PHARMACY EMEDNY CLAIM FORM 000301 INSTRUCTIONS

The following guide gives instructions for proper claim form completion when submitting claims for Pharmacy Services using the eMedNY 000301 Pharmacy claim form. A field-by-field description is provided to indicate what entries are required when submitting claims to the eMedNY system.

1. PROVIDER ID NUMBER: Enter the 8-digit Medicaid Management Information System Identification Number assigned to the Provider at the time of enrollment in MMIS.

2. DATE FILLED: Enter the date filled in MMDDYY format.

3. SA EXCEPTION CODE: Enter the appropriate code from the list below if it was necessary to provide service and a UT Service Authorization (SA) could not be obtained.

1 = Immediate/Urgent Care
2 = Services Rendered in a Retroactive Period
3 = Emergency Care
4 = Client has Temporary Medicaid (DSS-2831A)
5 = Request from County for Second Opinion to Determine if Recipient can work
6 = Request for Override Pending
7 = Special Handling – used to indicate services are exempt from UT

4. CODE A/V: This field is only used to adjust or void a previously paid claim. Place an X over the A if submitting an Adjustment or an X over the V if submitting a Void.

4A. ORIGINAL TRANSACTION CONTROL NUMBER: This field is only used to adjust or void a previously paid claim. Enter the Transaction Control Number (TCN) of the claim that was previously processed. This field has been expanded to 16 spaces to accommodate the 16-digit TCN that replaces the 15-digit CRN.

- If you are submitting an adjustment or void to a claim that was processed prior to Phase II Implementation, you must enter the 15-digit CRN in the first 15 spaces and leave the last space blank.
- If you are submitting an adjustment to a claim that was processed after Phase II Implementation, enter the 16-digit TCN in this field. Pharmacy claims submitted with multiple lines (up to 4) will have a unique TCN assigned to each line.

5. RECIPIENT ID NUMBER: Enter the Recipient ID Number. Format must be 2 alpha - 5 numeric - 1 alpha.

6. DATE OF BIRTH: Enter the Recipient's date of birth in MMDDYYYY format.

7. SEX: Place an X on M for Male or on F for Female to indicate the Recipient's sex.

8. RECIPIENT OTHER INSURANCE CODE: This field is used as the copay bypass. Enter a code of Z9 if the client is exempt from copay or has met their copay maximum for the year.

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9. RECIPIENT NAME: Enter the Recipient's last name followed by the first name.

10. PROF CD: Enter the 3-digit profession code when a License number is entered in field 10A - Ordering/Prescribing Provider ID/License. The profession code identifies the profession assigned to the license number and is completed only when the Referring/Ordering Provider's License Number is used. If an MMIS Provider ID Number is entered in field 10A - Ordering/Prescribing Provider ID/License Number - the Prof Cd field must be blank.

10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER:

Prescriptions from Practitioners
Enter the Medicaid ID Number of the ordering/prescribing provider. If the orderer/prescriber is not enrolled in the Medicaid program, enter his/her License number.

Prescriptions from Facilities
For orders originating in a hospital, clinic, or other health care facility, the following rules apply:

> When a prescription is written by an unlicensed intern or resident, the supervising physician's Medicaid ID number or license number should be entered in this field. The facility's Medicaid ID number may be entered only when the prescriber's or the supervising physician's Medicaid ID or License number is unavailable.

Prescriptions from Physician's Assistants
When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number or license number should be entered in this field.

Prescriptions from Nurse Practitioners
Licenses issued to Nurse Practitioners certified to write prescriptions have seven characters which includes the letter "F" followed by six digits. Example: F012346.

Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders. If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field.

Note: If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.

Prescriptions for Restricted Recipients
When filling prescriptions/orders for a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) and the primary provider is the prescribing/ordering provider, the Medicaid ID number of this provider must be entered in this field. The license number of the primary provider is not acceptable in this case. If the restricted recipient was referred by his/her primary provider to another provider and this provider is the prescriber/orderer, the pharmacy provider must enter this provider's Medicaid ID number or license number in this field; then, the primary provider's Medicaid ID number must be entered in field 11A.

Instructions for Entering a License Number
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to the end of this document for Post Office state abbreviations.

10B. NAME (ORDERING/PRESCRIBING PROVIDER): Enter the last name and first name of the individual whose name appears as the Prescriber on the prescription/fiscal order.

11. PROF CODE (OTHER REFERRING/ORDERING PROVIDER): Leave this field blank.

11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER: If the Client is in the Restricted Recipient Program and was referred by his/her Primary Provider to another Provider who orders/prescribes services, enter the Primary Provider's MMIS Provider ID number in this field. A LICENSE NUMBER CANNOT BE USED IN THIS FIELD.

11B. NAME (OTHER REFERRING/ORDERING PROVIDER): Enter the last name and first name of the Primary Provider.

12. PRIOR APPROVAL/AUTHORIZATION NO: Enter the Prior Approval Number in this field if applicable.

12A. LINE: Enter the number of the claim line that corresponds to the prior approval/authorization that applies to the NDC/HCPCS code.

13. PRIOR APPROVAL/AUTHORIZATION NO: Enter the second prior approval/prior authorization number if applicable.

13A. LINE: Enter the number of the claim line that corresponds to the prior approval/authorization that applies to the second NDC/HCPCS code if applicable.

14. FOR OFFICE USE: Leave this field blank.

15. PRESCRIPTION/ORDER NUMBER: Enter the pharmacy prescription/order number in this field.

16. DATE ORDERED: Enter the original date the prescription/order was prescribed as it appears on the prescription/order signed by the Prescriber.

17. DRUG SUPPLY CODE: This field must be completed as follows:

For Prescription Drugs and OTCs: Enter the National Drug Code (NDC) of the drug on the package. The NDC code field is divided into 3 segments separated by hyphens. The 11-digit NDC code must be entered in the 3 segments in the following format: 5-digits, 4-digits, 2-digits. Enter the numbers appearing in the first segment of the NDC on the package in the first 5-digit segment on the claim. If the number is not a 5-digit code, enter zeroes to the left so that all 5 spaces are filled in. In similar fashion, fill in the remaining 2 segments of the field.

If billing for a compound, enter the 11-digit compound code of 99999999999.

For Supplies: Leave the first four spaces of this field blank. Enter the 5-character code from the procedure code section of the Pharmacy Provider manual in the next five spaces. Leave the next two spaces of this field blank unless a modifier is required. When a modifier is required, enter the 2-character modifier in the last two spaces of this field.

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18. QUANTITY DISPENSED: When completing this field, pharmacists must bill the decimal quantity dispensed. Claims can be billed in quantities up to seven characters before the decimal and three characters after the decimal. Do not round up at any point in the process.

19. DAYS SUPPLY: Enter the number of days for which the prescription/order was written. For example, a 30-day supply would be right justified as follows:

	3	0

If the prescription/order directs the patient "to take when necessary," enter PRN in this field.

P	R	N

20. NEW REFILL NUMBER: Enter a 0 in this field if the claim is for an original prescription/order. If the order is a refill, indicate the number of the refill. For example: Enter 1 for first refill. Enter 5 for the fifth refill.

20A. NUMBER OF REFILLS AUTHORIZED: Enter the number of refills indicated on the prescription for the drug or supply ordered. This number may not exceed 5 for drugs or supplies. If no refills are indicated on the prescription, enter 0 in this field.

21. BRAND NECESSARY: If the prescription form indicates "daw" in the Dispense As Written box and Prescriber writes "brand necessary" or "brand medically necessary" in their own handwriting on the face of the prescription, you must place an X on Y for Yes in the proper field to indicate brand dispensed.

22. AMOUNT CHARGED: Enter your usual and customary charge to the public for the quantity of the drug/supply dispensed. The dispensing fee of $3.50 for brand and $4.50 for generic drugs should be included in the total amount charged field.

MEDICARE: The Medicare fields must be filled out if the Client is a Medicare Beneficiary. It is the responsibility of the Provider to determine whether the NDC/HCPCS code is covered by the Client's Medicare coverage. The Provider must first submit the claim to Medicare prior to billing Medicaid.

23. MEDICARE CO-INSURANCE: Enter the amount of Medicare Coinsurance due which is the patient's responsibility. This amount may be obtained from the Medicare EOMB.

23A. MEDICARE DEDUCTIBLE: Enter the Medicare Part B deductible amount due for the services rendered. This amount may be obtained from the Medicare EOMB.

23B. MEDICARE CO-PAY: Enter the Medicare Co-pay amount.

23C. MEDICARE PAID: Enter the amount actually paid by Medicare for this service. If Medicare denies payment, enter $0.00. If the Provider knows that the service billed would not be covered by Medicare, enter $00.00 in this field.

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24. OTHER INSURANCE PAID: If the Client is covered by a third party insurance other than Medicare, this field must be completed. Enter the amount actually paid by the other insurance. If the Provider bills and receives a denial from the other insurance, enter $0.00 in this field.

This field is also used to report Client spenddown amount. Spenddown is a method by which an individual may incur a pre-determined amount of medical expenses in order to qualify for Medicaid. If the individual meets his/her requirement during the purchase of drugs or supply items, enter the amount in this field.

25. CASE MANAGER ID: Leave this field blank.

26. – 28. TOTALS: All of these Totals fields may be left blank.

29. SIGNATURE: The individual who has the legal responsibility for the operation of the pharmacy must sign each claim form. Rubber stamp signatures are not acceptable.

30. COUNTY OF SUBMITTAL: Enter the name of the county wherein the claim form is signed. The county of submittal field may be left blank only when the Provider's address is within the county wherein the claim form is signed.

31. BILLING DATE: Enter the billing date (the date you are completing the claim form) using 6 digits – MMDDYY format.

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NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER

2. DATE FILLED — MO DAY YR

3. SA EXCP. CODE

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4. CODE — A V
4A. ORIGINAL TRANSACTION CONTROL NUMBER

5. RECIPIENT ID NUMBER

6. DATE OF BIRTH — M M D D Y Y Y Y

7. SEX — M F (1 2)

8. RECIPIENT OTHER INSURANCE CODE

9. RECIPIENT NAME — LAST FIRST

PRIOR APPROVAL/AUTHORIZATION NO. — LINE

10. PROF CD
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER
10B. NAME
12. 12A.
FOR OFFICE USE ONLY

11. PROF CD
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
11B. NAME
13. 13A. 14.

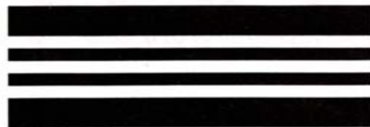
LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED (MO. DAY YR.)	17. DRUG/SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW/ REFILL NUMBER	20A. NO OF REFILLS AUTHOR-IZED	21. BRAND NECES-SARY (Y N)	22. AMOUNT CHARGED	MEDICARE 23. CO INSURANCE	MEDICARE 23A. DEDUCT-IBLE	MEDICARE 23B. CO PAY	MEDICARE 23C. PAID	24. OTHER INSURANCE PAID
1								Y N						
2								Y N						
3								Y N						
4								Y N						
5								Y N						
				25. CASE MGR. I.D.		TOTALS ▶			26.	27.	27A.	27B.	27C.	28.

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

29. SIGNATURE | 30. COUNTY* | 31. BILLING DATE — MO. DAY YR.

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

DO NOT WRITE IN BARCODE AREA



EMEDNY - 000301 (01/04) 1-11-0071 (12/03)

FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$

DOSAGE FORM AND DIRECTIONS		
	TOTAL INGREDIENT COST	
	COMPOUNDING FEE	
	DISPENSING FEE	
	AMOUNT CHARGED	$

Appendix A – Code Sets

PLACE OF SERVICE

Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
60	Mass immunization center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

UNITED STATES STANDARD POST OFFICE ABBREVIATIONS

Standard Post Office Abbreviations for States

State	Abbreviation	State	Abbreviation
Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	North Carolina	NC
Delaware	DE	North Dakota	ND
District of Columbia	DC	Ohio	OH
Florida	FL	Oklahoma	OK
Georgia	GA	Oregon	OR
Hawaii	HI	Pennsylvania	PA
Idaho	ID	Rhode Island	RI
Illinois	IL	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI
Mississippi	MS	Wyoming	WY

American Territories

Territory	Abbreviation	Territory	Abbreviation
American Samoa	AS	Puerto Rico	PR
Canal Zone	CZ	Trust Territories	TT
Guam	GU	Virgin Islands	VI

Note: Required only when reporting out-of-state license numbers.