the pharmacy permit must accompany the provider application and Medicaid contract. Subsequent permits must be provided when renewed.

1. Subsequent license renewal must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance.

2. Failure to ensure that current licensure and/or certification is on file with the Medicaid Provider Enrollment Unit will result in termination from the Arkansas Medicaid Program.

C. The pharmacy must have a DEA number issued by Drug Enforcement Agency. A current copy of the DEA certificate must accompany the provider application, Request for Taxpayer Identification Number and Certification, and Medicaid contract. Subsequent certificates must be provided when renewed.

1. Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issuance.

2. Failure to ensure that current DEA certification is on file with the Medicaid Provider Enrollment Unit will result in termination from the Arkansas Medicaid Program.

D. Indian Health Services (HIS) pharmacy providers enrolled in other states' pharmacy programs will meet Arkansas enrollment criteria if they provide proof of other state enrollment.

E. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program.

204.000 Administrative Requirements for Pharmacies 9-1-05

A. Pharmacy providers are prohibited from offering incentives (e.g., discounts, rebates, refunds or any other similar gratuity) for the purpose of soliciting the patronage of Medicaid beneficiaries. (See Section I of this manual.)

B. Pharmacies may be required to participate in studies as the Department of Health and Human Services deems necessary in order to maintain an equitable program.

C. In order to maintain program integrity, the Arkansas Division of Medical Services has the right to collect medication samples from the recipients (or long-term care facility, if a beneficiary is a patient there).

D. Information regarding ownership or financial interest and the identity of any agent or managing employee convicted of a Medicaid-related offense must be provided to the Arkansas Division of Medical Services within thirty (30) days of a written request.

205.000 Regulations and Procedures Governing Payment to Pharmacies for Pharmaceutical Services for Eligible Medicaid Recipients 9-1-05

A. Clozapine must be billed as one prescription for a month's supply. Medicaid must be billed when the first week's supply is given. If the patient does not receive a full month's supply, the claim can be adjusted at the end of the month to the quantity actually dispensed to the patient.

B. When a Medicaid beneficiary receives BetaSeron for ten consecutive months, the manufacturer will provide a two-month supply free of charge. Providers can not bill Medicaid for the two (2) free months.

211.000 Scope 9-1-05

The Arkansas Medicaid Pharmacy Program conforms to the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Web site at **www.medicaid.state.ar.us**. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes. As additions or deletions by labelers are submitted to the State by the Centers for Medicare and Medicaid Services (CMS), the Web site will be updated.

The Arkansas Medicaid Program will cover the following drug categories:

A. Prescription drugs are covered by the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. The Multisource Drugs Listing located on the DMS Web site at **www.medicaid.state.ar.us** lists those products covered by the Arkansas Medicaid Program that have a generic upper limit (See Section 251.300 for an explanation of generic upper limit.)

   As changes are made to the drug coverage, providers will be notified of the revisions.

B. Over-the-counter items are listed on the Web site at **www.medicaid.state.ar.us**. These items are covered only if they contain an appropriate National Drug Code on their label and are manufactured by a company that has signed a rebate agreement. Over-the-counter items are not covered for long-term care facility residents. **View or print a list of over-the-counter items.**

   NOTE: The Arkansas Medicaid Program will cover the above-listed vaccines only for Medicaid recipients age 21 years and older.

C. For individuals age 21 years and older, the Arkansas Medicaid Program will reimburse pharmacies the cost of administering, by injection, two types of vaccines:

   1. Influenza virus vaccine, whole virus, for intramuscular or jet injection use and
   2. Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use.

A prescription order from an authorized prescriber must be on file; however, no primary care physician (PCP) referral is required to administer the vaccines.

These vaccines are payable for Medicaid-eligible beneficiary age 21 years and older. The influenza virus vaccine is limited to one per state fiscal year (July through June). The pneumococcal polysaccharide vaccine is limited to one every ten years.

Medicaid will reimburse the Medicare deductible and/or coinsurance for all beneficiaries receiving both Medicare and Medicaid benefits.

Pharmacies must use the CMS-1500 claim form when billing Medicaid for these vaccines.

213.100 Monthly Prescription Limits 9-1-05

A. Each prescription for all Medicaid-eligible beneficiaries may be filled for up to a maximum thirty-one-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum 31-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding 31 days, the days supply limit (other than 31), as approved by the Agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days supply limits on specially packaged dosage units. **View or print the EDS Pharmacy Help Desk contact information.**

B. Each Medicaid-eligible beneficiary age 21 years and older is limited to three (3) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. This includes, but is not limited to, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics and diaphragms.
2. Prescriptions for Medicaid-eligible long-term care facility residents. (Prescriptions must be for Medicaid-covered drugs.)
3. Prescriptions for Medicaid-eligible beneficiaries under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. (Prescriptions must be for Medicaid-covered drugs.)

219.000 Use of Generic Drugs 9-1-05

When a pharmacist receives a prescription for a brand- or trade-name drug, the pharmacist must

A. Dispense the lower-cost generically equivalent drug product, when available. However, this does not prevent the beneficiary from purchasing the brand- or trade-name product if they choose to pay for the prescription.

or

B. If the brand-name drug has a federal or state generic-upper-limit price, the pharmacist may dispense the brand-name product but will only be reimbursed at the generic upper limit. (See **www.medicaid.state.ar.us** for an explanation of generic upper limit.)

220.000 Utilization Review 9-1-05

Drug utilization review procedures have been established for program control. It is expected that with the cooperation of provider pharmacists, high standards of patient care may be achieved through the promotion of rational drug therapy.

The pharmacist assumes professional responsibility in dispensing drugs to eligible beneficiaries under the Medicaid Program. He or she may refuse to dispense any prescription that appears to be improperly executed or, in his or her professional judgment, is unsafe as presented. He or she may refuse to dispense drugs to known addicts or to persons known to "shop" for physicians or pharmacies in an effort to obtain more drugs than one physician would authorize.

Prospective Drug Utilization Review (ProDUR) alerts will provide for a review of drug therapy at the point of sale where each prescription is filled to allow the pharmacist to make sound professional judgment decisions concerning any potential drug therapy problems. The pharmacist may override the ProDUR alert, after professional consideration of the information, if an override is necessary for the health and well-being of the beneficiary. All information pertaining to ProDUR overrides is retained on file with Medicaid.

221.000 Record-Keeping Requirements 9-1-05

Medicaid requires that drug records (e.g., purchase invoices, official dispensing records, prescriptions and inventory records) must be kept in a manner that is readily retrievable and retained for at least five (5) years or until all issues are resolved regarding audits, litigations, appeals, etc. Although the Arkansas State Board of Pharmacy requires record retention for at least two (2) years, the record-retention requirement is expanded to five (5) years for Medicaid providers.

Upon request, providers must furnish records to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Unit, representatives of the Department of Health and Human Services (DHHS), the Medicaid Fraud Division of the Attorney General's Office and the Centers for Medicare and Medicaid Services (CMS). Failure to furnish records upon request may result in sanctions being imposed.

251.101 Discounts and Other Promotions 9-1-05

Discrimination against Medicaid beneficiaries is prohibited. No Medicaid beneficiary shall be excluded from any temporary or promotional discount or price reduction available to persons who are not Medicaid beneficiaries. If a temporary or promotional discount or price reduction is targeted to a specific population by a characteristic such as age, only Medicaid beneficiaries who are similarly situated to persons to whom the promotion is directed are entitled to the discount or reduced price. Amounts billed to the Medicaid Program must be adjusted to reflect temporary or promotional discounts or price reductions irrespective of coupon or card presentation. If it is determined, by audit or otherwise, that one or more Medicaid beneficiaries was excluded from any temporary or promotional discount or price reduction, the difference between the reduced or discounted price and the price paid will be recouped from the Medicaid provider.

This section applies only to price reductions and discounts, not to the provider's usual and customary charges or to rates paid by other third-party payers. Nothing in this section shall be construed in any manner that is inconsistent with any other provision in this manual, or with 42 U.S.C. § 1320a-7b.

252.000 Dispensing Fee Reimbursement for Long-Term Care Recipients 9-1-05

Only one dispensing fee per month per drug strength will be reimbursed by the Medicaid Program for certified long-term care beneficiaries. This applies even if various brands of the same generic drug or chemical entity are dispensed during the month. The provider must bill the National Drug Code number for the generic drug or chemical entity actually dispensed.

253.000 Compounded Prescriptions 9-1-05

Compounded prescription claims may be submitted to the Program when multiple ingredients are used in the preparation of the medication provided to the Arkansas Medicaid beneficiary. Up to twenty-five (25) National Drug Codes (NDCs) may be submitted for compounded prescription claims. The provider must indicate the metric decimal quantity of each submitted NDC. The metric decimal quantity field at the header level should reflect the total quantity of the final compounded prescription. A prescription is only considered a compounded prescription if two or more NDCs are submitted as ingredients on the claim. If one or more of the ingredients is not payable by the Program, the cost of those non-covered products will not be included in the payment for the claim. If the pharmacist opts to provide a compounded prescription in spite of the non-coverage of one or more ingredients, the beneficiary is not responsible for the cost of any non-covered ingredients used to prepare the prescription, but only for the applicable co-payment. The provider may submit a Prescription Clarification Code of 08 (in field 420-DK) to accept payment for only the covered ingredients of the compound. If the Prescription Clarification Code of 08 is not submitted, the program will reject the claim with an error message informing the provider of the non-covered status of one or more ingredients. The compounded prescription claim, with two to twenty-five ingredients, will count as one claim against the Medicaid beneficiary's prescription drug benefit limit.

Due to provisions set forth in the Omnibus Budget Reconciliation Act (OBRA 90), only the NDC that is dispensed and the quantity of the NDC that is dispensed can be submitted to Medicaid. If a pharmacy provider is unable to bill according to these guidelines due to software limitations, the vendor should be notified of these requirements immediately. Any pharmacy that continues to bill compounded prescription claims improperly will be subject to recoupment of the **total paid amount** of those claims.

254.000 Claims with Incorrect National Drug Code (NDC) Numbers 9-1-05

On each claim submitted for payment, the pharmacy provider must accurately record the NDC number for the drug product. The NDC number must be for the drug and package size actually dispensed. The entire 11-digit NDC number must be billed properly for the NDC to be correct. **When an audit determines that the incorrect NDC number was billed, providers are not allowed to reverse and file the claim again.** Instead, the state will recoup 20% of the paid amount for claims with incorrect NDC numbers. For example, if a pharmacy has claims with incorrect NDCs in the amount of $464.33, the following amount will be recouped:

$464.33 X 20% = $92.87.

261.000 Introduction to Billing 9-1-05

For paper billing of non-NCPDP claims (including immunosuppressant drug crossover claims or influenza virus and pneumococcal polysaccharide vaccine claims), pharmacy providers use the CMS-1500 form to bill the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

The Arkansas Medicaid Program is no longer accepting paper claim forms. Vendor systems are widely available for incorporation of claims submission in the pharmacy practice. EDS provides Provider Electronic Solutions (PES) software to providers. The PES software is posted on the Arkansas Medicaid Web site where providers may download it for use in submitting electronic transmissions, including NCPDP claims, reversals and eligibility inquiries. Providers experiencing difficulties in utilizing one of the available electronic transmission methodologies should contact the EDS Pharmacy Help Desk. **View or print EDS Pharmacy Help Desk contact information.**

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures 9-1-05

262.100 Procedure Codes for Influenza Virus and Pneumococcal Polysaccharide Vaccines 9-1-05

90658	90732

NOTE: The Arkansas Medicaid Program will cover the above vaccines only for Medicaid beneficiaries age 21 years and older.

262.300 Billing Instructions—Paper Only 9-1-05

Pharmacies must use the CMS-1500 claim format to bill for the administration of the Influenza Virus and Pneumococcal Polysaccharide Vaccines. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.**

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the EDS Claims Department contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Form 9-1-05

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.

	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
	c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is not required for Pharmacy services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.

18. Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19. Reserved for Local Use	Not applicable to Pharmacy claims.
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See section 262.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See section 262.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT procedure code.
Modifier	Not applicable to Pharmacy claims.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.

	I. EMG	Emergency - This field is not required for Medicaid.
	J. COB	Coordination of Benefit - This field is not required for Medicaid.
	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.

33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."