Paper Claim Form 150003 - Instructions for Drugs Billed Separately

Pharmacies must use the eMedNY 150003 paper claim form when submitting claims for certain high-cost drugs, such as but not limited to Zynteglo.
IMPORTANT NOTE: Pharmacy providers must have a category of service (COS) **0442** to submit an eMedNY 150003 paper claim form.

Form Completion Instructions

Box 1. PATIENT'S NAME: Enter the member's first name, followed by the last name.

Box 2. DATE OF BIRTH: Enter the member's date of birth. The only accepted entry format is MMDDYYYY.

Box 5A. PATIENT'S SEX: Place an 'X' in the appropriate box to indicate the member's sex.

Box 6A. MEDICAID NUMBER: Enter the member's ID. The only accepted entry format is **two letters, five numbers and one letter** (e.g. AA11111A)

Box 10. WAS CONDITION RELATED TO: If applicable, place an 'X' in the appropriate box to indicate whether the service rendered to the member was work related or for a condition resulting from an accident or a crime. Select the boxes in accordance with the following:

- Member's Employment: If the claim is covered by Worker's Compensation, place an X in the box.
- Crime Victim: Use this box to indicate that the condition treated was the result of an assault or crime.
- Auto Accident: Use this box to indicate Automobile No-Fault. Leave this box blank if condition is related to an auto accident other than no-fault or if no-fault benefits are exhausted.
- Other Liability: Use this box to indicate that the condition was related to an accident-related injury of a different nature from those indicated above.

Please Note: If the condition being treated is not related to any of the above situations, leave these boxes blank.

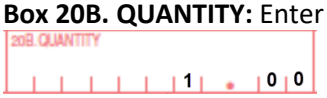
Box 16A. EMERGENCY RELATED: Place an 'X' in the YES box **only** when the condition being treated is related to an emergency; otherwise leave this field blank.

Box 19C. **IDENTIFICATION NUMBER:** Enter the prescriber's 10-digit National Provider ID (NPI).

Box 20. NATIONAL DRUG CODE: Enter the 11- digit NDC associated with the procedure code entered in box 24C. Do not use spaces or hyphens. **Note:** If the package NDC is not 11 digits, see General Professional Billing Guidelines for leading zero placement examples.

Box 20A. UNIT: Refer to the "NDC Billing Unit Type" on the Practitioner Administered Drug (PAD) Search Tool .

Box 20B. QUANTITY: Enter the number of units administered from Box 20A.



Box 20C. COST: Enter the acquisition cost. **Please note:** If actual acquisition cost exceeds what is allowed on the eMedNY 150003 form, a maximum of $99,999.99 should be submitted on the claim form. **Providers will be reimbursed up to the acquisition cost of the drug based on the invoice submitted, irrespective of the amount entered.**

Box 22F. POSSIBLE DISABILITY: Place an 'X' in the Y box for YES or an 'X' in the N box for NO to indicate whether the service was for treatment of a condition which appeared to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months).

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Box 22H. FAMILY PLANNING: Place an 'X' in the Y box for YES box if ***all*** services being claimed are family planning services. Place an 'X' in the N box for NO box if ***at least one*** of the services being claimed is not a family planning service.

Box 23A. PRIOR APPROVAL NUMBER: If the drug procedure code in box 24C requires a PA, enter the 11-digit PA number here. Otherwise leave blank.

Box 23B. PAYM'T SOURCE CD: See Exhibit 2.4.2-8 in the General Professional Billing Guidelines for an illustration of how to complete this box.

Box 24A. DATE OF SERVICE: Enter the date filled. The only accepted entry format is MMDDYY.

Box 24B. PLACE: Enter the two-digit number that indicates the type of location where the drug was filled. The place of service codes and descriptions can be found at Place of Service Code Set - CMS.

Box 24C. PROCEDURE CD: Enter the procedure code in the format of one letter and four numbers (e.g. X1111)

Box 24D. MOD: If applicable, enter a modifier. Otherwise leave blank. **Note:** When billing for a Medicare B deductible, modifier "U2" must be used. Do not enter the "U2" modifier if billing for Medicare B coinsurance.

- If Medicare approved amount is greater than zero, and there is a Medicare deductible and co-insurance, two separate lines are required.
  - Line 1: Deductible line. Include U2 modifier in box 24D, the deductible amount in box 24J and 0.00 in box 24K.
  - Line 2: Co-insurance line. Include Medicare approved amount in box 24J and the sum of the deductible + the Medicare paid amount in box 24K.

Box 24H. DIAGNOSIS CODE: Enter the ICD-10 diagnosis.

Box 24I. DAYS OR UNITS: Enter the appropriate number of HCPCS units.

Box 24J. CHARGES: Enter ***either*** the Amount Charged **or** the Medicare B Approved Amount.

- When Box M in field 23B has an entry value of 1 or 3, enter the amount charged. The Amount Charged may not exceed the provider's customary charge for the procedure.
- When Box M in field 23B has an entry value of 2, enter the Medicare Approved Amount in field 24J. The Medicare Approved amount is determined as follows:
  - **If billing for the Medicare deductible**, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the established amount for the year in which the service was rendered.
  - **If billing for the Medicare coinsurance**, the Medicare Approved amount should equal the sum of the amount paid by Medicare plus the Medicare co-insurance amount plus the Medicare deductible amount, if any.

Box 24K. : This field is used to indicate the Medicare B Paid Amount and must be completed if Box M in field 23B has an entry value of 2 or 3. Otherwise leave blank. See General Professional Billing Guidelines for additional details.

Box 24L. : This field must be completed when Box O in field 23B has an entry value of 2 or 3. Otherwise leave blank. See General Professional Billing Guidelines for additional details.

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Box 25. CERTIFICATION: The billing provider or authorized representative must sign the claim form. Rubber stamp signatures are not acceptable.

Box 25A. PROVIDER IDENTIFICATION NUMBER: Enter the pharmacy's 10-digit National Provider ID (NPI).

Box 25C. LOCATOR CODE: Enter the locator code assigned by NYS Medicaid that corresponds to the pharmacy address where the medication was filled.

Box 25E. DATE SIGNED: Enter the date on which the provider or an authorized representative signed the claim form. The only accepted entry format is MMDDYY.

Box 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE: Enter the pharmacy's name and correspondence address, using the 5 digit ZIP code or the ZIP plus four.

NOTE: Boxes that are not mentioned in the above *Form Completion Instructions* should be left blank.
Additionally, see section 2.2.1 in General Professional Billing Guidelines for detailed guideline to ensure accuracy of the claim imaging.

To Order Claim Forms

Contact the eMedNY Call Center: (800) 343-9000

Claim Mailing Address

eMedNY
P.O. Box 4601
Rensselaer, NY 12144-4601

Phone Contact

eMedNY Call Center: (800) 343-9000
Hours of Operation:

For provider inquiries pertaining to non-pharmacy billing, claims, or provider enrollment: 7:30 a.m. - 6:00 p.m. Eastern Time, Monday through Friday (excluding holidays)

For provider inquiries pertaining to eligibility or pharmacy claims: 7:00 a.m. - 10:00 p.m. Eastern Time, Monday through Friday (excluding holidays). 8:30 a.m. - 5:30 p.m. Eastern Time, Weekends and Holidays