Arizona Community Plan pharmacy billing guidelines for COVID-19 vaccines

AHCCCS members, ages 16 and older

As the COVID-19 vaccine has been approved, UnitedHealthcare Community Plan wanted to provide direction for our pharmacies regarding the billing guidelines as they may differ from the normal process. The vaccine will be distributed by the federal government and will be free to all persons receiving a vaccine.

Billing guidelines

All vaccine administration claims should be billed on a CMS-1500 claim form* or submitted electronically using the 837P format.

- **Paper:** CMS-1500 claim form mailing address:
    - UnitedHealthcare Community Plan
      P.O. Box 5290
      Kingston, NY 12402-5240
- **Electronic:** 837P claim submission instructions can be found at **UHCprovider.com/en/resource-library/edi/edi-837-claims.html**
    - Our EDI Payer ID is 03432
- Claims should be submitted under the members AHCCCS ID (see Field 1a)
- Pharmacies should bill Medicare Fee for Service (FFS) directly, even if the member is enrolled in a UnitedHealthcare Community Plan Dual Complete® program
    - See the CMS website at **cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration**
- National drug codes (NDC) are **not** required
- The Ordering and Rendering provider should be the pharmacy administering the vaccine
    - Please see Field 17 and 17b for the Ordering provider information on the example provided
    - Please see Field 24J for the Rendering provider information on the example provided
- Place of Service (POS) should be the 2-digit code where the vaccine was administered. For example, if administered in a skilled nursing facility, the POS would be 31 in Field 31

*CMS-1500 claim form example provided on page 2

Initial vaccine codes

- Initial vaccine administration reimbursement will be $16.94
- 0001A – (Pfizer) ADM SARSCOV2 30MCG/0.3ML first dose
- 0011A – (Moderna) ADM SARSCOV2 100MCG/0.5ML first dose
- 91300 – SARSCOV3 VAC 30MCG/0.3ML toxoid

Second vaccine codes

- Second vaccine administration reimbursement will be $28.39
- 0002A – (Pfizer) ADM SARSCOV2 30MCG/0.3ML second dose
- 0012A – (Moderna) ADM SARSCOV2 100MCG/0.5ML second dose
- 91301 – (Moderna) SARSCOV2 VAC 100MCG/0.5ML toxoid

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United Healthcare Community Plan

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): AHCCCS ID (starts with A)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Mary J.

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1900 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Phoenix STATE: AZ

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 85004 TELEPHONE (Include Area Code) ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: UnitedHealthcare Comm.Plan

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK Pharmacy Name

17a. | 17b. NPI: Pharm.NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. Z23 | 3. | 2. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 14 20	12 14 20	31		0001A	1	30 00	1		NPI	Pharmacy NPI
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: Pharmacy TIN SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 30 00

29. AMOUNT PAID $

30. BALANCE DUE $ 30 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED ____ DATE ____

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

(Insert for Pharmacy pay-to address)

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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We're here to help

If you have questions, please call Provider Services at **800-445-1638** for AHCCCS Complete Care (ACC) and Developmental Disabilities (DD) or **800-293-3740** for Arizona Long-Term Care System (ALTCS). Thank you.

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