STATE OF NEW YORK
DEPARTMENT OF HEALTH

eMedNY
MEVS Provider Manual

September 22, 2006
Version 1.17

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1.0 INTRODUCTION TO THE NEW YORK STATE MEDICAID ELIGIBILITY VERIFICATION SYSTEM (Rev. 10/03)

New York State operates a Medicaid Eligibility Verification System (MEVS) as a method for providers to verify client eligibility prior to provision of Medicaid services. The Identification Card does not constitute full authorization for provision of medical services and supplies. A client must present an official Common Benefit Identification Card to the provider when requesting services. The verification process through MEVS must be completed to determine the client's eligibility for Medicaid services and supplies. A provider not verifying eligibility prior to provision of services will risk the possibility of nonpayment for those services. In some instances, a provider not obtaining a service authorization prior to submitting a claim will be denied payment.

The verification process through MEVS can be accessed using one of the following methods:

- the MEVS Terminal (VeriFone).
- a telephone verification process (Audio Response Unit).
- alternate access methods: (CPU-CPU link, batch transmission, PC-Host link and ePACES).

Information available through MEVS will provide you with:

- The eligibility status for a Medicaid client for a specific date (today or prior to today).
- The county having financial responsibility for the client (used to determine the contact office for prior approval and prior authorization.)
- Any Medicare, third party insurance or HMO coverage that a client may have for the date of service.
- Any limitations on coverage which may exist for the client through Utilization Threshold (UT) or Post and Clear (PC) programs and the necessary service authorizations, if applicable.
- Any restrictions to primary providers or exception codes, which further clarify a client's eligibility.
- Co-payment information.
- Dispensing Validation Numbers (DVS) for certain Drugs, Durable Medical Equipment, and Dental Services. (Not available via telephone access.)
- The ability to verify or cancel a previously obtained Service Authorization (SA) (not available via ARU).

The above information is not available on the Common Benefit Identification Card issued to the client.

MEVS is convenient and easy to use; it is available 24 hours a day, seven days a week.

MEVS is accurate; it provides current eligibility status information for all Medicaid clients and is updated on a daily basis.

MEVS is responsive; verification information is given in clear, concise and understandable messages.

MEVS should result in a reduction of claims pending or denied due to Medicaid eligibility problems.

This manual is designed to familiarize you with MEVS. The manual contains different sections discussing the Common Benefit Identification Card, the verification equipment, procedures for verification, a description of eligibility responses, definitions of codes, and descriptions of alternate access methods.

ALTERNATE ACCESS TO MEVS (Rev. 02/05)

Additional alternative methods of access allow providers to use their own equipment to access MEVS. The following is a brief description of these alternate access methods.

- **ePACES**

Refer to ePACES on http://www.emedny.org/HIPAA/SupportDocs/ePACES.html

- **CPU-CPU LINK**

This method is for providers who want to link their computer system to the MEVS contractor's computer system via a dedicated communication line. Upon receiving a MEVS verification request, the MEVS contractor sends back a response within seconds.

CPU-CPU link is suggested for service bureaus and high volume (5,000 to 10,000 transactions per day) providers.

- **eMedNY eXchange**

This method allows users to transfer files from their computer via a web-based interface. Users are assigned an “inbox” and are able to send and receive transaction files in an email-like fashion. Transaction files are “attached” and sent to eMedNY for processing. Responses are delivered to the user’s inbox, and can be downloaded to the user’s computer.

- **Batch Transmission**

This method is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer (upload) or from another computer to their computer (download). Each batch file transmission sent to the eMedNY contractor is required to be completed within two hours. Any transmission exceeding two hours will be disconnected.

- **PC-HOST LINK**

This method requires a PC, a dial up modem, and a specific message format. Verification requests are transmitted to the MEVS contractor one transaction at a time. Verification responses are returned within seconds.

The PC-Host method is suggested for low volume (under 500 transactions per month) and medium volume (500-2,000 transactions per month) providers. It is also recommended for providers who want to capture Medicaid information electronically to combine with billing and claims processing.

For further information about alternate access methods and the approval process, please call 1-800-343-9000.

2.0 BENEFIT IDENTIFICATION CARDS/FORMS (Rev. 10/05)

The Benefit Identification Cards with which you will need to become familiar are:

- a CBIC permanent plastic photo card.
- a CBIC permanent plastic non-photo card.
- a replacement paper card.

Presentation of a Benefit Identification Card alone is not sufficient proof that a client is eligible for services. Each of the Benefit Identification Cards must be used in conjunction with the electronic verification process. If you do not verify the eligibility of each client each time services are requested, you will risk the possibility of nonpayment for services which you provide.

In addition, there is a Temporary Medicaid Authorization Form which constitutes full coverage for medical services and does not need to be verified via the electronic process. The following is a detailed description of the Temporary Medicaid Authorization Form and each of the cards.

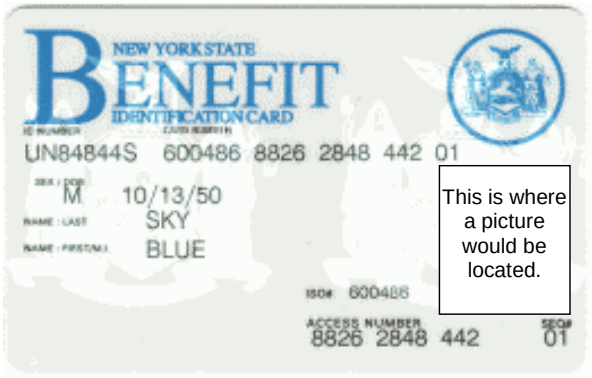
Temporary Medicaid Authorization Form

In some circumstances, the client may present you with a Temporary Medicaid Authorization (TMA) Form DSS-2831A (not pictured). This authorization is issued by the Local Department of Social Services when the client has an immediate medical need and a permanent plastic card has not been received by the client. The Temporary Medicaid Authorization Form is a guarantee of eligibility and is valid for 15 days. If presented with the authorization form after the time frame specified, the client should be requested to present his/her permanent Common Benefit Identification Card.

Providers should always make a copy of the TMA form for their records. Since an eligibility record is not sent to the eMedNY contractor until the CBIC Card is generated, the MEVS system will not have eligibility data for a client in TMA status. Note that any claim submitted for payment may pend waiting for the eligibility to be updated. If the final adjudication of the claim results in a denial for client eligibility, please contact the New York State Department of Health, Office of Medicaid Management, Local District Support. The phone number for inquiries on TMA issues for clients residing Upstate is (518)-474-8887. For New York City client TMA issues, the number is (212) 417-4500.

2.1 Permanent Common Benefit Identification Photo Card (Rev. 10/03)

The Permanent Common Benefit Identification Photo Card is a permanent plastic card issued to clients as determined by the Local Department of Social Services. This permanent card has no expiration date. Eligibility must be verified using the MEVS system.



COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
ID Number	Eight-digit number assigned by the State of New York which identifies each individual Medicaid client. This number contains both alpha and numeric digits. **This is the Client Identification Number (CIN) to be used for billing purposes. Client ID # must be two alpha, five numeric and one alpha.**
Sex	One letter character indicating the sex of the client. This character is located on the same line as date of birth. M = Male F = Female U = Unborn (Infant)
Date of Birth	Client's date of birth, presented in MM/DD/YY format. Example: August 15, 1980 is shown as 08/15/1980. Unborns (Infants) are identified by 00000000. The date is located on the same line as sex.
Last Name	Last name of the client who will use this card for services.
First, M.I.	First name and middle initial of the person named above.
Signature	Electronic Signature of cardholder, parent, or guardian.
ISO#	Six-digit number assigned to the New York State Department of Health (DOH). Disregard when manually entering access number for Medicaid verification.

COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
Access Number	Thirteen-digit number (including the 2 digit sequence number) used for entry into the Medicaid Eligibility Verification System. The access number is not used for billing.
Sequence Number	Two-digits at the end of the access number. This number is used in the entry process of access number and client number (CIN) verifications.
Photo	Photograph of the individual cardholder.
Magnetic Stripe	Stripe with enclosed information that is read by the MEVS terminal.
Signature Panel	Must be signed by the individual cardholder, parent or guardian to be valid for services.

2.2 Permanent Common Benefit Identification Non-Photo Card (Rev. 10/03)

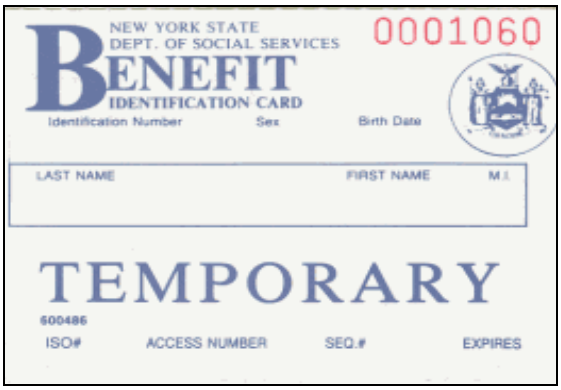
The Common Benefit Identification Non-Photo Card is a permanent plastic card issued to clients as determined by the Local Department of Social Services. This permanent card has no expiration date. Eligibility must be verified using the MEVS system.

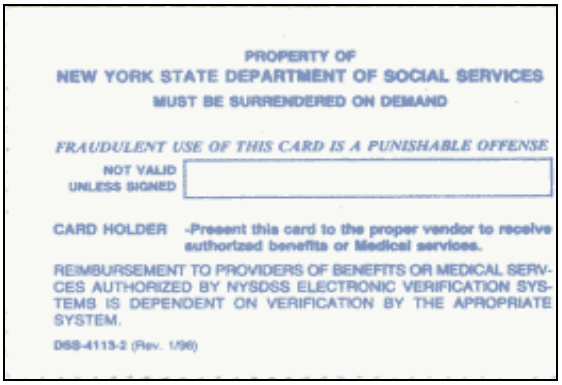
COMMON BENEFIT IDENTIFICATION NON-PHOTO CARD DESCRIPTION	
ID Number	Eight-digit number assigned by the State of New York, which identifies each individual client. **This is the Client Identification Number (CIN) to be used for billing purposes. Client ID # must be two alpha, five numeric and one alpha.**
Sex	One letter character indicating the sex of the client. This character is located on the same line as date of birth. M = Male F = Female U = Unborn (Infant)
Date of Birth	Client's date of birth, presented in MM/DD/YY format. Example: August 15, 1980 is shown as 08/15/1980. Unborns (Infants) are identified by 00000000. The date is located on the same line as sex.
Last Name	Last name of the client who will use this card for services.
First, M.I.	First name and middle initial of the person named above.
ISO#	Six-digit number assigned to the New York State Department of Health (DOH). Disregard when manually entering access number for Medicaid verification.
Access Number	Thirteen-digit number (including the 2 digit sequence number) used for entry into the Medicaid Eligibility Verification System. The access number is not used for billing.

COMMON BENEFIT IDENTIFICATION NON-PHOTO CARD DESCRIPTION	
Sequence Number	Two-digits at the end of the access number. This is used in the entry process of access number and client number (CIN) verifications.
Magnetic Stripe	Stripe with encoded information that is read by the MEVS terminal.
Signature Panel	Must be signed by the individual cardholder, parent or guardian to be valid for services.

2.3 Replacement Common Benefit Identification Card (Rev. 10/03)

The Replacement Common Benefit Identification Card is a temporary paper card issued by the Local Department of Social Services to a client. This card will be issued when the Permanent Common Benefit Identification Card is lost, stolen or damaged. When using the MEVS terminal for eligibility verification, all information will need to be entered manually.





REPLACEMENT COMMON BENEFIT IDENTIFICATION CARD DESCRIPTION	
ID Number	Eight-digit number assigned by the State of New York which identifies each individual client. **This is the Client Identification Number (CIN) to be used for billing purposes. Client ID # must be two alpha, five numeric and one alpha.**
Sex	One letter character indicating the sex of the client. This character is located on the same line as date of birth. M = Male F = Female U = Unborn (Infant)
Date of Birth	Client's date of birth, presented in MM/DD/YY format. Example: August 15, 1980 is shown as 08/15/1980. Unborns (Infants) are identified by 00000000.
Name	Name of the client who will be able to use this card for services.
ISO#	Six-digit number assigned to the New York State Department of Health (DOH). Disregard when manually entering access number for Medicaid verification.
Access Number	Thirteen-digit number (including the 2 digit sequence number) used for entry into the Medicaid Eligibility Verification System. The access number is not used for billing.

REPLACEMENT COMMON BENEFIT IDENTIFICATION CARD DESCRIPTION	
Sequence Number	Two-digits at the end of the access number. This number is used in the entry process of access number and client number (CIN) verifications.
Expiration Date	Date the temporary card expires.
Signature Panel	Must be signed by the individual cardholder, parent or guardian to be valid for services.

Note: When verifying a client's eligibility be aware of the expiration date on the front of the card. The card is not valid if the date has expired. A response "INVALID CARD THIS RECIPIENT" will be returned.

3.0 INTRODUCTION TO TELEPHONE (AUDIO RESPONSE UNIT) VERIFICATION
(Rev. 10/03)

Verification requests for client eligibility may be entered into the MEVS system through a touch-tone telephone. This access method is suggested for providers with very low transaction volume (under 50 transactions per month). For convenience, providers with higher volumes should use the VeriFone Terminal or refer to Alternate Access to MEVS on page 1.0.2.

Access to the Telephone Verification System (Rev. 02/05)

A toll free number has been established for both New York State and Out of State Providers. To access the system, dial **1-800-997-1111**.

If you wish to be transferred directly to an eMedNY Provider Services Representative, you may press “0” on the telephone keypad at any time during the first four prompts.
The following message will be heard:
“The ARU Zero Out Option”
You will then be connected to the eMedNY Provider Services Helpdesk.

If you are unable to connect to MEVS by dialing the above primary number, dial the back-up number, **1-800-225-3040**. This back-up number must only be used when the primary number is not working. Once you complete your verification, you must return to using the primary number.

If the connection is unsuccessful using either number, call Provider Services at **1-800-343-9000**.

3.1 Telephone Equipment Specifications (Rev. 11/02)

A regular touch-tone telephone is the only access to the Audio Response Unit (ARU). It can be identified by the push button dial and different tones when dialing or entering information into MEVS.

The telephone keypad has two keys with which you should become familiar:

- The *(asterisk) key is used to clear a mistake that you have made. Once the incorrect information is cleared, re-enter the correct information for that step.

  Note: This key must be pressed before you press the # key.

  The * (asterisk) key is also used to repeat the verification response.

- The # (pound) key separates information. It must be pressed after each piece of information is entered.

3.2 Telephone Verification Using the Access Number or Medicaid Number (CIN)
(Rev. 10/03)

The access number is a thirteen-digit numeric identifier on the Common Benefit Identification Card that includes the sequence number. The easiest and fastest verification method is by using the access number.

The Medicaid number (CIN) is an eight-digit alpha/numeric identifier on the Common Benefit Identification Card. The Medicaid number (CIN) can also be used to verify a client's eligibility. You must convert the eight-digit identifier to a number with eleven-digits. The three letters are the only characters converted in the number. You should refer to the chart below when converting the Medicaid number (CIN). For example:

A D 12345 Z = eight-digit Medicaid number (CIN)
21 31 12345 12 = becomes an eleven-digit number

For this example, the chart indicates that the letter A = 21, D = 31 and Z = 12. Replace the letters A, D and Z with the numbers 21, 31 and 12 respectively. The converted number is 21311234512

ALPHA CONVERSION CHART

A = 21	N = 62
B = 22	O = 63
C = 23	P = 71
D = 31	Q = 11
E = 32	R = 72
F = 33	S = 73
G = 41	T = 81
H = 42	U = 82
I = 43	V = 83
J = 51	W = 91
K = 52	X = 92
L = 53	Y = 93
M = 61	Z = 12

Note: Perform the required conversion before dialing MEVS.

3.3 Telephone Verification Input Section (Rev. 02/05)

Instructions for Completing a Telephone Transaction

• If using a CIN, be sure to convert the number before dialing. Refer to the chart on the previous page.

• Dial 1-800-997-1111.

• Once you have dialed and a connection is made, an Audio Response Unit (ARU) will prompt you for the input data that needs to be entered.

• If you wish to hear a prompt repeated, press *, (asterisk).

• To bypass a prompt, press #, (the pound key).

• To clear a mistake, press the * key and re-enter the correct information. This step is only valid if done prior to pressing the # key which registers the entry.

• Once you are familiar with the prompts and wish to make your entries without waiting for the prompts, just continue to enter the data in the proper sequence. As in all transactions (prompted or unprompted), press the # key after each entry.

• For assistance or further information on input or response messages, call the Provider Services staff at 1-800-343-9000.

• For some prompts, if the entry is invalid, the ARU will repeat the prompt. This allows you to correct the entry without re-keying the entire transaction.

• The call is terminated if excessive errors are made.

• To be transferred to an eMedNY Provider Services Representative, press “0” on the telephone keypad at any time during the first four prompts. The following message will be heard: “The ARU Zero Out Option”. You will then be transferred to the eMedNY Provider Services Helpdesk.

• If you will be entering co-payment information, be sure to convert the alpha co-payment type to a number, prior to dialing. Refer to Section 13.1 on page 13.0.1 for Co-payment Type codes.

• The following types of transactions cannot be processed via the telephone:

- Cancel Transactions
- Authorization Confirmation Transactions
- Dispensing Validation System Transactions

Note: Detailed instructions for entering a transaction begin on the next page. The Voice Prompt column lists the instructions you will hear once your call is connected. The Action/Input column describes the data you should enter.

VOICE PROMPT	ACTION/INPUT
	TO BEGIN Dial 1-800-997-1111
NEW YORK STATE MEDICAID	None
IF ENTERING ALPHA/NUMERIC IDENTIFIER, ENTER NUMBER 1 **IF ENTERING NUMERIC IDENTIFIER, ENTER NUMBER 2**	Enter 1, If using converted CIN. Enter 2, If using Access Number.
ENTER IDENTIFICATION NUMBER	Enter converted alpha/numeric Medicaid number (CIN) or numeric access number. Press #.
ENTER NUMBER 1 FOR SERVICE AUTHORIZATION OR NUMBER 2 FOR ELIGIBILITY INQUIRY	One of the following transaction types must be entered: **1** To request a Service Authorization as well as Eligibility Information. This must be used to obtain a service authorization for Post and Clear (P & C) and Utilization Threshold (UT). Co-payment entries may also be made using this transaction type. **2** To request Eligibility Information only. This may also be used to determine if ordered/prescribed services are available for the client under the UT program. Co-payment entries can also be made using this transaction type.
ENTER SEQUENCE NUMBER	If the Identification Number entry was a Medicaid Number (CIN), enter the two-digit sequence number. No entry is necessary if the numeric Access Number was entered. Press # to bypass the prompt.
ENTER DATE	Press # for today's date or enter MMDDYY for a previous date of service. For all inpatient co-payment entries, the date should equal the discharge date.
ENTER PROVIDER NUMBER	Enter the eight-digit provider identification number assigned at the time of enrollment in the NYS Medicaid Program.
ENTER SPECIALTY CODE	Enter the three-digit MMIS specialty code that describes the type of service that will be rendered and press #. If you are providing a service that is exempt from the UT program or you are a clinic or hospital clinic using a transaction type 1, a code MUST be entered. If you do not have a specialty code, press # to bypass this prompt.

VOICE PROMPT	ACTION/INPUT
ENTER REFERRING PROVIDER NUMBER	Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press #. If a client enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's ID number in response to this prompt. If the client is not a referral, press the # key to bypass this prompt.
ENTER FIRST CO-PAYMENT TYPE	Enter the alpha converted co-payment type. Refer to Section 13.1 on page 13.0.1 for Co-payment Type codes. If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, bypass all the co-payment prompts by pressing #.
ENTER CO-PAYMENT UNITS	Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable. If the first entry is valid, you will be prompted to enter “SECOND CO-PAYMENT TYPE”, then a “THIRD CO-PAYMENT TYPE” and finally “FOURTH CO-PAYMENT TYPE”. The additional co-payment prompts would be used by a provider who is rendering more than one co-payment type of service. If not applicable, press # to bypass the rest of the co-payment prompts.
ENTER SECOND CO-PAYMENT TYPE	Enter the alpha converted co-payment type for the second co-payment and press #.
ENTER CO-PAYMENT UNITS	Enter the number of units being rendered. Only a one or a two-digit numeric entry is acceptable. Press #.
ENTER THIRD CO-PAYMENT TYPE	Enter the alpha converted co-payment type for the third co-payment and press #.
ENTER CO-PAYMENT UNITS	Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable. Press #.
ENTER FOURTH CO-PAYMENT TYPE	Enter the alpha converted co-payment type for the fourth co-payment and press #.
ENTER CO-PAYMENT UNITS	Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable. Press #.

VOICE PROMPT	ACTION/INPUT
ENTER NUMBER OF SERVICE UNITS	Enter the total number of service units rendered and press #. If you are performing an eligibility inquiry only, press # to bypass this prompt.
IF YOU ARE A DESIGNATED POSTING PROVIDER, ENTER NUMBER OF LAB TESTS YOU ARE ORDERING	If you are a designated Posting Provider**,** enter the total number of Lab tests being ordered and press #, or press # to bypass.
IF YOU ARE A DESIGNATED POSTING PROVIDER ENTER NUMBER OF PRESCRIPTIONS OR OVER THE COUNTER ITEMS YOU ARE ORDERING	If you are a designated Posting Provider**,** enter the total number or prescriptions or over the counter items being ordered and press #, or press # to bypass.
ENTER ORDERING PROVIDER NUMBER	Enter the MMIS Provider ID of the ordering provider and press #. All providers who fill written orders/scripts must complete this field. If you do not have the provider number of the ordering provider, you may enter the profession code and license number. If entering a license number for New York State providers, after entering a profession code, enter two zeros and the six-digit license number. If entering out of state license numbers, after entering the profession code, enter the two character converted alpha state code (see page 3.2.1), followed by the license number. A Nurse Practitioner must have a “F” preceding their license number in order to prescribe drugs. If entering a NYS nurse practitioner license number, enter the profession code followed by 33 (converted F) and then the license number. NYS Optometrists who are allowed to prescribe certain medications will have an alpha character (U or V) preceding their license number. When entering their license number, enter the profession code, convert the alpha character to a number (see page 3.2.1) and enter that number followed by the actual license number. **Examples** MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 0606251345678 Nurse Practitioner # 04233421212 NYS Optometrist # 05683452749 **Press # to bypass this prompt if you are not a dispensing provider.**
NOTE: When entering a profession code and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 05683000867 (Profession Code + V + Zero fill + License Number).	

THIS IS THE LAST PROMPT YOU WILL HEAR. THE MEVS SYSTEM WILL NOW RETURN YOUR RESPONSE.
THIS ENDS THE INPUT DATA SECTION.

3.4 Telephone Verification Response Section (Rev. 12/05)

AN ELIGIBILITY SERVICE AUTHORIZATION RESPONSE THAT CONTAINS NO ERRORS WILL BE RETURNED IN THE FOLLOWING SEQUENCE.

Note: Although all types of eligibility coverages are listed below, only one will be returned in the response.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CIN	MEDICAID NUMBER AA22346D	The response begins with the client's eight-digit Medicaid CIN.
COUNTY CODE	COUNTY CODE XX	The two-digit code which indicates the client's county of fiscal responsibility. Refer to Section 13.4 on page 13.4.1 for county codes.
CLIENT'S MEDICAID COVERAGE	COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Client is eligible to receive most Medicaid services. Client is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Client is not eligible for managed long-term care in a SNF, hospice in a SNF, intermediate care facility services and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	Client is eligible for acute inpatient care, care in a psychiatric center, some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency services except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting, intermediate care facility services, residential treatment facility services and services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	ELIGIBLE CAPITATION GUARANTEE	A response of "Eligible Capitation Guarantee" indicates guaranteed status under a Prepaid Capitation Program (PCP). The PCP provider is guaranteed the capitation rate for a period of time after a client becomes ineligible for Medicaid services. Clients enrolled in some PCPs are eligible for some fee-for-service benefits if referred by the PCP provider. To determine exactly what services are covered, contact the PCP designated in the insurance code field.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	ELIGIBLE EXCEPT NURSING FACILITY SERVICES	Client is eligible to receive all Medicaid services except nursing home services provided in an SNF or inpatient setting and/or waived services provided under the Long Term Health Care Program. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
	ELIGIBLE ONLY FAMILY PLANNING SERVICES	A client who was pregnant within the past two years and was on Medicaid while pregnant is eligible for Medicaid covered family planning services for up to 26 months after the end date of pregnancy, regardless of whether the pregnancy ended in a miscarriage, live birth, still birth or an induced termination.
	ELIGIBLE ONLY OUTPATIENT CARE	Client is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
	ELIGIBLE PCP	A response of "Eligible PCP" indicates coverage under a Prepaid Capitation Program (PCP). This status means the client is PCP eligible as well as eligible for limited fee-for-service benefits. To determine exactly what services are covered, listen to the PCP services returned in the response. If further clarification is needed, contact the PCP designated in the insurance code field.
	EMERGENCY SERVICES ONLY	Client is eligible for emergency services from the first treatment for the emergency medical condition until the condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	FAMILY HEALTH PLUS	Client is enrolled in the Family Health Plus Program (FHP) and receives all services through a FHP participating Managed Care Plan. The Medicaid program does not reimburse for any service that is excluded from the benefit package of the FHP Managed Care Plan.
	MEDICAID ELIGIBLE	Client is eligible for all benefits.
	MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Client is eligible to receive all Medicaid services with prescribed limits for physician, psychiatric and medical clinic, laboratory, dental clinic and pharmacy services. A service authorization must be obtained.
	MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	Client is eligible for payment of Medicare coinsurance and deductible only. Deductible and coinsurance payments will be made for Medicare approved services only.
	OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Client is eligible for most ambulatory care, including prosthetics, and one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Client is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	Client is eligible for some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services. Client is not eligible for inpatient coverage other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	Client is eligible for all ambulatory care, including prosthetics. Client is not eligible for inpatient coverage or waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	PERINATAL FAMILY	Client is eligible to receive a limited package of benefits. The following services are excluded: podiatry, long-term home health care, long term care, hospice, ophthalmic services, DME, therapy (physical, speech, and occupational), abortion services, and alternate level care.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	PRESUMPTIVE ELIGIBLE LONG-TERM/HOSPICE	Client is eligible for all Medicaid services except hospital based clinic services, hospital emergency room services, hospital inpatient services, and bed reservation.
	PRESUMPTIVE ELIGIBILITY PRENATAL A	Client is eligible to receive all Medicaid services except inpatient care, institutional long-term care, alternate level care, and long-term home health care.
	PRESUMPTIVE ELIGIBILITY PRENATAL B	Client is eligible to receive only ambulatory prenatal care services. The following services are excluded: inpatient hospital, long-term home health care, long-term care, hospice, alternate level care, ophthalmic, DME, therapy (physical, speech, and occupational), abortion, and podiatry.
ANNIVERSARY MONTH	ANNIVERSARY MONTH OCTOBER	This is the beginning month of the client's benefit year.
CATEGORY OF ASSISTANCE	CATEGORY OF ASSISTANCE "S"	The code S signifies that the client is enrolled in the SSI assistance program.
MEDICARE DATA	Identifies the Medicare coverage for which the client is eligible, for the date of service entered.	
	MEDICARE PART A	Client has only Part A Medicare (inpatient hospital).
	MEDICARE PART B	Client has only Part B Medicare (outpatient).
	MEDICARE PARTS A and B	Client has both Parts A and B Medicare Coverage.
	MEDICARE PARTS A & B & QMB	Client has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART A & QMB	Client has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART B & QMB	Client has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEDICARE DATA (contd.)	MEDICARE QMB Only	Client is a Qualified Medicare Beneficiary (QMB) Only.
	MEDICARE PART D	Client has only Part D Medicare coverage (prescription drugs).
	MEDICARE PARTS A & D	Client has both Part A and Part D Medicare coverage (inpatient hospital and prescription drugs).
	MEDICARE PARTS B & D	Client has both Part B and Part D Medicare coverage (outpatient and prescription drugs).
	MEDICARE PARTS A & B & D	Client has Part A and Part B and Part D Medicare coverage (inpatient hospital, outpatient and prescription drugs).
	MEDICARE PARTS A & B & D & QMB	Client has Part A and Part B and Part D Medicare coverage (inpatient hospital, outpatient and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PARTS A & D & QMB	Client has Part A and Part D Medicare coverage (inpatient hospital and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PARTS B & D & QMB	Client has Part B and Part D Medicare coverage (outpatient and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART D & QMB	Client has Part D Medicare coverage (prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	HEALTH INSURANCE CLAIM NUMBER XXXXXXXXXXX	Actual Health Insurance Claim number consisting of up to twelve-digits. If a number is not available, the following message will be returned.
	HEALTH INSURANCE CLAIM NUMBER NOT ON FILE	Actual Health Insurance Claim number is not on file.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
THIRD PARTY INSURANCE AND COVERAGE CODES	INSURANCE COVERAGE CODE 21: DENTAL, PHYSICIAN, INPATIENT	Insurance and Coverage Codes equal the Insurance carrier and the scope of benefits. You will hear a two character insurance code and up to 13 coverage code descriptions. If you hear a third insurance code of ZZ call 1-800-343-9000 to obtain additional insurance and coverage information. Refer to your MMIS Provider Manual for insurance codes. Refer to Section 13.6 on page 13.6.1, for the Codes Section for definitions/descriptions.
EXCEPTION RESTRICTION CODES	EXCEPTION CODE 35	If applicable, a client's exception and/or restriction code will be returned. Refer to Section 13.5 on page 13.5.1, for the Exception Codes for the definitions/descriptions.
CO-PAY DATA	NO CO-PAYMENT REQUIRED	This message will be heard if the client is under 21 or exempt from co-payment and co-payment data has been entered.
	CO-PAYMENT REQUIREMENTS MET ON MM/DD/YY	Client has reached his/her co-payment maximum. The date equals the date of inquiry, which brought the co-payment over the maximum. You should not collect the co-payment until the next co-payment period.
UTILIZATION THRESHOLD POST AND CLEAR DATA	AT SERVICE LIMIT	The client has reached his/her limit for that particular service category. No service authorization is created. The service is **not** approved and payment by Medicaid will **not** be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.
UTILIZATION THRESHOLD POST AND CLEAR DATA (contd.)	DUPLICATE - UT PREVIOUSLY APPROVED	The service authorization request is a duplicate of a previously approved service authorization request for a given provider, client, and date of service.
	PARTIAL APPROVAL XX SERVICE UNIT(S) POST AND CLEAR	Indicates that the full complement of requested services relative to Post and Clear processing is not available. The **XX** represents the number of services approved/available.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
	PARTIAL APPROVAL XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S) UTILIZATION THRESHOLD	Indicates that the full complement of requested services relative to Utilization Threshold processing is not available. The **XX** represents the number of services approved/available.
	SERVICE APPROVED NEAR LIMIT XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The service authorization has been granted and recorded. The client has almost reached his/her service limit. For the convenience of the provider and the client, this message also indicates that the patient is using services at a rate that could exhaust his/her limit for that particular service category.
	SERVICE APPROVED UTILIZATION THRESHOLD XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The service units requested are approved, as the client has not utilized his/her UT limit. A service authorization will be created.
	SERVICES APPROVED POST AND CLEAR XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The ordering provider has posted services and those service units have been approved. This message will also be returned for all providers who are designated card swipers, except pharmacy, for Tran Type 1 entry.
DATE OF SERVICE	FOR DATE MMDDYY	This will be heard when the message is complete and reflects the date for which services were requested. **You can repeat the message one time by pressing the * key.**

Note: You will be allowed to perform a maximum of three transactions during a single call. If less than three transactions have been completed, you will automatically be prompted for another transaction. If no other transactions are needed, disconnect your call.

3.5 Telephone Verification Error and Denial Responses (Rev. 02/05)

The next few pages contain processing error and denial messages that may be heard. Error responses are heard immediately after an incorrect or invalid entry. To change the entry, enter the correct data and press the # key. Denial responses are heard when the transaction is rejected due to the type of invalid data entered. The entire transaction must be reentered.

RESPONSE	DESCRIPTION/COMMENTS
CALL 800-343-9000	When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
DECEASED ORDERING PROVIDER	The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a deceased status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.
DISQUALIFIED ORDERING PROVIDER	The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a disqualified status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.
EXCESSIVE ERRORS, REFER TO MEVS MANUAL OR CALL 800-343-9000 FOR ASSISTANCE	Too many invalid entries have been made during the transaction. Refer to Section 3.3 on page 3.3.1 for the input data section, or call **800-343-9000**.
INVALID ACCESS METHOD	The received transaction is classified as a Provider Type/Transaction Type Combination that is not allowed to be submitted through the telephone. For example: a Pharmacy can submit an eligibility transaction via the telephone but cannot submit a Service Authorization Transaction unless exempt from the ProDUR Program.
INVALID ACCESS NUMBER	An invalid access number was entered. Check the number and retry the transaction.
INVALID CARD THIS RECIPIENT	Client has used an invalid card. Check the number you have entered against the client's Common Benefit Identification Card. If they agree, the client has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.

RESPONSE	DESCRIPTION/COMMENTS
INVALID CO-PAYMENT	This message is heard at the prompt if the data entered is not in the correct format (invalid number of digits or number doesn't covert to an alpha character). Receiving this message will prohibit the next prompt from being spoken. To proceed, re-enter the data in the correct format.
INVALID CO-PAYMENT, REFER TO MEVS MANUAL	The Data entered is not a valid co-payment value. Refer to Section 13.0 on page 13.0.1 for the Codes Section.
INVALID DATE	An illogical date or a date which falls outside of the allowed MEVS inquiry period was entered. The allowed period is 24 months retroactive from the entry date.
INVALID ENTRY	An invalid number of digits was entered for service units. Service units must be one or two-digits.
INVALID IDENTIFICATION NUMBER	The client identification number entered was an incorrect length, or an invalid alpha converted number was entered.
INVALID PROFESSION CODE	The Profession Code entered in the ordering provider field is not a valid value. Refer to the eMedNY website at http://www.emedny.org for a list of valid Profession Codes.
INVALID MEDICAID NUMBER	An invalid CIN was entered. Refer to the alpha conversion chart on page 3.2.1 in the beginning of this manual. Verify that the CIN was correctly converted to an eleven-digit number.
INVALID MENU OPTION	An invalid entry was made when selecting the identifier type. The entry must be 1 (alphanumeric identifier) or 2 (numeric identifier).
INVALID ORDERING PROVIDER NUMBER	The license number or MMIS Provider ID number that was entered in the ordering provider field was not found on the license or provider files.
INVALID PROVIDER NUMBER	The provider number entered is an invalid eight-digit number.
INVALID REFERRING PROVIDER NUMBER	The referring provider ID number was entered incorrectly or is not a valid MMIS Provider ID number. A license number cannot be entered in this field.
INVALID SEQUENCE NUMBER	The sequence number entered is not valid or not current. Check the client's card for the current sequence number.

RESPONSE	DESCRIPTION/COMMENTS
INVALID SPECIALTY CODE	The specialty code was either entered incorrectly, or not associated with the provider's category of service, or the provider is a clinic and a required specialty was not entered.
MCCP RECIPIENT NO AUTHORIZATION	Services must be provided, ordered, or referred by the primary provider. Enter the MMIS Provider ID of the primary provider to whom the client is restricted.
NO COVERAGE EXCESS INCOME	Client has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess to the Local Department of Social Services, or by submitting bills for the medical services that are at least equal to the amount of the excess income. Medical services received prior to meeting the excess income amount can be used to reduce the amount of the excess.
NO COVERAGE PENDING FAMILY HEALTH PLUS	Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
NO SERVICE UNITS ENTERED	No entry was made and the units are required for this transaction.
NOT MEDICAID ELIGIBLE	Client is not eligible for benefits on the date requested. Contact the client's Local Department of Social Services for eligibility discrepancies.
PRESCRIBING PROVIDER LICENSE NOT IN ACTIVE STATUS	The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.
PROVIDER INELIGIBLE FOR SERVICE ON DATE PERFORMED	The Category of Service for the Provider number submitted in the transaction is inactive or invalid for the entered Date of Service. This message will also be returned if Specialty Codes 760 (Clinic Pharmacy) or 307 (DME) are entered in the transaction and the associated Category of Service is not on file or is invalid for the entered Date of Service.
PROVIDER NOT ELIGIBLE	The verification was attempted by an inactivated or disqualified provider.

RESPONSE	DESCRIPTION/COMMENTS
PROVIDER NOT ON FILE	The provider number entered is not identified as a Medicaid enrolled provider. Either the number is incorrect or not on the provider master file.
RECIPIENT NOT ON FILE	Client identification number (CIN) is not on file. The number is either incorrect or the client is no longer eligible and the number is no longer on file.
REENTER ORDERING PROVIDER NUMBER	The license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
RESTRICTED RECIPIENT NO AUTHORIZATION	This client is restricted to services from a specific provider. Enter the MMIS Provider ID to whom the client is restricted.
SERVICES NOT ORDERED	The ordering provider did not post the services you are trying to clear. Contact the ordering provider.
SSN ACCESS NOT ALLOWED	The provider is not authorized to access the system using a social security number. The Medicaid Number (CIN) or Access Number must be entered.
SSN NOT ON FILE	The entered nine-digit number is not on the Client Master file.
SYSTEM ERROR #	A network problem exists. Call 1-800-343-9000 with the error number.
THE SYSTEM IS CURRENTLY UNAVAILABLE. PLEASE CALL 800-343-9000 FOR ASSISTANCE.	The system is currently unavailable. After this message is voiced, you will be disconnected.

4.0 INTRODUCTION TO THE VERIFONE OMNI 3750 MEVS TERMINAL (Rev. 10/03)

The VeriFone terminal is designed to provide an accurate and timely verification of a client's eligibility for Medicaid services. Specific features and conveniences, such as a large LCD screen, ATM style buttons and a built in printer, make the verification process easy to learn and use with a minimum of training time.

Multiple provider identification numbers can be programmed into the VeriFone terminal in the Provider Menu. When programmed, the two-digit shortcut code assigned to that Provider can be selected, instead of entering the full eight-digit Provider ID number. Refer to Section 7.3 on page 7.3.1 for Instructions for Provider Menu or call 1-800-343-9000 for assistance in adding multiple provider numbers to your terminal.

The Quick Start (Refer to Section 5.0 on page 5.0.1) is a quick and easy way to install the VeriFone Omni 3750 terminal. For step-by-step instructions use the VeriFone Installation Instructions (Refer to Section 7.0 on page 7.0.1).

Initial Screen

When the VeriFone Omni 3750 terminal is not actively being used, the device normally shows its "initial screen" (see below). This screen is referenced often in this manual. To get to this screen in most circumstances, press the red cancel key.

Initial screen example:

```
FRI 9/5 9-13A

EMEDNY

SWIPE CARD OR
PRESS F4 TO BEGIN

Vxxxx
```

The "xxxx" in "Vxxxx" on the bottom line is the software version the terminal is using. This number may be needed when calling provider services for assistance.

5.0 QUICK START (Rev. 10/03)

The Quick Start is an easy way to setup up the VeriFone Omni 3750 terminal. For a full and detailed description of the terminal refer to Section 6.0 on page 6.0.1 for the VeriFone Omni 3750 Terminal.

1. Select a location that has access to a power outlet and a telephone line for your terminal. Open the box and unpack the terminal. (Refer to Section 7.0 on page 7.0.1 for the VeriFone Installation Instructions for step-by-step instructions).

2. Connect the telephone line cord into the telephone jack labeled 'H S'. Connect the other end into the wall jack. (Refer to Section 6.2 on page 6.0.3 for the VeriFone Omni 3750 Terminal – Back).

3. Connect the power connector into the power port on the back of the terminal, and the power cord into the power pack. Plug the three-prong power cord into the power outlet. (Refer to Section 6.2 on page 6.0.3 for the VeriFone Omni 3750 Terminal – Back).

4. After the device has gone through its start-up routine, the day, date, and time is displayed on the top line of the terminal.

   Note: The terminal uses it's internal clock to calculate the date that will be entered on your transaction. Please ensure that the Day, Date and Time are correct. For instructions on resetting Day, Date and Time, please refer to Section 7.1 on page 7.1.1.

5. The terminal will arrive with the requestor's Provider number pre-programmed. It is recommended to review the Medicaid Provider number before using the terminal. Press the **P2** key (labeled "Provider") to enter the Provider Menu. "Provider Setup" is briefly displayed. When the Password prompt is displayed, enter the following six-digit number '123456' and press the **ENTER** key. When the terminal displays "ENTER PROVIDER NUMBER", enter the two-digit number '01' and press the **ENTER** key. "PROVIDER NUMBER 01" is displayed with the pre-programmed Provider number below the text.

6. To use the pre-programmed Provider number, press the **CANCEL/CLEAR** key, to return to the initial screen. To change the pre-programmed Provider number, press the **BACKSPACE** key eight times to clear the number. Then enter the eight-digit Medicaid Provider number and press the **ENTER** key. If you have no additional Provider numbers to enter, press the **CANCEL/CLEAR** key. To store additional Provider numbers refer to Section 7.3 on page 7.3.1 for Instructions for Provider Menu.

7. If you are required to dial a number to get an outside line (e.g. '9'), press the **P1** key (labeled "Setup") to enter the Setup Menu. When the Password prompt is displayed, enter the following six-digit number '123456' and press the **ENTER** key. The "DIAL PREFIX" is displayed, enter the access code (e.g. single digit "9") and press the **ENTER** key. After the access code has been entered, press the **CANCEL/CLEAR** key to return to the Initial Screen. (Refer to Section 7.2 on page 7.2.1 for Instructions for Setup Menu).

8. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to begin processing transactions to eMedNY.

6.0 VERIFONE OMNI 3750 TERMINAL (Rev. 10/03)

The VeriFone Omni 3750 terminal is a verification device that uses basic telephone outlets to connect with Medicaid Eligibility Verification System (MEVS).

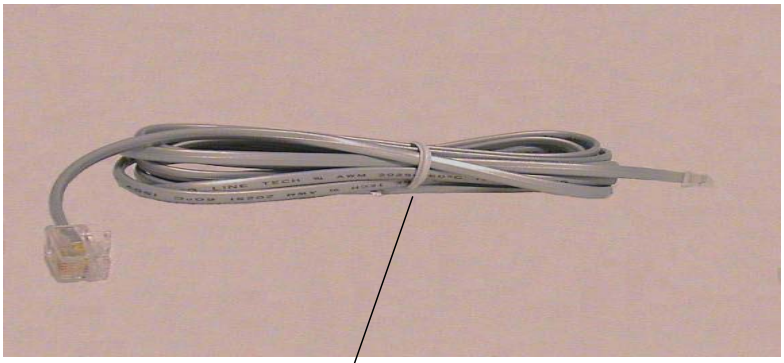
6.1 VeriFone Omni 3750 Terminal - Front

6.1.1 VeriFone Omni 3750 Terminal Description - Front

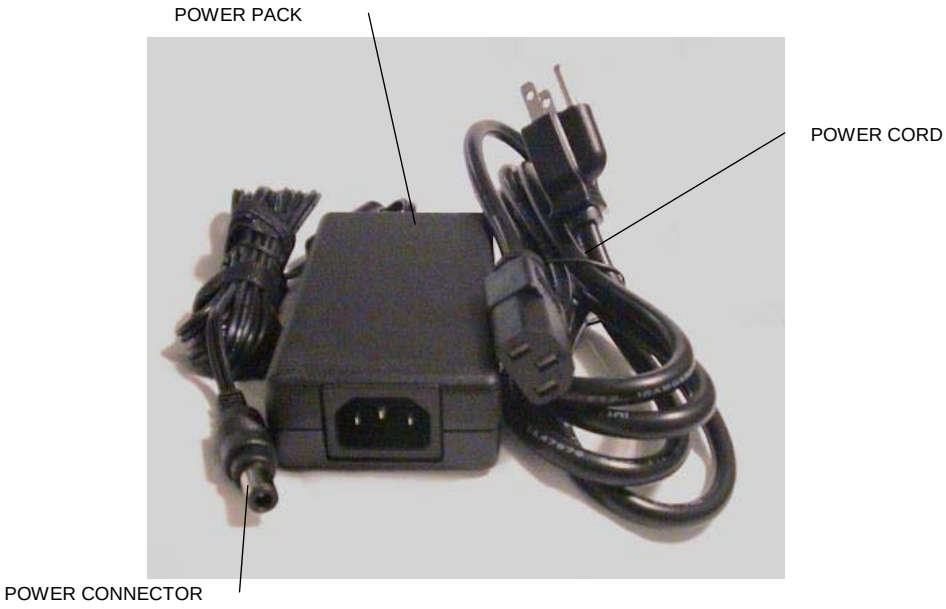
A.	INTERNAL THERMAL PRINTER	A dot matrix printer in which heat is applied to the pins of the matrix to form dots on heat-sensitive paper.
B.	INDICATOR LED	Power and Paper Indicator. NOTE: A blinking light indicates to check paper supply or paper is not inserted properly.
C.	PAPER COVER RELEASE	Open the printer paper compartment.
D.	**F4** ATM-STYLE FUNCTION KEY	Starts a verification transaction through entry of the access number or Medicaid Number (CIN).
E.	LCD SCREEN	The verification response and system messages will be displayed in this area.
F.	MAGNETIC CARD READER	Slot that reads the magnetic stripe on the back of the card. This allows for quicker entry of verification transactions.
G.	ALPHA KEY	Converts numeric digits to alphabetic letters.
H.	PAPER ADVANCE KEY	Press the 3 Key from the initial screen to advance the paper one line at a time.
I.	TELEPHONE STYLE KEYPAD	Area where user enters data needed for the Medicaid verification.
J.	ENTER KEY	Inputs new data into the system.
K.	BACKSPACE KEY	Erases the last numeric digit or alphabetic letter entered.
L.	CANCEL/CLEAR KEY	Erases all previously entered data and returns to the ready mode.
M.	REPRINT KEY	From the initial screen, prints a duplicate copy of the verification message.
N.	**P1** SETUP KEY	Allows modification of the Terminal Settings. (Refer to Section 7.2 on page 7.2.1 for the Instructions for Setup Menu)
O.	**P2** PROVIDER KEY	Allows for add, update, delete, and review of multiple provider Ids. (Refer to Section 7.3 on page 7.3.1 for the Instructions for Provider Menu)
P.	**P3** SCROLL BACK KEY	Facilitates scrolling to the previous line, if applicable.
Q.	**P4** SCROLL FORWARD/REVIEW KEY	Facilitates scrolling to the next line, if applicable. Also is used to review the previous transaction. (Refer to Section 12.0 on page 12.0.1 for the Review Function)

6.2 VeriFone Omni 3750 Terminal – Back

Telephone Line Cord



Power Pack



7.0 VERIFONE INSTALLATION INSTRUCTIONS (Rev. 10/03)

These instructions will assist with the setup of the VeriFone Omni 3750 terminal. Select a location that has access to a power outlet and a telephone line for your terminal.

Connecting the Telephone Line

1. Connect one end of the telephone line cord to the telephone jack labeled “H S” on the right hand side at the rear of the terminal

2. Connect the other end of the telephone line cord to your RJ11-type modular telephone wall jack. If you do not have a telephone wall jack, obtain an adapter from your local telephone company.

Connecting the Terminal Power Pack

1. Connect the power connector into the power port.

2. To lock the power connector, align the plastic lock tab pointing up and turn to the left. To unlock the power connector, turn to the right.

3. Connect the power cord into the power pack.

4. Plug the three-prong AC power cord into an indoor 120-volt AC outlet.

WARNING: Do not plug the power pack into an outdoor outlet or operate the terminal outdoors.

Inserting Thermal Paper into the Internal Thermal Printer

1. To open the printer paper compartment, press the Paper Cover Release button located on the right side of the terminal.

2. Insert a roll of thermal paper, and ensure paper feeds from underneath. (See illustration 2b of the Quick Instruction Guide provided with the new device).

3. Press down to close the printer paper compartment.

Ordering Thermal Paper for the Internal Thermal Printer

To order additional thermal paper (2.25 Inches by 85 Feet thermal paper), contact TASQ Technology at 1-800-420-3197 or your nearest office supply store.

7.1 Instructions to Reset Day/Date/Time

To set or reset the day, date, and time follow the Display/Action table.

DISPLAY	ACTION
The Initial Screen is displayed.	Press the **F2** and **F4** key at the same time
SYSTEM MODE ENTRY PASSWORD	Enter “Z66831” (1-alpha-alpha 66831) and press the **ENTER** key
SYS MODE MENU 1	Press the **F3** key for CLOCK
SYS MODE CLOCK YEAR: YYYY MONTH: MM DAY: DD	Enter the current date as “**CCYYMMDD**“
	Press the **P2** key labeled **Provider**.
SYS MODE CLOCK HOUR: HH MINUTE: MM	Enter Time as “**HHMM**” Enter HH in 24-Hour clock format (e.g. 1:00 p.m. HOUR: 13 MINUTE: 00) Press the **ENTER** key to Save and Exit
SYS MODE MENU 1	Press the **F4** key to restart the device
Initial screen	

7.2 Instructions for Setup Menu (P1 Key)

Access this menu by pressing the **P1** key labeled as the Setup Menu. This menu allows the user to modify several variables that the device uses. To edit the Setup Menu follow the Display/Description/Action table.

Press the **CANCEL/CLEAR** key to return to the initial screen.

DISPLAY	DESCRIPTION	ACTION
Initial Screen		Press the **P1** key to enter the Setup Menu
Terminal Setup **ENTER PASSWORD**		Enter the following six-digit number '123456' and press the **ENTER** key.
DIAL PREFIX **##** **----------**	The Dial Prefix is dialed before the telephone number. If a value has already been entered, it will display on the second line ("##").	If you are required to dial a number (e.g. '9') to get an outside line, enter the access code here (e.g. single digit "9") and press the **ENTER** key. After the access code has been entered, press the **CANCEL/CLEAR** key.
ENTER NYM TELE # **1-866-828-4814** **----------**	This is the number the device will dial to submit transactions.	Press the **ENTER** key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
ENTER BACKUP # **1-866-828-4815** **----------**	This is the number the device will dial in case the main number does respond.	Press the **ENTER** key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
DIAL TYPE **TONE** **TONE** **PULSE**	The type of phone system used. Touchtone is most commonly used. Default is 'Tone'.	The current setting is the word under "DIAL TYPE". If you need to change the setting, press the **F1** key for Tone or press the **F2** key for Pulse. Otherwise, press the **ENTER** key to continue.

DISPLAY	DESCRIPTION	ACTION
PRINT ALL **YES** **YES** **NO**	This designates whether the device will automatically print responses. Default is 'YES'.	The current setting is the word under "PRINT ALL". To change the setting, press the **F1** key to automatically print responses or press the **F2** key to not automatically print responses. NOTE: When the "PRINT ALL" is set to "no", you may print manually by pressing the asterisk "*" key from the initial screen. Press the **ENTER** key to continue.
KEY BEEP **NO** **YES** **NO**	This designates whether the device will beep when a key is pressed. Default is 'NO'.	The current setting is the word under "KEY BEEP". To change the setting, press the **F1** key to beep or press the **F2** key to not beep. NOTE: Errors will still cause a beep to sound. Press the **ENTER** key to continue.
DOWNLOAD TELE # **1-888-843-7160** **----------**	This is the phone number the device will dial to download a new application to the device.	Press the **ENTER** key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
ENTER NEW PASSWORD **-------**	This is the password used to access the Setup Menu and the Provider Menu.	**WARNING:** If you need to have a different password, enter it here. Be advised that if you change it, Provider Services will not be able to reset it for you. Press the **ENTER** key to return to the initial screen without changing the password.

7.3 Instructions for Provider Menu (P2 key)

Access this menu by pressing the **P2** key labeled as the Provider Menu. The VeriFone Omni 3750 terminal can store up to 20 MMIS Provider ID numbers to quickly process transactions. Each Provider number can be used by entering the two-digit shortcut code that corresponds to the Provider submitting the transaction. To store additional Provider numbers in the terminal follow the Step/Action/Display table.

Press the **CANCEL/CLEAR** key to return to the initial screen.

NOTE: If only one MMIS Provider ID is entered in the table, it will automatically be used for each transaction and the prompt "Select Provider" will not be displayed.

DISPLAY	ACTION
Initial Screen	Press the **P2** key to enter the Provider Menu
ENTER PASSWORD	Enter the following six-digit number '123456' and press the **ENTER** key
Provider Setup is displayed	
ENTER PROVIDER NUMBER **--**	Enter a valid two-digit number (01 – 20). The first shortcut assigned must start with 01. NOTE: It is <u>important</u> to keep track of the shortcuts that correspond with each Provider ID.
PROVIDER NUMBER nn ######## *The 'nn' on the first line is the two-digit shortcut number corresponding to the Provider.* *The "########" on the second line is the eight-digit MMIS Provider ID.* *If a provider number is not associated with 'nn', then a blank line will display instead of the Provider number.*	Enter the eight-digit MMIS Provider ID that you are assigning to that shortcut and press the **ENTER** key To change the number currently displayed press the **BACKSPACE** key to clear the existing Provider number, enter the new number and press the **ENTER** key OR Press the **ENTER** key to keep the current value
ENTER PROVIDER NUMBER **--**	Press the **CANCEL/CLEAR** key to return to the Initial Screen OR Repeat Steps 2 through 4 to store additional Providers

8.0 VERIFONE VERIFICATION INPUT SECTION (Rev. 10/03)

8.1 VeriFone Verification Using the Access Number or Medicaid Number (CIN)

The access number is a thirteen-digit numeric identifier on the Common Benefit Identification Card that includes the sequence number. The easiest and fastest verification method is using the Access Number by swiping the card through the terminal. The Medicaid number (CIN) is an eight-character alpha/numeric identifier on the Common Benefit Identification Card.

8.2 Instructions for Completing a VeriFone Transaction

- **ENTER** key must be pressed after each field entry.
- For assistance or further information on input or response messages call Provider Services Staff, **1-800-343-9000**.
- To add provider numbers to your terminal, refer to Section 7.3 on page 7.3.1 for the Instructions for Provider Menu or call **1-800-343-9000**. (Please maintain a listing of provider numbers and corresponding shortcuts.)
- To enter a number, press the key with the desired number.
- To enter a letter, press the key with the desired letter, and then press the alpha key until the letter appears in the display window.

8.2.1 Instructions for Completing Tran Type 1 (Rev. 02/05)

Note: Laboratories and Pharmacies should **NOT** use Tran Type 1. Please refer to Section 8.2.6 on page 8.2.6.1 for Tran Type 7.

Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs. Co-payment entries will be determined based on the entry in the SERVICE TYPE and/or TAXONOMY and the # SERVICE UNITS prompts.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL/CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	If you are using the client access number, swipe the card through the reader or key the access number and press the **ENTER** key. To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. The six-digit ISO number on the Benefit Identification Card does not need to be entered when manually entering the access number. If you are using the Client Medicaid number (CIN), enter the Medicaid number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**1** Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs. Press the **ENTER** key.
ENTER SEQ #	If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the ENTER key. The sequence number is the last two-digits of the access number. If the Access Number was entered, this prompt will not display.

PROMPT DISPLAYED	ACTION/INPUT
ENTER DATE	Press the **ENTER** key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the **ENTER** key. For all inpatient co-payment entries, the date should equal the discharge date.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the **ENTER** key to bypass if not required.
ORDERING PRV #	Enter the MMIS Provider ID number of the ordering provider and press the **ENTER** key. All providers who fill written orders/scripts must complete this field. If you do not have the provider number of the ordering provider, you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code followed by the two-digit alpha character state code then the six-digit license number. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have an alpha character (U or V) preceding their license number. When entering their license number, enter the profession code followed by a zero, the alpha character and the six-digit license number. **Examples:** MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 060NJ345678

PROMPT DISPLAYED	ACTION/INPUT
ORDERING PRV # **(contd.)**	Nurse Practitioner # 0420F421212 NYS Optometrist # 0560U452749 **NOTE:** When entering a profession code and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 0560U000867 (Profession Code + 0U + Zero fill + License Number).
REFERRING PRV #	Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press the **ENTER** key. If a client enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's Medicaid ID number in response to this prompt. If the client is not restricted or in MCCP, press the **ENTER** key to bypass this prompt.
NOTE: The system will default the copay type based on the entry of the Service Type and/or Taxonomy.	
COPAY EXEMPT	If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, **enter 1 for yes**. If the client is not exempt from co-payment, **enter 2 for no**. **NOTE:** Bypassing this prompt will enter a 2 for no.
# SERVICE UNITS	Enter the total number of service units and press the **ENTER** key.
NOTE: If you are a POST and CLEAR Provider, enter the appropriate data for the following two prompts. Bypass by pressing the **ENTER** key.	
# LAB TESTS	Enter the number of lab tests you are ordering and press the **ENTER** key. If no lab tests are required, bypass by pressing the **ENTER** key.
# RX/OTC	Enter the number of prescriptions or over the counter items you are ordering and press the **ENTER** key. If no RX/OTC are required, bypass by pressing the **ENTER** key.

PROMPT DISPLAYED	ACTION/INPUT
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

8.2.2 Instructions for Completing Tran Type 2 (Rev. 02/05)

Eligibility Inquiry only: This transaction may also be used to determine if a client is at limit for the service category you are providing or ordering under the UT program.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL/CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	If you are using the client access number, swipe the card through the reader or key the access number and press the **ENTER** key. To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. The six-digit ISO number on the Benefit Identification Card does not need to be entered when manually entering the access number. If you are using the Client Medicaid number (CIN), enter the Medicaid number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**2** Eligibility Inquiry only: This transaction may also be used to determine if a client is at limit for the service category you are providing or ordering under the UT program. Press the **ENTER** key.
ENTER SEQ #	If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the **ENTER** key. The sequence number is the last two-digits of the access number. If the Access Number was entered, this prompt will not display.
ENTER DATE	Press the **ENTER** key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.

PROMPT DISPLAYED	ACTION/INPUT
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes) Press the **ENTER** key to bypass if not required.
ORDERING PRV #	Enter the MMIS Provider ID number of the ordering provider and press the **ENTER** key. All providers who fill written orders/scripts must complete this field. If you do not have the provider number of the ordering provider, you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code, followed by the two-digit alpha character state code then the six-digit license number. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have an alpha character (U or V) preceding their license number. When entering their license number, enter the profession code followed by a zero, the alpha character and the six-digit license number. **Examples:** MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 060NJ345678 Nurse Practitioner # 0420F421212 NYS Optometrist # 0560U452749 **NOTE:** When entering a profession code and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero

PROMPT DISPLAYED	ACTION/INPUT
ORDERING PRV # **(contd.)**	fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 0560U000867 (Profession Code + 0U + Zero fill + License Number).
NOTE: The Referring Provider # prompt will be displayed only if the prompt for the Ordering Provider is bypassed.	
REFERRING PRV #	Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press the **ENTER** key. If a client enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's Medicaid ID number in response to this prompt. If the client is not restricted or in MCCP, press the **ENTER** key to bypass this prompt.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

8.2.3 Instructions for Completing Tran Type 3

Authorization Confirmation: This transaction is used to determine if an authorization has already been requested for this client, for a particular date of service. To be used with Medicaid Number (CIN) ONLY.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL/CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	Enter the Medicaid number (CIN) and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**3** Authorization Confirmation: This transaction is used to determine if an authorization has already been requested for this client, for a particular date of service. To be used with Medicaid Number (CIN) ONLY. Press the **ENTER** key.
ENTER SEQ #	Enter the two-digit sequence number and press the **ENTER** key. The sequence number is the last two-digits of the access number.
ENTER DATE	Press the **ENTER** key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes) Press the **ENTER** key to bypass if not required.

PROMPT DISPLAYED	ACTION/INPUT
# SERVICE UNITS	Enter the total number of service units and press the ENTER key.
# LAB TESTS	Enter the number of lab tests and press the **ENTER** key. If no lab tests are required, bypass by pressing the **ENTER** key.
# RX/OTC	Enter the number of prescriptions or over the counter items and press the **ENTER** key. If no RX/OTC are required, bypass by pressing the **ENTER** key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

8.2.4 Instructions for Completing Tran Type 4 (Rev. 05/06)

Authorization Cancellation: This transaction is used to cancel an authorization. Use Medicaid Number (CIN) ONLY. Authorizations for DME, prescription footwear, and orthotic/prosthetic devices may be cancelled for up to 90 days. All others must be done within 24 hours of the authorization you are canceling.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	Enter the Medicaid number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**4** Authorization Cancellation: This transaction is used to cancel an authorization. Use Medicaid Number (CIN) ONLY. Authorizations for DME, prescription footwear, and orthotic/prosthetic devices may be cancelled for up to 90 days. All others must be done within 24 hours of the authorization you are canceling. Press the **ENTER** key.
ENTER SEQ #	Enter the two-digit sequence number and press the **ENTER** key. The sequence number is the last two-digits of the access number.
ENTER DATE	Press the **ENTER** key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.

PROMPT DISPLAYED	ACTION/INPUT
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the **ENTER** key to bypass if not required.
# SERVICE UNITS	Enter the total number of service units and press the **ENTER** key.
# LAB TESTS	Enter the number of lab tests you are canceling and press the **ENTER** key. If no lab tests are required, bypass by pressing the **ENTER** key.
# RX/OTC	Enter the number of prescriptions or over the counter items you are canceling and press the **ENTER** key. If no RX/OTC are required, bypass by pressing the **ENTER** key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

8.2.5 Instructions for Completing Tran Type 6 (Rev. 05/06)

Dispensing Validation System (DVS) Request: This transaction allows suppliers of prescription footwear items, certain medical surgical supplies and equipment to request a DVS number (Prior approval). This transaction code is also used to obtain Dental DVS Numbers.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	If you are using the client access number, swipe the card through the reader or key the access number and press the **ENTER** key. To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. “NY Access #” will be displayed for one second. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. The six-digit ISO number on the Benefit Identification Card does not need to be entered when manually entering the access number. If you are using the Client Medicaid number (CIN), enter the Medicaid number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**6** Dispensing Validation System (DVS) Request: This transaction allows suppliers of prescription footwear items, certain medical surgical supplies and equipment to request a DVS number (Prior Approval). This transaction code is also used to obtain Dental DVS Numbers for selected Dental Procedure Codes. Press the **ENTER** key.
ENTER SEQ #	Enter the two-digit sequence number and press the **ENTER** key. The sequence number is the last two-digits of the access number. If the Access Number was entered, this prompt will not display.
ENTER DATE	Press the **ENTER** key for today's date. DVS transactions require a current date entry.

PROMPT DISPLAYED	ACTION/INPUT
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the **ENTER** key to bypass if not required.
ORDERING PRV #	Enter the MMIS Provider ID number of the ordering provider and press the **ENTER** key. All providers who fill written orders/scripts must complete this field. If you do not have the provider number of the ordering provider, you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code, followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code followed by the two-digit alpha character state code then the six-digit license number. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have an alpha character (U or V) preceding their license number. When entering their license number, enter the profession code followed by a zero, the alpha character and the six-digit license number. **Examples:** MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 060NJ345678 Nurse Practitioner # 0420F421212 NYS Optometrist # 0560U452749 **NOTE:** When entering a profession code and license number, the last six positions of the entry should be the actual numeric license number. If the

PROMPT DISPLAYED	ACTION/INPUT
ORDERING PRV # **(contd.)**	license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 0560U000567 (Profession Code + 0U + Zero fill + License Number).
REFERRING PRV #	Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press the **ENTER** key. If a client enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's Medicaid ID number in response to this prompt. If the client is not restricted or in MCCP, press the **ENTER** key to bypass this prompt.
COPAY EXEMPT	If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, **enter 1 for yes**. If the client is not exempt from co-payment, **enter 2 for no**. **NOTE:** Bypassing this prompt will enter a 2 for no.
ENTER ITEM/NDC #	Enter the five-character HCPCS alpha/numeric item code of the item being dispensed. The following modifiers may be used to further describe certain procedure codes for orthotic and prosthetic devices, and prescription footwear: • LT (Left Side) • RT (Right Side) For DVS authorization, enter the modifier immediately following the procedure code, with no spaces between the modifier and code. For DME, prescription footwear and orthotic/prosthetic devices, DVS will be created for an authorization period of 180 days. **Note:** Date-of-Service entered on the DVS request will be used to begin the authorization period. The actual date of service, which is entered on the claim, can be anytime within the 180 day authorization period. For some items, if instructed by New York State, the eleven-digit National Drug Code may be entered.

PROMPT DISPLAYED	ACTION/INPUT
	For Dental DVS: Enter a constant value of D; the five character Dental procedure code and a two-digit tooth number, or one character primary tooth or two-character tooth quadrant/arch.
ENTER QUANTITY	Enter the total number of units dispensed for the current date of service only. Do not include refills. For Dental DVS: Enter the number of times the procedure was performed.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

8.2.6 Instructions for Completing Tran Type 7 (Rev. 02/05)

Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs by Pharmacy and Lab providers. Co-payment entries will be determined based on the entry in the number of Lab Tests, Generic/OTC, Brand, and Supplies prompts.

PROMPT DISPLAYED	ACTION/INPUT
	TO BEGIN: Press the **CANCEL**/**CLEAR** key. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to start the verification.
ENTER CARD OR ID	If you are using the client access number, swipe the card through the reader or key the access number and press the **ENTER** key. To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. “NY Access #” will be displayed for one second. **Note:** The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. The six-digit ISO number on the Benefit Identification Card does not need to be entered when manually entering the access number. If you are using the Client Medicaid number (CIN), enter the Medicaid number and press the **ENTER** key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	**7** Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs by Pharmacy and Lab providers. Co-payment entries will be determined based on the entry in the number of Lab Tests, Generic/OTC, Brand, and Supplies prompts. Press the **ENTER** key.
ENTER SEQ #	If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the **ENTER** key. The sequence number is the last two-digits of the access number. If the Access Number was entered, this prompt will not display.

PROMPT DISPLAYED	ACTION/INPUT
ENTER DATE	Press the **ENTER** key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the **ENTER** key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number or enter an eight-digit MMIS Provider ID and press the **ENTER** key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the **ENTER** key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the **ENTER** key to bypass if not required.
ORDERING PRV #	Enter the MMIS Provider ID number of the ordering provider and press the **ENTER** key. All providers who fill written orders/scripts must complete this field. If you do not have the provider number of the ordering provider, you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code, followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code, followed by the two-digit alpha character state code then the six-digit license number. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have an alpha character (U or V) preceding their license number. When entering their license number, enter the profession code followed by a zero, the alpha character and the six-digit license number. **Examples:** MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 060NJ345678 Nurse Practitioner # 0420F421212 NYS Optometrist # 0560U452749

PROMPT DISPLAYED	ACTION/INPUT
ORDERING PRV # **(contd.)**	**NOTE:** When entering a profession code and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 0560U000867 (Profession Code + 0U + Zero fill + License Number).
REFERRING PRV #	Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press the **ENTER** key. If a client enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's Medicaid ID number in response to this prompt. If the client is not restricted or in MCCP, press the **ENTER** key to bypass this prompt.
COPAY EXEMPT	If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, **enter 1 for yes**. If the client is not except from co-payment, **enter 2 for no**. **NOTE:** Bypassing this prompt will enter a 2 for no.
NOTE: The system will default the copay type based on the entry in the number of Lab tests, number of Generic/OTC, number of Brand, and number of Supplies prompts.	
# LAB TESTS	Enter the number of lab tests you are performing and press the **ENTER** key. If no lab tests are required, bypass by pressing the **ENTER** key.
NOTE: The # GENERIC/OTC, # BRAND and # SUPPLIES prompts will be displayed only if the # LAB TESTS prompt is bypassed.	
# GENERIC/OTC	Enter the number of generic prescriptions or over the counter items you are dispensing and press the **ENTER** key. If no Generic/OTC prescriptions are required, bypass by pressing the **ENTER** key.
# BRAND	Enter the number of brand prescriptions you are dispensing and press the **ENTER** key. If no brand prescriptions are required, bypass by pressing the **ENTER** key.
# SUPPLIES	Enter the number of supplies you are dispensing and press the **ENTER** key. If no supplies are required, bypass by pressing the **ENTER** key.

PROMPT DISPLAYED	ACTION/INPUT
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and **RECEIVING.**	These processing messages are displayed.

9.0 VERIFONE VERIFICATION RESPONSE SECTION (Rev. 06/04)

The device will automatically display and print the response data unless you have specified in the setup menu to not automatically print your receipts. To print an additional copy of the response data, press the '*****' asterisk key. To advance the paper by a line, press the '3' key from the initial screen. If your device has paper but is not printing a response, refer to the "PRINT ALL" setting in Section 7.2 on page 7.2.1 for Instructions for Setup Menu.

Note: The screen will display up to eight (8) lines of text. If the response is longer than eight (8) lines, use the P3 (Scroll Back) and P4 (Scroll Forward/Review) keys.

9.1 Fields on MEVS receipt (Rev. 11/05)

The MEVS receipt presents information in two sections:

- Input: The Input section displays the information entered into the MEVS device for the last transaction and always starts with the **TODAY'S DATE** field which reflects the terminal's internal date and time.
- Response: The Response section only displays fields, which contain data. The fields displayed also vary based on the Tran Type used to conduct the transaction. The Response section always starts with the PROV NO. field.

Some fields are required fields (as stated in the transaction descriptions in Section 8.2 on page 8.0.1), so they will always appear.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
PROV NO.:	The eight-digit MMIS Provider ID.
DATE SVC:	The date for which services were requested.
MEDICAID ID:	The Medicaid number (CIN) is displayed on the receipt if the client is identified. If the client cannot be identified, the information entered in the MEVS Device will be displayed.
HIC NO.:	Health Insurance Claim number consisting of up to twelve-digits.
DOB:	This field displays the client's date of birth.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
GENDER:	The Client's gender. Values are: M = Male F = Female U = Unborn
CNTY/OFF:	The two-digit county code is displayed for Upstate client's county of fiscal responsibility. The Office code is a three-digit code for Downstate clients. Refer to Section 13.4 on page 13.4.1 for a complete listing of county codes.
ANNIV DT:	This is the beginning of the client's benefit year.
MSG:	If applicable, a client's Category of Assistance and/or exception code will be returned. Refer to Section 13.5 on page 13.5.1, for the Exception Codes for the definitions/descriptions. The Month that the client is due for Recertification will also be displayed here.
---------- ELIG REQUEST REJECT ----------	This message is displayed when the eligibility request cannot be validated. The fields listed below provide further information for the validation of the eligibility request.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes.
Folw-Up Act Cd:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Call the telephone number displayed on the receipt for more information.
---------- SERV REQUEST REJECT ----------	This message is displayed when a Service Authorization (SA) or DVS request cannot be processed or the client is ineligible. The fields listed below provide further information for the validation of the Service request or DVS.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
Folw-Up Act Cd:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Call the telephone number displayed on the receipt for more information.
---------- **PLAN ELIG. & BENEFITS** **----------**	The fields listed below display the client's eligibility and benefit information with Medicaid, as well as any other insurance. The client's Medicaid, Medicare and/or other insurance information are separated by dashes (----------).
Plan:	This field displays the name of the plan
Plan Policy Number	This field displays the policy number assigned to the other Third Party Insurance.
Plan Cd:	The field displays a 2-character code for other Third Party Insurance. If you see an Insurance Code of **ZZ**, call 1-800-343-9000 to obtain additional Insurance and coverage information. For Medicaid PCP only, the 2 character code and coverage codes are displayed. This field is displayed if the plan code is available.
Plan Address	This field displays the Address, City, State and Zip Code of the Managed Care Plan or other Third Party Insurance.
Elig/Ben Info:	This field displays the client's level of medical coverage or other coverages. Refer to Section 10.0 on page 10.0.1 for Accepted Reason Codes.
INFO #:	Call the telephone number displayed on the receipt for more information.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
Serv Type Cd:	We will return one or more of the following values to further define coverage, exclusions and limitations. 30 = Health Benefit Plan Coverage 48 = Hospital Inpatient 54 = Long Term Care 82 = Family Planning 86 = Emergency If the Eligibility Response reads: **Exclusions**, and Service Types of 48 (Hospital Inpatient) and 54 (Long Term Care) are also displayed, this means the Client's coverage is: (Eligible Only Outpatient Care) OR If a Service Type of 54 (Long Term Care) is also displayed, this means the Client's coverage is: (Eligible Except Nursing Facility Services). If the Eligibility Response reads: **Limitations**, and a Service Type of 48 (Hospital Inpatient) is also displayed, this means the Client's coverage is: (Eligible Only Inpatient Care). OR If a Service Type of 82 (Family Planning) is also displayed, this means the Client's coverage is: (Family Planning Services Only). OR If a Service Type of 86 (Emergency) is also displayed, this means the Client's coverage is: (Emergency Services Only).

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
Insr Type Cd:	Values are: C1 = Commercial MP = Medicare Primary MC = Medicaid QM = Qualified Medicare Beneficiary
Plan Cov Desc:	This field will display a literal that further defines the response with respect to UT limits exceeded, client restrictions and limitations of coverage. If the message "Restricted to following provider" is returned, this field will display the type of restriction. We suggest submitting Tran Type 1 to ensure the ordering/referring provider is correct.
Time Per Qual:	This field displays the time period qualifiers. Values for this field are: 29 = Copay remaining 30 = UT exceeded
Dollar Amt:	This field displays the copay remaining only when **29** is present in the **Time Per Qual** field.
---------- **HEALTH CARE SERVICES** **----------**	The fields listed below display information relating to Service Authorization (SA) or DVS requests which can contain several groups of information and are separated by dashes (----------).
Action Cd:	Values are: A1 = Certified in total A3 = Not Certified A6 = Modified CT = Contact Payer NA = No Action Required

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	**DESCRIPTION**
INFO #:	Call the telephone number displayed on the receipt for more information.
Ref Id:	This field displays a message or DVS number.
Modified Units:	This field shows the partial units that were approved for the Service Authorization (SA) requested. Indicates that the full compliment of requester services relative to Utilization Threshold **and/or Post and Clear** processing is NOT available. The NN represents the number of services approved/available. An authorization will be created for that number only. This field also shows the number of Utilization Threshold and/or Post and Clear units reversed (canceled) for the Service Authorization Cancel request.
Units: N/X/X	For confirmations, this field shows the approved units, posted lab units and posted Rx/OTC units.
Item/NDC Code:	This field shows the approved Item/NDC code only for a DVS confirmation.
Dental Info:	This field shows the tooth, arch, or quadrant for a DVS confirmation.
Quantity Approved:	This field shows the quantity that was approved for a DVS confirmation.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes.
- End of Receipt -	

10.0 ACCEPTED REASON CODES (Rev. 07/04)

RESPONSE/RETURN		POSSIBLE CAUSES
1	ACTIVE COVERAGE	**MA ELIGIBLE**
		Client is eligible for all benefits
		MA ELIGIBLE HR UTILIZATION THRESHOLD
		Client is eligible to receive all Medicaid services with prescribed limits for physician, psychiatric and medical clinic, laboratory, dental clinic and pharmacy services. A service authorization must be obtained.
B	COPAYMENT	**COPAYMENT**
		Client has copay remaining if this response is returned.
E	EXCLUSIONS	**ELIGIBLE ONLY OUTPATIENT CARE**
		Client is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
		ELIGIBLE EXCEPT NURSING FACILITY SERVICES
		Client is eligible to receive all Medicaid services except nursing home services provided in an SNF or inpatient setting and/or waived services provided under the Long Term Health Care Program. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
F	LIMITATIONS	**AT SERVICE LIMIT**
		The client has reached his/her limit for that particular service category. No service authorization is created. The service is not approved and payment by Medicaid will not be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.

RESPONSE/RETURN	POSSIBLE CAUSES
F LIMITATIONS (contd.)	**COMMUNITY COVERAGE NO LTC**
	Client is eligible for acute inpatient care, care in a psychiatric center, some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency services except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting, intermediate care facility services, residential treatment facility services and services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	COMMUNITY COVERAGE W / CBLTC
	Client is eligible to receive most Medicaid services. Client is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Client is not eligible for managed long-term care in a SNF, hospice in a SNF, intermediate care facility services and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

RESPONSE/RETURN	POSSIBLE CAUSES
F LIMITATIONS (contd.)	**ELIGIBLE ONLY FAMILY PLANNING SERVICES**
	A client who was pregnant within the past two years and was on Medicaid while pregnant is eligible for Medicaid covered family planning services for up to 26 months after the end date of the pregnancy, regardless of whether the pregnancy ended in a miscarriage, live birth, still birth or an induced termination.
	EMERGENCY SERVICES ONLY
	Client is eligible for emergency services from the time first given treatment for the emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part.
	MEDICARE COINSURANCE DEDUCTIBLE ONLY
	Client is eligible for payment of Medicare coinsurance and deductible only. Deductible and coinsurance payments will be made for Medicare approved services only.
	OUTPATIENT COVERAGE NO LTC
	Client is eligible for some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services. Client is not eligible for inpatient coverage other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

RESPONSE/RETURN	POSSIBLE CAUSES
F LIMITATIONS (contd.)	**OUTPATIENT COVERAGE NO NFS**
	Client is eligible for all ambulatory care, including prosthetics. Client is not eligible for inpatient coverage or waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	OUTPATIENT COVERAGE W / CBLTC
	Client is eligible for most ambulatory care, including prosthetics, and one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Client is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.
	PERINATAL FAMILY
	Client is eligible to receive a limited package of benefits. The following services are excluded: podiatry, long-term home health care, long term care, hospice, ophthalmic services, DME, therapy (physical, speech, and occupational), abortion services, and alternate level of care.
	PRESUMPTIVE ELIGIBILITY LONG-TERM/HOSPICE
	Client is eligible for all Medicaid services except hospital based clinic services, hospital emergency room services, hospital inpatient services, and bed reservation.
	PRESUMPTIVE ELIGIBILITY PRENATAL A
	Client is eligible to receive all Medicaid services except inpatient care, institutional long-term care, alternate level of care, and long-term home health care.
	PRESUMPTIVE ELIGIBILITY PRENATAL B
	Client is eligible to receive only ambulatory prenatal care services. The following services are excluded: inpatient hospital, long-term home health care, long-term care, hospice, alternate level of care, ophthalmic, DME, therapy (physical, speech, and occupational), abortion, and podiatry.

RESPONSE/RETURN		POSSIBLE CAUSES
N	SERVICES RESTRICTED TO THE FOLLOWING PROVIDER	**SERVICES RESTRICTED TO THE FOLLOWING PROVIDER**
		For restricted clients, this response is returned if the ordering provider entered is not who the client is restricted to.
R	OTHER OR ADDITIONAL PAYER	**ELIGIBLE CAPITATION GUARANTEE**
		A response of “Eligible Capitation Guarantee” indicates guaranteed status under a Prepaid Capitation Program (PCP). The PCP provider is guaranteed the capitation rate for a period of time after a client becomes ineligible for Medicaid services. Clients enrolled in some PCPs are eligible for some fee-for-service benefits if referred by the PCP provider. To determine exactly what services are covered, contact the PCP designated in the insurance code field.
		FAMILY HEALTH PLUS
		Client is enrolled in the Family Health Plus Program (FHP) and receives all services through a FHP participating Managed Care Plan. The Medicaid program does not reimburse for any service that is excluded from the benefit package of the FHP Managed Care Plan.
MC	MANAGED CARE COORDINATOR	**ELIGIBLE PCP**
		A response of “Eligible PCP” indicates coverage under a Prepaid Capitation Program (PCP). This status means the client is PCP eligible as well as eligible for limited fee-for-service benefits. To determine exactly what services are covered, review the coverage codes returned in the response. The Coverage Code definitions can be found in the Codes section of this manual. If further clarification of exact coverage is needed, contact the PCP.

11.0 REJECT REASON CODES (Rev. 09/06)

NOTE: The table below displays the mapping of HIPAA codes to eMedNY codes.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
CT	CONTACT PAYER	**CALL 1-800-343-9000**
		When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
I	NON COVERED	**NOT MA ELIGIBLE**
		Patient does not have Medicaid coverage for the date you are requesting.
		NO COVERAGE PENDING FAMILY HEALTH PLUS
		Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
U	CONTACT FOLLOWING ENTITY FOR ELIGIBILITY OR BENEFIT INFORMATION	**CALL 1-800-343-9000**
		When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
Y	SPENDDOWN	**NO COVERAGE: EXCESS INCOME**
		Client has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess to the Local Department of Social Services, or by submitting bills for the medical services that are at least equal to the amount of the excess income. Medical services received prior to meeting the excess income amount can be used to reduce the amount of the excess.
15	REQUIRED APPLICATION DATA MISSING	**NO UNITS ENTERED**
		No entry was made and the units are required for this transaction.
33	INPUT ERRORS	**ITEM NOT COVERED**
		The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
	MISSING/INVALID DVS QUANTITY
	The entered quantity's format is invalid or missing and is required.
	CURRENT DATE REQUIRED
	A DVS transaction requires a current date entry. The date entered was NOT today's date.
	MISSING/INVALID CATEGORY OF SERVICE
	The entered taxonomy/service type does not map to a valid category of service on the provider's file for the entered Date of Service.
	MISSING/INVALID TOOTH/QUADRANT
	The tooth number, tooth quadrant, or arch was not entered and is required, or was entered incorrectly.
41 AUTHORIZATION/ACCESS RESTRICTIONS	**DOWNLOAD REQUIRED**
	The VeriFone software is obsolete and must be updated. This message is displayed once a day until the download is completed.
	INVALID TRAN TYPE
	An invalid transaction type other than 1-4, 6 or 7 was entered.
	INVALID TERMINAL ACCESS
	The received transaction is classified as a Provider Type/Transaction Type Combination that is not allowed to be submitted through the POS VeriFone terminal. Additionally, this message will be returned if a pharmacy submits a DVS transaction for an NDC code through the POS VeriFone terminal because NDC codes must be submitted through the online NCPDP DUR format. Pharmacies are only allowed to submit DVS transactions through the POS VeriFone terminal for HCPCS codes (five-digit alpha/numeric codes). For example: a Pharmacy can submit an eligibility transaction via the Terminal but cannot submit a Service Authorization Transaction unless exempt from the ProDUR Program.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
41	AUTHORIZATION/ACCESS RESTRICTIONS (contd.)	**SERVICE NOT ORDERED**
		The ordering provider did not post the services you are trying to clear. Contact the ordering provider.
		LOST/STOLEN TERMINAL
		The terminal serial ID is indicated as being a lost or stolen terminal. Call 1-800-343-9000 for assistance.
		PAYMENT PAST DUE
		The terminal serial ID is indicated as having past due payments. Call 1-800-343-9000 for assistance.
		SSN ACCESS NOT ALLOWED
		The provider is not authorized to access the system using a social security number. The Medicaid Number (CIN) or Access Number must be entered.
42	UNABLE TO RESPOND AT CURRENT TIME	**RESUBMIT TRANSACTION**
43	INVALID/MISSING PROVIDER INFORMATION	**INVALID PROVIDER NUMBER**
		The Provider ID entered is not valid.
		REENTER ORDERING PROVIDER
		The license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
		INVALID PROFESSION CODE
		The Profession Code entered in the ordering provider field is not a valid value. Refer to the eMedNY website at http://www.emedny.org for a list of valid Profession Codes.
		DISQUALIFIED ORDERER
		The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a disqualified status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
43	INVALID/MISSING PROVIDER INFORMATION (contd.)	**DECEASED ORDERER**
		The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a deceased status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.
		INVALID ORDERING PROVIDER
		The license number or MMIS Provider ID that was entered in the ordering provider field was not found on the license or provider files.
		INVALID REFERRING PROVIDER NUMBER
		The referring provider ID number was entered incorrectly or is not a valid MMIS Provider ID. A license number cannot be entered in this field.
		PRESCRIBING PROVIDER LICENSE INACTIVE
		The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.
45	INVALID/MISSING PROVIDER SPECIALTY	**INVALID TAXONOMY OR SERVICE TYPE**
		The Taxonomy and/or Service Type entered does not map to a specialty or category of service on the provider's file for the entered Date of Service.
48	INVALID/MISSING PROVIDER IDENTIFICATION	**REENTER ORDERING PROVIDER**
		The license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
		DISQUALIFIED ORDERER
		The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a disqualified status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
		DECEASED ORDERER
		The License Number or eight-digit MMIS Provider ID that was entered in the ordering provider field is in a deceased status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct profession code/license number combination and format was entered.
		INVALID ORDERING PROVIDER
		The license number or MMIS Provider ID that was entered in the ordering provider field was not found on the license or provider files.
		INVALID REFERRING PROVIDER ID NUMBER
		The referring provider ID number was entered incorrectly or is not a valid MMIS Provider ID number. A license number cannot be entered in this field.
		PRESCRIBING PROVIDER LICENSE INACTIVE
		The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.
49	PROVIDER IS NOT PRIMARY PHYSICIAN	**RESTRICTED RECIPIENT NO AUTHORIZATION**
		This client is restricted to services from a specific provider. In the referring provider field, enter the MMIS Provider ID of the primary provider (physician, clinic, inpatient hospital etc.) to whom the client is restricted.
		MCCP RESTRICTED RECIPIENT NO AUTHORIZATION
		Services must be provided, ordered or referred by the primary. In the referring provider field, enter the MMIS Provider ID of the primary provider (physician, clinic, inpatient hospital etc.) to whom the client is restricted.
50	PROVIDER INELIGIBLE FOR INQUIRIES	**PROVIDER NOT ELIGIBLE**
		The verification was attempted by an inactivated or disqualified provider.
51	PROVIDER NOT ON FILE	**PROVIDER NOT ON FILE**
		The provider number entered is not identified as a Medicaid enrolled provider. Either the number is incorrect or not on the provider master file.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
52	SERVICE DATES NOT WITHIN PROVIDER PLAN ENROLLMENT	**PROVIDER INELIGIBLE SERVICE ON DATE PERFORMED**
		The Taxonomy and/or Service Type entered does not map to a specialty or category of service on the provider's file for the entered Date of Service. This message will also be returned if Taxonomy code (Clinic Pharmacy) or Service Type (DME) are entered in the transaction and the associated Category of Service is not on file or is invalid for the entered Date of Service.
53	INQUIRED BENEFIT INCONSISTENT WITH PROVIDER TYPE	**COS NOT VALID FOR ITEM/NDC CODE**
		The entered Taxonomy and/or Service Type does not map to a COS that is valid for the Item/NDC procedure code.
60	DATE OF BIRTH FOLLOWS DATE(S) OF SERVICE	**SERVICE DATE PRIOR TO BIRTHDATE**
		A date which occurs before the birthdate.
62	DATE OF SERVICE NOT WITHIN ALLOWABLE INQUIRY PERIOD	**INVALID DATE**
		An illogical date or a date which falls outside the MEVS inquiry period. (Dates up to 24 months retroactive will be supported.)
69	INCONSISTENT WITH PATIENT'S AGE	**AGE EXCEEDS MAXIMUM**
		The client's age exceeds the maximum allowable age on the NYS Drug Plan file for the item/NDC code entered.
		AGE PRECEDES MINIMUM
		The client's age is below the minimum allowable age on the NYS Drug Plan file for the item/NDC code entered.
70	INCONSISTENT WITH PATIENT'S GENDER	**ITEM/GENDER INVALID**
		The item/NDC code entered is not reimbursable for the client's gender resident on the eligibility file.
72	INVALID/MISSING SUBSCRIBER/INSURED ID	**INVALID CARD THIS RECIPIENT**
		Client has used an invalid card. Check the number you have entered against the client's Common Benefit Identification Card. If they agree, the client has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.
		INVALID ACCESS NUMBER
		An incorrect access number was entered.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
		INVALID MEDICAID NUMBER
		The Medicaid number (CIN) entered is not valid.
		INVALID SEQUENCE NUMBER
		The sequence number entered is not valid or not current. Check the client's card for the current sequence number.
75	SUBSCRIBER/INSURED NOT FOUND	**SOCIAL SECURITY NUMBER NOT ON FILE**
		The entered nine-digit number is not on the Client Master File.
		RECIPIENT NOT ON FILE
		Client identification number (CIN) is not on file. The number is either incorrect or the client is no longer eligible and the number is no longer on file.
		NO COVERAGE: PENDING FHP
		Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
		NO MATCH ON FILE
		Client is not found on file.
76	DUPLICATE SUBSCRIBER/INSURED ID NUMBER	**CALL LOCAL DISTRICT**
		When a Name Search transaction is submitted and more than one eligible client identification number (CIN) is found, please contact the client's local county of fiscal responsibility**.**
84	CERTIFICATION NOT REQUIRED FOR THIS SERVICE	**PA NOT REQ/MEDIA TYPE INVALID**
		The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through MEVS or this is not the appropriate access for obtaining a Prior Approval number for this item/NDC. This response will be returned except on the OMNI 3750. For those developing their own software, refer to the NYS Medicaid HIPAA Companion Documents, 278 Request and Response.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
		DVS NUMBER NOT REQUIRED
		The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through MEVS. This response will be returned for the Verifone OMNI 3750 Terminal.
87	EXCEEDS PLAN MAXIMUMS	**AT SERVICE LIMIT**
		The client has reached his/her limit for that particular service category. No service authorization is created. The service is NOT approved and payment by Medicaid will NOT be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.
		EXCEEDS FREQUENCY LIMIT
		The client has already received the allowable quantity limit of the item/NDC code entered in the time frame resident on the NYS Drug Plan file or the quantity you requested will exceed that limit.
		MAXIMUM QUANTITY EXCEEDED
		The quantity entered exceeds the maximum allowable quantity resident on the NYS Drug Plan file. Make sure the quantity entered is for the current date of service only. (no refills).
88	NON-COVERED SERVICE	**PROCEDURE CODE NOT COVERED**
		The procedure code entered was either entered incorrectly or is not a NYS reimbursable code, or has been discontinued.
		ITEM NOT COVERED
		The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.
89	NO PRIOR APPROVAL	**NO AUTHORIZATION FOUND**
		No matching transaction found for the authorization confirmation transaction or cancellation request.
91	DUPLICATE REQUEST	**DUPLICATE – UT PREVIOUSLY APPROVED**
		The service authorization request is a duplicate of a previously approved service authorization request for a given provider, client, and date of service.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
	DUPLICATE DVS
	The entered transaction is a duplicate of a previously submitted and approved DVS transaction.
95 PATIENT NOT ELIGIBLE	**NOT MEDICAID ELIGIBLE**
	Client is not eligible for benefits on the date of service requested.
	FAMILY HEALTH PLUS
	Client has Family Health Plus.
	NO COVERAGE: PENDING FHP
	Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
	NO COVERAGE: EXCESS INCOME
	Client has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess to the Local Department of Social Services, or by submitting bills for the medical services that are at least equal to the amount of the excess income. Medical services received prior to meeting the excess income amount can be used to reduce the amount of the excess.
	CLIENT MEDICARE PART D DENIAL
	DVS Requests for Pharmacy and DME Prior Approvals will be rejected for Clients who have Part D Medicare coverage (prescription drugs).

11.1 MEVS Terminal Messages (Rev. 10/03)

CHECK LINE	The VeriFone terminal is not plugged in or the terminal is on the same line as a telephone, which is off the hook or in use.
CONNECT XXXX	This message is displayed until transmission to the host computer begins.
DOWNLOAD DONE	This message is displayed when the download function process is complete. Pres ENTER to continue.
NO ENQ FROM HOST	No enquiry received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact Provider Services at 1-800-343-9000 for assistance.
NO RESPONSE FROM HOST	No response received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact Provider Services at 1-800-343-9000 for assistance.
PLEASE TRY AGAIN	The card swipe was unsuccessful because you partially swiped the card, the card was damaged, or the equipment malfunctioned. Re-swipe or manually enter the access number.
PROCESSING	This message is displayed until the host message is ready to be displayed.
RECEIVING	This message is displayed until the host message is received by the VeriFone.
RETRY TRANSACTION	After a successful Transaction has been completed, this message will be received during the Review Function if an invalid sequence of keys Is pressed or an Access Number is entered which differs in length from the original number.
TRANSMITTING	This message is displayed until the host computer acknowledges the transmission.
UNREADABLE CARD	Will be displayed after three unsuccessful attempts to swipe the card.

12.0 REVIEW FUNCTION (Rev. 11/02)

The Review function allows you to review the last response received, edit the transaction data and resubmit the transaction. To begin follow the Action/Display table.

DISPLAY	ACTION
Initial Screen	Press the **P4 SCROLL FORWARD/ REVIEW** key
The response from the last transaction is displayed	Press the **ENTER** key to edit the data
Each screen displays the data that was entered	Reenter new data Or Press the **ENTER** key to accept current data

13.0 CODES SECTION (Rev. 10/03)

13.1 Co-payment Type Codes

For ARU only, codes used to designate the type of co-payment service you are rendering. Select the code which corresponds to the type of service being rendered. These codes are the only valid codes to be entered in the co-payment prompt.

CODES	DESCRIPTION
21	Inpatient Hospital
22	Emergency Room - non-emergency, non-urgent
23	Clinic
31	Prescription Drugs - brand name
32	Prescription Drugs - generic
33	Non-prescription Drugs (OTC)
41	Sickroom Supplies
42	Laboratory
43	X-Ray
92	No Co-pay

13.2 Taxonomy and Service Type Codes (Rev. 07/04)

To ensure correct Utilization Threshold processing use the appropriate Taxonomy Code/Service Type Code Combinations. Clinic providers must enter a Taxonomy Code or a Service Type Code or both on a Service Authorization transaction. Out of State Providers see section 13.3

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
AIDS Clinic - Freestanding	249, 355		85 - AIDS
Clinic - Freestanding	300, 301, 302, 303, 304, 305, 308, 309, 320, 900, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 960, 961, 962, 967, 968, 970, 975, 976, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1-Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital - Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 – Maternity 76 – Dialysis 78 – Chemotherapy A9 – Rehabilitation AJ – Alcoholism AK - Drug Addiction
Clinic -Hospital Based	300, 301, 302, 303, 304, 305, 308, 309, 320, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 960, 961, 962, 967, 968, 970, 972, 973, 975, 976, 979, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1 - Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital - Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 – Maternity 76 – Dialysis 78 – Chemotherapy A9 – Rehabilitation AJ – Alcoholism AK - Drug Addiction
Clinic -Hospital Based	740		56 - Medically Related Transportation

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Clinic – Hospital Based or Freestanding	902, 903, 905, 909, 914, 915, 916, 917, 925, 926, 927, 928, 929, 930, 931, 932, 933, 950, 951, 952, 953, 954, 955, 956, 957, 965, 966, 999		2 – Surgical 3 – Consultation 17 - Pre-Admission Testing 20 - Second Surgical Opinion 21 - Third Surgical Opinion 50 - Hospital – Outpatient 64 – Acupuncture 67 - Smoking Cessation 71 – Audiology Exam (Non-DVS) 72 - Inhalation Therapy 73 - Diagnostic Medical 79 - Allergy Testing 80 - Immunizations 98 - Professional (Physician) Visit – Office 99 - Professional (Physician) Visit – Inpatient A0 – Professional (Physician) Visit – Outpatient A1 - Professional (Physician) Visit - Nursing Home A2 - Professional (Physician) Visit - Skilled Nursing Facility A3 - Professional (Physician) Visit – Home BD - Cognitive Therapy BE - Massage Therapy BF - Pulmonary Rehabilitation BG - Cardiac Rehabilitation BS - Invasive Procedures
Clinic – Hospital Based or Freestanding	918		93 – Podiatry 94 - Podiatry - Office Visits 95 - Podiatry - Nursing Home Visits
Clinic - Freestanding	919, 920, 921, 923, 924, 958	261Q00000X --- or No Taxonomy	50 - Hospital – Outpatient --- or AC - Rehabilitation – Outpatient AD - Occupational Therapy AE - Physical Medicine AF - Speech Therapy AL - Vision (Optometry)

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Clinic -Hospital Based	919, 920, 921, 923, 924, 958	282N00000X --- or No Taxonomy	50 - Hospital – Outpatient --- or AC - Rehabilitation – Outpatient AD - Occupational Therapy AE - Physical Medicine AF - Speech Therapy AL - Vision (Optometry)
Clinic –Hospital Based or Freestanding	922		AI - Substance Abuse
Clinic – Hospital Based or Freestanding	935		77 - Otological Exam
Clinic – Hospital Based or Freestanding	969		75 - Prosthetic Device
Clinic – Hospital based or Freestanding - DVS	967		71 - Audiology Exam
Clinic Abortion – Hospital based or Freestanding	907		84 - Abortion
Clinic Family Planning - Hospital based or Freestanding	906		82 - Family Planning
Clinic Pharmacy - Hospital based or Freestanding	760		88 - Pharmacy
Clinic Radiology - Hospital based or Freestanding	998		4 - Diagnostic X-Ray 62 - MRI/CAT Scan
Clinic/Center - Multispecialty - Hospital based or Freestanding	321	261QM1300X	
Clinic/Center - Student Health - Freestanding	306, 325	261QS1000X	
Dental Clinic - Hospital Based or Freestanding	350, 351	261QD0000X	35 - Dental Care
Dental Clinic - Hospital Based or Freestanding	910, 911		40 - Oral Surgery

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Dental Clinic - Hospital Based or Freestanding	911		23 - Diagnostic Dental 24 – Periodontics 25 - Restorative 26 – Endodontics 27 - Maxofocial Prosthetics 28 - Adjunctive Dental Services 35 - Dental Care 36 - Dental Crowns 37 - Dental Accident 39 - Prosthodontics
Dental Clinic - Hospital based or Freestanding	912		38 - Orthodontics
DME Dealer –DVS Only			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Emergency Room - Hospital Based or Freestanding	901		51 - Hospital - Emergency Accident 52 - Hospital - Emergency Medical 86 - Emergency Services
Home Health DME – DVS			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Hospital General Acute Care - Special Use	060, 110, 181, 730	282N00000X	
Hospital Inpatient - Non-DVS	899		48 - Hospital – Inpatient 63 - Donor Procedures 70 – Transplants A7 - Psychiatric – Inpatient AB - Rehabilitation - Inpatient
Hospital Inpatient DVS	COS 0285		48 - Hospital – Inpatient 63 - Donor Procedures 70 – Transplants A7 - Psychiatric – Inpatient AB - Rehabilitation - Inpatient

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Lab	411, 412, 413, 414, 415, 416, 419, 420, 421, 422, 423, 427, 430, 431, 432, 435, 436, 438, 439, 440, 441, 442, 450, 451, 460, 470, 481, 482, 483, 484, 485, 486, 491, 510, 511, 512, 513, 514, 515, 516, 518, 521, 523, 524, 531, 540, 550, 551, 552, 553, 560, 571, 572, 573, 580, 599		5 - Diagnostic Lab
Clinic Pharmacy – Hospital based or Freestanding	760	333600000X	
Pharmacy DME	307		12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Physician	010, 030, 040, 041, 050, 060, 062, 063, 064, 065, 066, 067, 068, 069, 070, 080, 089, 092, 093, 100, 110, 120, 131, 135, 136, 137, 138, 139, 141, 142, 143, 146, 148, 160, 162, 170, 182, 183, 184, 185, 194, 200, 201, 202, 210, 220, 230, 241, 242, 402, 403, 404, 777		A0 - Professional (Physician) Visit - Outpatient
Physician	020, 130, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 161, 163, 169, 186, 187, 191, 192, 193, 195, 196, 205, 247, 249, 252, 253, 254, 270, 306, 401, 751		98 - Professional (Physician) Visit - Office
Physician			86 - Emergency Services
Physician	750		AK - Drug Addiction
Physician Abortion			84 - Abortion
Physician Group	010, 060, 063, 089, 100, 150, 158, 159, 161, 750	193400000X	
Physician Radiology	081, 206, 207, 208		04 - Diagnostic X-Ray

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Psychiatric Clinic – Hospital Based	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 971, 974		A4 – Psychiatric A6 – Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic - Freestanding	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 974		A4 – Psychiatric A6 – Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic – Hospital Based or Freestanding	312, 313, 314, 317, 318, 319, 323, 352, 353, 354, 959, 978, 980, 982, 992		A8 - Psychiatric – Outpatient BB - Partial Hospitalization (Psychiatric)
Transportation DME – DVS Only			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental

13.3 Out of State Providers

If you are an Out of State provider of one of the types listed below use the Taxonomy Code provided.

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Out of State Clinical Psychologist		103GC0700X	
Out of State Licensed Practical Nurse		164W00000X	
Out of State Midwife, Certified Nurse		367A00000X	
Out of State Nurse Practitioner		363L00000X	
Out of State Occupational Therapist		225X00000X	
Out of State Physical Therapist		225100000X	
Out of State Physician - General Practice		208D00000X	
Out of State Registered Nurse - General Practice		163WG0000X	
Out of State Speech-Language Pathologist		235Z00000X	

13.4 County/District Codes (Rev. 10/03)

The County/District, two-digit codes are used to identify the client's county of fiscal responsibility.

01	Albany	31	Onondaga
02	Allegany	32	Ontario
03	Broome	33	Orange
04	Cattaraugus	34	Orleans
05	Cayuga	35	Oswego
06	Chautauqua	36	Otsego
07	Chemung	37	Putnam
08	Chenango	38	Rensselaer
09	Clinton	39	Rockland
10	Columbia	40	St. Lawrence
11	Cortland	41	Saratoga
12	Delaware	42	Schenectady
13	Dutchess	43	Schoharie
14	Erie	44	Schuyler
15	Essex	45	Seneca
16	Franklin	46	Steuben
17	Fulton	47	Suffolk
18	Genesee	48	Sullivan
19	Greene	49	Tioga
20	Hamilton	50	Tompkins
21	Herkimer	51	Ulster
22	Jefferson	52	Warren
23	Lewis	53	Washington
24	Livingston	54	Wayne
25	Madison	55	Westchester
26	Monroe	56	Wyoming
27	Montgomery	57	Yates
28	Nassau	66	New York City
29	Niagara	97	OMH Administered
30	Oneida	98	OMR/DD Administered
		99	Oxford Home

13.5 Exception Codes (Rev. 09/06)

Exception Codes are two-digit codes that identify a client's program exceptions or restrictions.

Code 30	This code identifies a Medicaid client who is enrolled in the Long Term Home Health Care Program Waiver also known as the Lombardi Program/nursing home without walls. The client is authorized to receive LTHHCP services from an enrolled LTHHCP provider. Clients with R/E 30 are not Utilization Threshold or Co-pay exempt.
Code 35	This client is enrolled in a Comprehensive Medicaid Case Management (CMCM) program and is exempt from Co-payment and Utilization Threshold processing. The client's participation in CMCM does not affect eligibility for other Medicaid services.
Code 38	The client is resident in an ICF-DD facility. As such, the individual is exempt from Co-payment and Utilization Threshold requirements and may be eligible for some fee-for-service Medicaid coverage. You should contact the ICF-DD to find out if the service is included in their per diem rate. If it is not, the claim can be submitted to the NYS Medicaid Program.
Code 39	This code identifies a client in the Aid Continuing program. As such, the client is subject to Utilization Threshold and exempt from Co-payment requirements.
Code 46	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 47	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Service (HCBS) Waiver and resides in a *supervised* Community Residence. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 48	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Service (HCBS) Waiver and resides in a *supportive* Community Residence (CR) or a *supportive* Individual Residential Alternative (IRA). As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.

Code 49	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver, resides in a *supervised* Individual Residential Alternative (IRA) and is authorized to receive IRA residential habilitation services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 50	This client has Connect services, plus is eligible for the service package available to all individuals with Perinatal Family. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements. For a Definition of Perinatal Family, refer to Section 3.4 on page 3.4.1 for the Eligibility Responses.
Code 51	This client has Connect services, plus is eligible for the services described in the Eligibility Response associated with the client. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements. For the range of possibilities, refer to Section 3.4 on page 3.4.1 for the Eligibility Responses.
Code 54	This code designates a client whose outpatient Medicaid coverage is limited to Home Health and Personal Care Services benefits. As such, the client is subject to Utilization Threshold and Co-payment requirements.
Code 60	This code identifies a client who is receiving Home and Community Based Services (HCBS) as part of the Nursing Home Transition and Diversion Waiver program.
Code 62	This code identifies a client in the Care At Home I program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 63	This code identifies a client in the Care At Home II program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 64	This code identifies a client in the Care At Home III program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 65	This code identifies a client in the Care At Home IV program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.

Code 66	This code identifies a client in the Care At Home V program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 67	This code identifies a client in the Care At Home VI program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 68	This code identifies a client in the Care At Home VII program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 69	This code identifies a client in the Care At Home VIII program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 70	This code identifies a client in the Care At Home IX program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 71	This code identifies a client in the Care At Home X program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 81	This code identifies a client in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI). As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 83	This code identifies a client who has been mandated by the local social services district to receive certain alcohol and substance abuse services as a condition of eligibility for public assistance or Medicaid as a result of welfare reform requirements. For managed care enrollees, the presence of this code allows certain substance abuse services to be paid on a fee for service basis. The code may be used to trigger prior approval requirements.
Code 84	This code identifies a client who is registered with a provider for base PROS and PROS clinical treatment. Other base and clinical PROS programs, OMH clinic, CDT, IPRT, PMHP, and ACT intensive claims will be denied payment. All other medical services are able to bill fee for service.

Code 85	This code identifies a client who is registered with a provider for base PROS without clinical treatment. Other base PROS programs, OMH CDT, IPRT, and ACT intensive claims will be denied payment. All other medical services are able to bill fee for service.
Code 86	This code identifies a client who is registered with a provider for intensive rehabilitation or ongoing support services. Other PROS providers will be denied payment for these services. OMH IPRT claims will be denied payment. All other medical services are able to bill fee for service.
Code NH	This code identifies a client in a Nursing Home facility. The majority of the client's care is provided by the Nursing Home and is included in their Medicaid per diem rate. If you provide a service to a NH client, you must contact the Nursing Home to find out if the service is included in their rate. If it is not, the claim can be submitted to the NYS Medicaid Program.
Code CC	This code identifies a client in a Child Care program facility. As such this individual has all of their care provided for by the Child Care facility provider on a per-diem basis. Any Medicaid services provided to the client by any other provider than the designated facility provider are not reimbursable.
Code ZZ	This code indicates that more Exception codes are applicable than can be displayed. Call 1-800-343-9000 to obtain additional Exception code information.

13.6 Insurance Codes (Rev. 06/04)

Insurance codes are two character codes which, if returned in the MEVS response, identifies the client's insurance carrier. If you see an Insurance Code of **ZZ**, call 1-800-343-9000 to obtain additional Insurance and coverage information. Refer to the billing section of your MMIS Provider Manual for a list of codes and descriptions.

Insurance Coverage Codes

The POS device will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the client's managed care plan.

COVERAGE CODES	DESCRIPTION	EXPLANATION
A	Inpatient Hospital	All inpatient services are covered except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory.
D	Clinic	Both hospital based and freestanding clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory.
F	Psychiatric Outpatient	Self-Explanatory.
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self-Explanatory.
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you **may not** request it from the client. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance which may cover the co-payment.

COVERAGE CODES	DESCRIPTION	EXPLANATION
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a major medical policy.
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory.
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory.
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare which require a coinsurance or deductible payment should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Svcs.	All substance abuse services, regardless of where they are provided are covered.
W	Substance Abuse Outpatient	Self-Explanatory.
X	Substance Abuse Inpatient	Self-Explanatory.

COVERAGE CODES	DESCRIPTION	EXPLANATION
Y	Durable Medical Equipment	Self-Explanatory.
Z	Optical	Self-Explanatory.
All	All of the above	All services listed in coverage codes A-Z are covered by the client's insurance carrier.

13.7 New York City Office Codes (Rev. 10/03)

The office codes and descriptions listed below are only returned for **County Code 66** clients. They are not returned for Telephone Verifications. Any data returned in this field for clients with other county codes may not be accurate since those counties are not required to enter an office code.

Public Assistance

Manhattan

013	Waverly
019	Yorkville
023	East End
024	Amsterdam
026	St. Nicolas
028	Hamilton
032	East Harlem
035	Dyckman
037	Roosevelt

Bronx

038	Rider
039	Boulevard
040	Melrose
041	Tremont
043	Kingsbridge
044	Fordham
045	Concourse
046	Crotona
047	Soundview
048	Bergen
049	Willis

Queens

051	Queensboro
052	Office of Treatment Monitoring
053	Queens
054	Jamaica
079	Rockaway

Brooklyn

061	Fulton
062	Clinton
063	Wyckoff
064	Dekalb
066	Bushwick
067	Linden
068	Prospect
070	Bay Ridge
071	Nevins
072	Livingston
073	Brownsville
078	Euclid
080	Fort Greene
084	Williamsburg

Staten Island

099	Richmond

Medical Assistance

500-593 34th Street Manhattan

Special Services for Children (SSC)

DOP	Division of Placement
OPA	Office of Placement and Accountability

Field Offices

071	Bronx
072	Brooklyn
073	Manhattan
074	Queens
075	Staten Island

Office of Direct Child Care Services

801	Brooklyn
802	Jamaica
806	Manhattan
810	Division of Group Homes
823	Division of Group Residence
826	Diagnostic Reception Centers

PCP Plan Codes

Refer to your MMIS Provider Manual for Prepaid Capitation Plan Codes.

14.0 DISPOSAL OF TRANZ 330 DEVICE (Rev. 10/03)

Before disposing of the Tranz 330 device, any provider and client data still in its memory must be cleared. By clearing the memory, the device will no longer be usable for eMedNY.

14.1 Instructions to clear memory

WARNING: Do not clear the memory until you are absolutely sure the Tranz 330 device is no longer needed.

The following steps will clear the memory:

1. Press the Asterisk (*) key and the **CANCEL/CLEAR** key at the same time.
2. Enter the password: 8 Alpha 0 Alpha 8 Alpha 5361041 Alpha and press the **ENTER** key.
3. Press the **CANCEL/CLEAR** key at the successful prompt.