

**NEW YORK STATE  
MEDICAID PROGRAM**

**PHARMACY MANUAL**

**BILLING GUIDELINES**

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## Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medical Remittance Advice.

This document is customized for Pharmacies and should be used by the provider as an instructional as well as a reference tool.

## Section II – Claims Submission

Pharmacies are required to submit most of their claims to NYS Medicaid electronically. However, certain types of claims are allowed to be submitted in electronic or paper formats. Examples of these types of claims are: claims requiring attachments, such as manufacturers' invoices for manual review and pricing, and claims exempt from the Drug Utilization Review (DUR) requirement.

### Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Pharmacies are required to use the HIPAA-compliant National Council for Prescription Drugs Program (NCPDP) 5.1 electronic format. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements:

- **NCPDP Standard Version 5.1 Implementation Guide** explains the proper use of the standards and program specifications. This document is available at [www.ncdp.org](http://www.ncdp.org).
- **NYS Medicaid NCPDP 5.1 Request and Response Companion Guides (CGs)** provide instructions for the specific requirements of NYS Medicaid for the NCPDP 5.1.
- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications.

These documents are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[eMedNY Companion Guides and Sample Files](#)

## Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic/Paper Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and password
- A Trading Partner Agreement
- Testing

### ETIN

This is a submitter identifier, issued by the eMedNY Contractor that must be used in every electronic submission to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

### [Provider Enrollment Forms](#)

### Certification Statement

All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for the electronic billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at [www.emedny.org](http://www.emedny.org) or can be accessed by clicking on the link above.

### **User ID and Password**

Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a User ID varies depending on the communication method chosen by the provider. For example: An ePACES User ID is assigned systematically via email while an FTP User ID is assigned after the submission of a Security Packet B.

### **Trading Partner Agreement**

This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

#### **[Provider Enrollment Forms](#)**

### **Testing**

Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

#### **[eMedNY Companion Guides and Sample Files](#)**

### **Communication Methods**

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

## **eMedNY eXchange**

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing, and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website at [www.emedny.org](http://www.emedny.org).**

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

## **FTP**

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**[Provider Enrollment Forms](#)**

## **CPU to CPU**

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

## **eMedNY Gateway**

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**[Provider Enrollment Forms](#)**

**Note: For questions regarding eXchange, FTP, CPU to CPU, or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**

## Paper Claims

For paper submissions, Pharmacies must use the New York State eMedNY-000301 claim form (Pharmacy Claim Form). To view the eMedNY-000301 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

### [Pharmacy - Sample Claim](#)

## General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As										
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">6.</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			6.	0		6.00	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">6.</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <span style="font-size: 2em;">→</span> Zero interpreted as six			6.	6	
		6.	0									
		6.	6									

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As		
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 30px; text-align: center;">2</td> </tr> </table>	2	2	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 30px; text-align: center;">7</td> </tr> </table> <span style="font-size: 2em;">→</span> Two interpreted as seven	7
2				
7				
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 30px; text-align: center;">3</td> </tr> </table>	3	3	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 30px; text-align: center;">2</td> </tr> </table> <span style="font-size: 2em;">→</span> Three interpreted as two	2
3				
2				



## Pharmacy Billing Guidelines

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- Characters should not touch each other. For example:

**Written As**

23

**Intended As**

23

**Interpreted As**

illegible



Entry cannot be interpreted properly

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign (\$) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections (i.e. information written over correction fluid or crossed out information). If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

**COMPUTER SCIENCES CORPORATION  
P.O. Box 4601  
Rensselaer, NY 12144-4601**

## Pharmacy Claim Form - eMedNY-000301

To view the eMedNY-000301 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

[Pharmacy - Sample Claim](#)

### General Information About the eMedNY-000301

Shaded fields are not required to be completed **unless noted otherwise**. Therefore, shaded fields that are not required to be completed in any circumstance are not listed in the instructions that follow.

Most claim form fields have been sized to contain the exact number of characters for the required information. However, some fields have been sized to accommodate potential future changes. For example, the Provider ID number has more spaces than the current number of characters for the required information. In this case, the entry must be **right justified (unless otherwise noted in the field instructions)**; that is, the extra spaces must be left blank at the left side of the box. For example, Provider ID number 02345678 should be entered as follows:

		0	2	3	4	5	6	7	8
--	--	---	---	---	---	---	---	---	---

### Billing Instructions for Pharmacy Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Pharmacies. Although the instructions that follow are based on the eMedNY-000301 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

## Field by Field Instructions for Pharmacy Claim Form-eMedNY-000301

### Header Section: Fields 1 through 13A

*The information entered in the Header Section of the claim form (fields 1 through 13A) must apply to all of the claim lines entered in the Encounter Section of the form.*

#### **PROVIDER ID NUMBER (Field 1)**

The Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the provider's ID number, the provider's name and correspondence address in this field for all providers.

#### **Notes:**

- **It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to Information for All Providers, Inquiry on the web page for this manual.**
- **Until New York State (NYS) Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.**

#### **DATE FILLED (Field 2)**

Enter the date on which the prescription/order is filled in the format MM/DD/YY.

**Example:** June 13, 2007 = 06/13/07

**SA EXCP CODE [Service Authorization Exception Code] (Field 3)**

If it was necessary to provide a service covered under the Utilization Threshold program and Service Authorization (SA/UT) could not be obtained, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix A – Code Sets.

For more information on the Utilization Threshold Program, please refer to Information for All Providers, General Policy on the web page for this manual available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Pharmacy Manual](#)

If not applicable, leave this field blank.

***Fields 4 and 4A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.***

**ADJUSTMENT/VOID CODE (Field 4)**

**Leave this field blank when submitting an original claim or resubmission of a denied claim.**

If submitting an **adjustment** (replacement) to a previously paid claim, enter **X** or the value **7** in the A box.

If submitting a **void** to a previously paid claim, enter **X** or the value **8** in the V box.

**ORIGINAL CLAIM REFERENCE NUMBER (Field 4A)**

**Leave this field blank when submitting an original claim or resubmission of a denied claim.**

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim and listed in the Remittance Advice.

**Adjustments**

An adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the **Provider ID Number** or the **Patient's Medicaid ID Number**, can be adjusted. The adjustment must be submitted in a new claim form (a copy of the original form is unacceptable) and all applicable fields must be completed. If multiple claim lines originally submitted on the same claim form need to be adjusted, a separate claim form must be submitted for each claim line to be adjusted. An adjustment is identified by the value **7** or **X** in the "A" box of field 4 and the claim to be adjusted is identified by the TCN entered in this field.

Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

**Example:**

TCN 0709819876543200 was paid on June 18, 2007. After receiving payment, the provider determines that an incorrect item code has been reported. An adjustment must be submitted to correct the claim records. Refer to Figures 1A and 1B for an illustration of this situation.

Figure 1A  
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER			2. DATE FILLED MO DAY YR 0 5   1 3   0 7			3. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM												
								4 CODE A V		4A. ORIGINAL CLAIM NUMBER										
City Pharmacy 111 Park Avenue Anytown, NY 11111			5. RECIPIENT ID NUMBER			6. DATE OF BIRTH			7. SEX X F 1 2		8. OTHER RECIPIENT INSURANCE CODE									
			A A 1 2 3 4 5 W 0 4 1 9 1 9 5 5			9. RECIPIENT NAME LAST Brandon FIRST John			12. PRIOR APPROVAL/AUTHORIZATION NO.											
			10. PROF CD			10A. ORDERING/PREScribing PROVIDER ID/LICENSE NUMBER			10B. NAME Peter Smith		12A. FOR OFFICE USE ONLY									
			11. PROF CD			11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER			11B. NAME		13.									
											14									

LINE	15. PRESCRIPTION/ORDER NUMBER	16. DATE ORDERED			17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY		22. AMOUNT CHARGED	MEDICARE			24. OTHER INSURANCE PAID						
		MO	DAY	YR						Y	X		23. CO-INSURANCE	23A. DEDUCTIBLE	23B. CO-PAY		23C. PAID					
1	6 0 0 0 1 0 0	0 5	0 3	0 7	5 1 0 7 9 0 2 0 0 2 0	6 0 0 0	3 0	1	5	1	X	1 5 0 0	.	.	.	.						
2	6 0 0 0 6 0 0	0 5	0 3	0 7	B 4 1 8 9	1 0 0	1 0	1	0	1	X	7 0 0 0	.	.	.	.						
3	6 0 0 0 1 6 0	0 5	0 3	0 7	A 6 2 4 7	3 0 0 0	3 0	0	0	1	X	2 0 0 0	.	.	.	.						
4										1	N	.	.	.	.	.						
5										1	N	.	.	.	.	.						
25. CASE MGR. ID							TOTALS ▶				26.		27.		27A.		27B.		27C.		28.	

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

29. SIGNATURE James Strong	30. COUNTY*	31. BILLING DATE MO DAY YR 0 5   1 3   0 7
-------------------------------	-------------	--

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

DO NOT WRITE IN BARCODE AREA



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

FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		\$ .
		.
		.
		.
		.
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	\$ .

**Figure 1B  
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM**

1. PROVIDER ID NUMBER    0   1   2   3   4   5   6   7				2. DATE FILLED MO DAY YR 0 5   1 3   0 7			3. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 4 CODE 7   V   4A. ORIGINAL CLAIM NUMBER 0 5   0 9   5 6   7 8   9 0   1 2   3 4   5 6														
City Pharmacy 111 Park Avenue Anytown, NY 11111				5. RECIPIENT ID NUMBER			6. DATE OF BIRTH			7. SEX X 1   F 2		8. OTHER RECIPIENT INSURANCE CODE						9. RECIPIENT NAME LAST Brandon   FIRST John					
				10. PROF CD A A   1 2   3 4   5 W		10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER 0 0   1 2   3 4   5 6			10B. NAME Peter Smith			12. PRIOR APPROVAL/AUTHORIZATION NO.						12A. LINE		FOR OFFICE USE ONLY			
11. PROF CD		11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER			11B. NAME						13.						13A.		14 1				

LINE	15. PRESCRIPTION/ORDER NUMBER	16. DATE ORDERED			17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY		22. AMOUNT CHARGED	MEDICARE			24. OTHER INSURANCE PAID				
		MO	DAY	YR						23. CO-INSURANCE	23A. DEDUCTIBLE		23B. CO-PAY	23C. PAID						
1	6 0 0 0 1 6 0	0 5	0 3	0 7	A 6   2   4   6	3 0 0 0	3 0	0	0	Y	X	1 0 0 0	.	.	.	.				
2										Y	X	.	.	.	.	.				
3										Y	X	.	.	.	.	.				
4										Y	N	.	.	.	.	.				
5										Y	N	.	.	.	.	.				
25. CASE MGR. ID						<b>TOTALS</b> ▶			26.		27.		27A.		27B.		27C.		28.	

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

29. SIGNATURE James Strong	30. COUNTY*	31. BILLING DATE MO DAY YR 0 6   1 3   0 7		
-------------------------------	-------------	--	--	--

\*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.  
DO NOT WRITE IN BARCODE AREA



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

FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		\$ .
		.
		.
		.
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	\$ .

**Void**

A void is submitted to nullify a paid claim. A void must be submitted in a new claim form (a copy of the original form is unacceptable) and all applicable fields must be completed. If multiple claim lines originally submitted on the same claim form need to be voided, a separate claim form must be submitted for each claim line to be voided. A void is identified by the value **8** or **X** in the “A” box of field 4, and the claim to be voided is identified by the TCN entered in this field.

**Example:**

The claim with TCN 0709818765432100 was paid on June 18, 2007. Later, the provider became aware that the patient was covered by another insurance. The other insurance was billed, and the provider received full payment from that payer. Medicaid must be reimbursed by submitting a void to the previously paid claim. Refer to figures 2A and 2B for an illustration of this situation.



Pharmacy Billing Guidelines

Figure 2A  
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER  0   0   1   2   3   4   5   6   7		2. DATE FILLED MO DAY YR 0   5   1   3   0   7			3. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM					
City Pharmacy 111 Park Avenue Anytown, NY 11111		5. RECIPIENT ID NUMBER			6. DATE OF BIRTH		7. SEX X 1 F 2		8. OTHER RECIPIENT INSURANCE CODE		9. RECIPIENT NAME LAST <b>Brandon</b> FIRST <b>John</b>	
		10. PROF CD A   A   1   2   3   4   5   W		10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER 0   0   1   2   3   4   5   6			10B. NAME <b>Peter Smith</b>		12. PRIOR APPROVAL/AUTHORIZATION NO.		12A. LINE FOR OFFICE USE ONLY	
11. PROF CD		11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER			11B. NAME		13.		13A.		14	

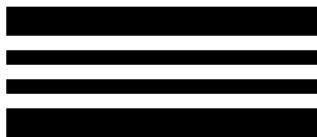
LINE	15. PRESCRIPTION/ORDER NUMBER	16. DATE ORDERED			17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY		22. AMOUNT CHARGED	MEDICARE				24. OTHER INSURANCE PAID
		MO	DAY	YR						Y	X		23. CO-INSURANCE	23A. DEDUCTIBLE	23B. CO-PAY	23C. PAID	
1	6 0 0 0 1 0 0	0 5	0 3	0 7	5 1 0 7 9 0 2 0 0 2 0	6 0 0 0	3 0	1	5	Y	X	1 5 0 0	.	.	.	.	.
2										Y	X	.	.	.	.	.	.
3										Y	X	.	.	.	.	.	.
4										Y	N	.	.	.	.	.	.
5										Y	N	.	.	.	.	.	.
25. CASE MGR. ID							<b>TOTALS</b> ▶				26.	27.	27A.	27B.	27C.	28.	

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

29. SIGNATURE <b>James Strong</b>	30. COUNTY*	31. BILLING DATE MO DAY YR 0   5   1   3   0   7
--------------------------------------	-------------	--

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

DO NOT WRITE IN BARCODE AREA



FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		\$ .
		.
		.
		.
DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST	.
	COMPOUNDING FEE	.
	DISPENSING FEE	.
	AMOUNT CHARGED	\$ .

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

**Figure 2B  
NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM**

1. PROVIDER ID NUMBER    0   1   2   3   4   5   6   7		2. DATE FILLED MO DAY YR 05 13 07			3. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 4 CODE: A 8      4A. ORIGINAL CLAIM NUMBER: 0509698765432123								
City Pharmacy 111 Park Avenue Anytown, NY 11111				5. RECIPIENT ID NUMBER		6. DATE OF BIRTH		7. SEX X 1    F 2		8. RECIPIENT OTHER INSURANCE CODE			9. RECIPIENT NAME LAST: <b>Brandon</b> FIRST: <b>John</b>		
				10. PROF CD: A A 1 2 3 4 5 W		10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6		10B. NAME: <b>Peter Smith</b>			12. PRIOR APPROVAL/AUTHORIZATION NO.		12A. LINE	FOR OFFICE USE ONLY	
11. PROF CD		11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER		11B. NAME			13.		13A.	14					

LINE	15. PRESCRIPTION/ORDER NUMBER	16. DATE ORDERED			17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY		22. AMOUNT CHARGED	23. CO-INSURANCE				24. OTHER INSURANCE PAID
		MO	DAY	YR						23A. DEDUCTIBLE	23B. CO-PAY		23C. PAID	23D. PAID			
1	600010100	05	03	07	51079020020	6000	30	1	5	Y	X	15.00	.	.	.	.	.
2										Y	X		.	.	.	.	.
3										Y	X		.	.	.	.	.
4										Y	N		.	.	.	.	.
5										Y	N		.	.	.	.	.
						25. CASE MGR. ID		<b>TOTALS</b> ▶			26.	27.	27A.	27B.	27C.	28.	

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

29. SIGNATURE <b>James Strong</b>		30. COUNTY*		31. BILLING DATE MO DAY YR 06 13 07		
--------------------------------------	--	-------------	--	---	--	--

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

DO NOT WRITE IN BARCODE AREA



FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		\$ .
		.
		.
		.
		.
DOSAGE FORM AND DIRECTIONS		TOTAL INGREDIENT COST
		COMPOUNDING FEE
		DISPENSING FEE
		AMOUNT CHARGED \$ .

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

**Fields 5-7 require information that should be obtained from the Client's (Recipient's) Common Benefit ID Card.**

**RECIPIENT ID NUMBER (Field 5)**

Enter the recipient's ID number (Client ID Number) as it appears in the Common Benefit Identification Card. Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

**Example:**

5.	RECIPIENT ID NUMBER						
A	A	1	2	3	4	5	W

**DATE OF BIRTH (Field 6)**

Enter the recipient's birth date indicated in the Common Benefit ID Card. The birth date must be in the format MMDDYYYY.

**Example:** Mary Brandon was born on January 2<sup>nd</sup>, 2004.

6.	DATE OF BIRTH						
0	1	0	2	2	0	0	4

**SEX (Field 7)**

Place an 'X' in the appropriate box to indicate the patient's sex.

**RECIPIENT OTHER INSURANCE CODE (Field 8)**

If the recipient is exempt from co-pay, enter the value Z9 in this field. For information on co-pay exemptions, refer to the Policy Guidelines available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Pharmacy Manual](#)

**RECIPIENT NAME (Field 9)**

Enter the recipient's last name followed by the first name as they appear on the Common Benefit Identification Card.

**PROF CD [Profession Code - Ordering/Prescribing Provider] (Field 10)**

If a license number is indicated in field 10A, the Profession Code that identifies the ordering/prescribing provider's profession must be entered in this field. Profession Codes are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web site below:

[eMedNY Crosswalks](#)

**ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER (Field 10A)**

**Prescriptions from Practitioners**

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

**Prescriptions from Facilities**

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

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

**Prescriptions from Physician's Assistants**

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

**Prescriptions from Nurse Practitioners**

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

**Example:** F012346

Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders.

If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field.

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

**Prescriptions for Restricted Recipients**

When filling prescriptions/orders for a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) and the primary provider is the prescribing/ordering provider, the Medicaid ID number of this provider must be entered in this field. **The license number of the primary provider is not acceptable in this case.**

If the restricted recipient was referred by his/her primary provider to another provider and this provider is the orderer/prescriber, the pharmacy provider must enter this provider's Medicaid ID number or license number in this field; then, the primary provider's Medicaid ID number must be entered in field 11A.

**Instructions for Entering a License Number**

If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A – Code Sets for the Post Office state abbreviations.

**NAME [Ordering/Prescribing Provider] (Field 10B)**

Enter the name of the individual whose name appears as the prescriber on the prescription or fiscal order.

**PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 11)**

Leave this field blank.

**OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 11A)**

**Prescriptions for Restricted Recipients**

If a restricted recipient was referred by his/her primary provider to another provider and this provider is the prescriber/orderer, enter the recipient's primary provider's Medicaid ID number in this field. The license number of the primary provider is not acceptable in this case.

**NAME [Other Referring/Ordering Provider] (Field 11B)**

Enter the name of the recipient's primary provider if a provider has been entered in field 11A.

**PRIOR APPROVAL/AUTHORIZATION NO. (Field 12)**

If the provider is billing for a prescription/order that requires prior approval or prior authorization, enter in this field the prior approval/authorization number assigned for the prescription/order.

**LINE (Field 12A)**

Enter the claim line number to which the prior approval/authorization entered in field 12 applies. If the prior approval/authorization number entered in field 12 applies to **all** claim lines, enter an “A” in this field.

**PRIOR APPROVAL/AUTHORIZATION NO. (Field13)**

If a prior approval/authorization number different from the one entered in field 12 applies to another claim line in the same claim form, enter the other prior approval/authorization number in this field.

**LINE (Field 13A)**

Enter the claim line number to which the prior approval/authorization entered in field 13 applies.

**Notes:**

- For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section on the web page for this manual.
- For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual.
- For information on how to submit a DVS transaction, refer to the MEVS manual.
- For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.

**Encounter Section: Fields 15 through 24**

**PRESCRIPTION/ORDER NUMBER (Field 15)**

Enter the pharmacy prescription/order number in this field.

**DATE ORDERED (Field 16)**

Enter the original date on which the prescription/order was written as it appears on the prescription/order note signed by the prescribing/ordering provider. The date should be entered in the format MM/DD/YY.

**Example:**

A drug was originally prescribed for a patient on 05/03/07. The prescription is being refilled on 06/03/07. Enter 05/03/07 in field 16.

**DRUG/SUPPLY CODE (Field 17)**

**For prescription drugs**, enter in this field the National Drug Code (NDC) of the drug displayed on the package.

**For OTC drugs**, bill using the 11-digit NDC code.

**Note: Do not use the UPC code found on packaging.**

**For supplies**, leave the first four spaces of this field blank. Enter the five-character code from the Procedure Code and Fee Schedule Section in the next five spaces and leave the next two spaces of this field blank unless a modifier is required. When a modifier is required, enter the two-character modifier in the last two spaces of this field.

Procedure Codes and Fee Schedules are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**[Pharmacy Manual](#)**

**Example:** Medical/Surgical supply item should be entered as follows:

				A	4	4	5	2		
--	--	--	--	---	---	---	---	---	--	--

**QUANTITY DISPENSED (Field 18)**

**Notes:**

- Quantities with decimals should not be rounded off.
- When completing this field, enter only the appropriate numbers; do not enter a quantity abbreviation, e.g., “mls.”

To determine units pricing, use the rules that follow:

## Legend Drugs

- When applicable, units must be expressed in the metric system. Examples:
  - ▶ A pint bottle of a liquid is billed as milliliters and the quantity supplied should be “473.”
  - ▶ A 2 oz. bottle of a liquid is billed as milliliters and the quantity supplied should be “60.”
  - ▶ A 2 oz. unit of a solid or semi-solid is billed as grams and the quantity supplied should be “60.”
- All liquid preparations that are dispensed in unbroken bottles must be billed for the same number of units (mls) indicated on the label. (e.g. Cough Preparation, 472.8 mls. bottle, is billed as a quantity of “472.8.”).
- All reconstituted medications must be expressed in terms of milliliters.
  - ▶ Oral penicillins and penicillin derivatives are priced by the number of mls. dispensed (e.g. Ampicillin Suspension, 5 ml. - 125 mg., 100 ml, is billed as a quantity of “100.”)
  - ▶ Powders for rectal administration are priced by the number of mls. dispensed (e.g. Cortenema, 100mg/60ml., is billed as a quantity of “60.”)
- All legend drugs are billed by the appropriate unit (e.g.: Caps, Tabs, Packets, Suppositories, etc.) with the following exceptions:
  - ▶ Ampules are billed in ml. units (e.g.: Lasix Ampules, 20 mg/cc, five 2 ml. ampules are billed as a quantity of “10.”)
  - ▶ Vials are billed as number of ml. (e.g.: Demerol, 100mg/ml, one 20 ml. vial is billed as a quantity of “20.”)

***For birth control pills and OTC drugs, please carefully comply with the instructions that follow:***

- Birth control pills are billed as tablet units. (e.g.: Ovrал-21 is billed as a quantity of “21.”).
- Over-the-counter (OTC) drugs are billed in the same manner as legend drugs.



***For medical/surgical supplies please refer to the Procedure Codes and the Fee Schedules available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:***

**[Pharmacy Manual](#)**

**DAYS SUPPLY (Field 19)**

Enter the number of days for which the quantity supplied should last as written on the prescription/order.

**Example:** Enter 30-day supply as:

19. DAYS SUPPLY		
	3	0

If the prescription/order directs the patient “to take when necessary,” enter **180** in this field.

**Example:**

19. DAYS SUPPLY		
1	8	0

**NEW/REFILL NUMBER (Field 20)**

**Original Prescription/Order**

Enter **0** in this field.

**Refill**

Indicate the number of the refill.

**Example:** Enter **1** for first refill. Enter **5** for fifth refill.

**Enteral Formula**

Prior authorizations for enteral formula are issued based on “times approved” rather than refills. When billing for enteral formula products enter **0** in this field always.

**NUMBER OF REFILLS AUTHORIZED (Field 20A)**

Enter the number of refills indicated on the prescription/order form for the particular drug/supply. This number of refills may not exceed 5. If no refills are indicated on the prescription or if billing for enteral formula, enter **0** in this field.

**BRAND NECESSARY (Field 21)**

If the prescription form indicates “DAW” in the “Dispense As Written” box and the ordering/prescribing provider wrote "brand necessary" or “brand medically necessary” in their own handwriting on the face of the order/prescription, place an ‘X’ on Y for Yes in the proper field to indicate the brand drug was dispensed. This indicator will cause the claim to be paid at the EAC price when multiple source generic drugs affected by Upper Payment Limits are available. Otherwise, place an ‘X’ on N for No.

**AMOUNT CHARGED (Field 22)**

Enter the total amount charged for each service rendered. The amount must not exceed the provider's usual and customary charge.

***Fields 23, 23A, 23B, and 23C are only applicable if the recipient is also a Medicare beneficiary.***

**Notes:**

- **It is the responsibility of the provider to determine whether Medicare covers the service being claimed. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.**
- **If the provider knows that the service rendered is not covered by Medicare, enter zero in field 23C.**

**MEDICARE CO-INSURANCE (Field 23)**

If applicable, enter the Medicare co-insurance amount for this drug/supply.

**MEDICARE DEDUCTIBLE (Field 23A)**

If applicable, enter the Medicare deductible amount for this drug/supply.

**MEDICARE CO-PAY (Field 23B)**

If applicable, enter the Medicare co-pay amount for this drug/supply.

**MEDICARE PAID (Field 23C)**

If applicable, enter the amount actually paid by Medicare for the drug/supply. If Medicare denies payment, enter 0.00 in this field.

**OTHER INSURANCE PAID (Field 24)**

This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage.

**Note: It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being claimed. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.**

If applicable, enter the amount actually paid by the other insurance carrier in this field.

If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ▶ The provider has had a previous denial of payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - ▶ In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for the same type of service. This communication should be documented in the patient's billing record.
- The provider bills the insurance company and receives a rejection because:
  - ▶ The service is not covered; or
  - ▶ The deductible has not been met.

- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to or uncooperative in submitting claims to the insurance company. In these cases, the LDSS must be notified prior to zero-filling. LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases, the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.
- The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

### **Pharmacy Claim Form-Certification Section: Fields 29 through 31**

#### **SIGNATURE (Field 29)**

The provider or an authorized representative must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

#### **COUNTY (Field 30)**

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, entered in Field 1, is within the county wherein the claim form is signed.

#### **BILLING DATE (Field 31)**

Enter the date on which the provider or an authorized representative signed the claim form. The date should be in the format MM/DD/YY.

**Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to the Information for All Providers, General Billing Section on the web page for this manual.**

**FOR COMPOUND USE ONLY (Field 35)**

**Electronic Claims (NCPDP 5.1)**

Please refer to the Procedure Codes available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Pharmacy Manual](#)

**Paper Claims**

**Ingredients:** Indicate each ingredient (as specified on the prescription) on a separate line. Indicate the manufacturer's name.

**Quantity:** Enter the metric quantity of each ingredient.

**Price:** Enter the cost of each ingredient.

**Dosage Form and Directions:** Indicate the form of the final preparation, i.e. cream, capsules, ointment, etc. Also, state the physician's directions in this box.

**Total Ingredient Cost:** Enter the total cost of the compound prescription.

**Compounding Fee:** Enter the fee for compounding a prescription.

**Dispensing Fee:** Enter the fee for dispensing a prescription.

**Amount Charged:** Enter the total amount charge. Also, be sure to enter this total amount in field 22 on the appropriate claim line.

## Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- **Subtotals** (by category, status, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

### Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers must complete the Electronic Remittance Request Form, which is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below;

[eMedNY Companion Guides and Sample Files](#)

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at [www.emedny.org](http://www.emedny.org). If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transactions for any processing cycle that produces pends.

## Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

## Remittance Sorts

The default sort for the paper remittance advice is:  
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers must complete the Paper Remittance Request Form, which is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Provider Enrollment Forms](#)

## Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - ▶ Medicaid Check
  - ▶ Notice of Electronic Funds Transfer (EFT)
  - ▶ Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four:
  - ▶ Financial Transactions (recoupments)
  - ▶ Accounts Receivable (cumulative financial information)
- Section Five: Edit (error) Description

## Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Pharmacy services followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only.

The following information applies to a remittance advice with the default sort pattern.



**Section One – Medicaid Check**

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).



TO: CITY PHARMACY

DATE: 2007-08-06  
 REMITTANCE NO: 070806000006  
 PROVIDER ID/NPI: 00123456/0123456789

070806000006 2007-08-06  
 CITY PHARMACY  
 111 PARK AVENUE  
 ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

$\frac{29}{2}$

DATE	REMITTANCE NUMBER	PROVIDER ID/NPI
2007-08-06 <small>VOID AFTER 90 DAYS</small>	070806000006	00123456/0123456789

DOLLARS/CENTS
PAY \$*****104.88

TO  
THE  
ORDER  
OF

070806000006 2007-08-06  
 CITY PHARMACY  
 111 PARK AVENUE  
 ANYTOWN NY 11111



MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
 CHECKS DRAWN ON  
 KEY BANK N.A.  
 60 STATE STREET, ALBANY, NEW YORK 12207

John Smith  
AUTHORIZED SIGNATURE

***Check Stub Information***

**UPPER LEFT CORNER**

Provider's name (as recorded in the Medicaid files)

**UPPER RIGHT CORNER**

Date on which the remittance advice was issued

Remittance number

\* Provider ID/NPI

**CENTER**

Remittance number/date

Provider's name/address

***Medicaid Check***

**LEFT SIDE**

Table

Date on which the check was issued

Remittance number

\* Provider ID/NPI

Remittance number/date

Provider's name/address

**RIGHT SIDE**

Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

**\* Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

**Section One – EFT Notification**

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: CITY PHARMACY



DATE: 2007-08-06  
REMITTANCE NO: 070806000006  
PROVIDER ID/NPI: 00123456/0123456789

070806000006 2007-08-06  
CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN NY 11111

CITY PHARMACY \$104.88

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

***Information on the EFT Notification Page***

**UPPER LEFT CORNER**

Provider's name (as recorded in the Medicaid files)

**UPPER RIGHT CORNER**

Date on which the remittance advice was issued

Remittance number

\* Provider ID/NPI

**CENTER**

Remittance number/date

Provider's name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

**Section One – Summout (No Payment)**

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: ABC PHARMACY



DATE: 08/06/2007  
REMITTANCE NO: 070806000006  
PROVIDER ID/NPI: 00123456/0123456789

NO PAYMENT WILL BE RECEIVED THIS CYCLE. SEE REMITTANCE FOR DETAILS.

CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN NY 11111

***Information on the Summout Page***

**UPPER LEFT CORNER**

Provider Name (as recorded in Medicaid files)

**UPPER RIGHT CORNER**

Date on which the remittance advice was issued

Remittance number

\* Provider ID/NPI

**CENTER**

Notification that no payment was made for the cycle (no claims were approved)

Provider name and address

**Section Two – Provider Notification**

This section is used to communicate important messages to providers.



PAGE 01  
DATE 08/06/07  
CYCLE 1563

TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111

ETIN:  
PROVIDER NOTIFICATION  
PROVIDER ID/NPI 00123456/0123456789  
REMITTANCE NO: 070806000006

REMITTANCE ADVICE MESSAGE TEXT

\*\*\* ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE \*\*\*

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT [WWW.EMEDNY.ORG](http://WWW.EMEDNY.ORG). CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF \$0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

***Information on the Provider Notification Page***

**UPPER LEFT CORNER**

Provider's name and address

**UPPER RIGHT CORNER**

Remittance page number

Date on which the remittance advice was issued

Cycle number

ETIN (not applicable)

Name of section: **Provider Notification**

\* Provider ID/NPI

Remittance number

**CENTER**

Message text



**Pharmacy Billing Guidelines**

**Section Three – Claim Detail**

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and adjudicated (paid or denied) during the specific cycle. This section may also contain pending claims from previous cycles that still remain in a pend status.


  
**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**  
**REMITTANCE STATEMENT**

PAGE 02  
 DATE 08/06/2007  
 CYCLE 1563

TO: CITY PHARMACY  
 111 PARK AVENUE  
 ANYTOWN, NEW YORK 11111

ETIN:  
 PHARMACY  
 PROVIDER ID/NPI: 00123456/0123456789  
 REMITTANCE NO: 070806000006

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267229	00173044100	54.000	BZ12345K	NICHOLS	05/01/07	07267-000000605-0-2	100.00	0.00	DENY	00162
4267240	00904391660	5.000	BZ12345K	NICHOLS	05/15/07	07267-000000614-0-1	50.00	0.00	DENY	00162
0426722	00904391660	5.000	CD54321J	RYDER	05/25/07	07267-000000573-0-1	30.00	0.00	DENY	00142 00144
0042664	00002411260	1.000	CD54321J	RYDER	05/01/07	07267-000000453-2-2	60.00	0.00	DENY	00142 00144

\* = PREVIOUSLY PENDED CLAIM  
 \*\* = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	240.00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

**Pharmacy Billing Guidelines**



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DATE 08/06/2007  
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT**

TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111

ETIN:  
PHARMACY  
PROVIDER ID/NPI: 00123456/0123456789  
REMITTANCE NO: 070806000006

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
0042663	00002411260	5.000	BB12345K	FREDERICKS	04/15/07	07267-000000437-2-1	100.00	100.00	PAID	
0042663	00002411260	5.000	BB12345K	FREDERICKS	04/15/07	07188-000000437-2-2	10.00	80.00-	ADJT	ORIGINAL CLAIM AS PAID 05/20/07
0426722	00904391660	1.000	BB12345K	FREDERICKS	05/25/07	07267-000000562-0-0	5.91	5.91	PAID	
0426711	00002411260	1.000	CG54321J	CARRS	05/10/07	07267-000000260-0-0	28.97	28.97	PAID	
0426712	00002411260	1.000	CG54321J	CARRS	05/20/07	07267-000000263-0-0	50.00	50.00	PAID	

\* = PREVIOUSLY PENDED CLAIM  
\*\* = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	84.88	NUMBER OF CLAIMS	3
NET AMOUNT ADJUSTMENTS	PAID	90.00	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS	PAID	20.00	NUMBER OF CLAIMS	1

**Pharmacy Billing Guidelines**



PAGE 04  
DATE 08/06/2007  
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT**

TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111

ETIN:  
PHARMACY  
PROVIDER ID/NPI: 00123456/0123456789  
REMITTANCE NO: 070806000006

PRESCRIP TION NO.	ITEM CODE	QUANTITY	CLIENT ID NUMBER	CLIENT NAME	SERVICE DATE	TCN	CHARGED	PAID	STATUS	ERRORS
4267241	00904391660	5.000	BZ12345G	CARTER	05/20/07	07272-000000027-0-1	56.00	0.00	PEND	00162 00127
4267241	00904391660	5.000	BZ12345G	CARTER	05/20/07	07272-000000028-0-2	55.00	0.00	PEND	00162 00127
4267242	00904391660	5.000	FR54321J	DUNNISON	05/07/07	07272-000000035-0-1	20.00	0.00	PEND	01154
4267243	00904391660	5.000	FR54321J	DUNNISON	05/10/07	07272-000000044-0-2	40.00	0.00	PEND	01154

\* = PREVIOUSLY PENDED CLAIM  
\*\* = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	171.00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	00.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		00.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – PHARMACY				
VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1
TOTAL PENDS		171.00	NUMBER OF CLAIMS	4
TOTAL PAID		84.88	NUMBER OF CLAIMS	3
TOTAL DENIED		240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID		64.88	NUMBER OF CLAIMS	4

MEMBER ID: 00123456				
VOIDS – ADJUSTS		20.00	NUMBER OF CLAIMS	1
TOTAL PENDS		171.00	NUMBER OF CLAIMS	4
TOTAL PAID		84.88	NUMBER OF CLAIMS	3
TOTAL DENIED		240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID		64.88	NUMBER OF CLAIMS	4

Pharmacy Billing Guidelines



**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT**

PAGE: 05  
DATE: 08/06/07  
CYCLE: 1563

ETIN:  
PHARMACY  
GRAND TOTALS  
PROVIDER ID/NPI: 00123456/0123456789  
REMITTANCE NO: 070806000006

TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	20.00	NUMBER OF CLAIMS	1
TOTAL PENDS	171.00	NUMBER OF CLAIMS	4
TOTAL PAID	84.88	NUMBER OF CLAIMS	3
TOTAL DENY	240.00	NUMBER OF CLAIMS	4
NET TOTAL PAID	64.88	NUMBER OF CLAIMS	4

***General Information on the Claim Detail Pages***

**UPPER LEFT CORNER**

Provider's name and address

**UPPER RIGHT CORNER**

Remittance page number

Date on which the remittance advice was issued

Cycle number. The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **PHARMACY**

\* Provider ID/NPI

Remittance number

***Explanation of the Claim Detail Columns***

**PRESCRIPTION NO.**

This column indicates the prescription number as it appears on the claim form.

**ITEM CODE**

This column shows the code that identifies the drug or supply that was dispensed (NDC code or HCPCS CODE).

**QUANTITY**

The quantity dispensed appears under this column. The quantity is indicated with three (3) decimal positions.

**CLIENT ID NUMBER**

The client's Medicaid ID number appears under this column.

**CLIENT NAME**

This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted, but no name will appear under this column.

**SERVICE DATE**

This column lists the service date as entered in the claim form.

**TCN**

The TCN is a unique identifier assigned to each claim line that is processed.

**CHARGED**

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

**PAID**

If the claim is approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

**STATUS**

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

**Denied Claims**

Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

**Approved Claims**

Approved claims will be identified by the statuses **PAID**, **ADJT** (adjustment), or **VOID**.

***Paid Claims***

The status **PAID** refers to **original** claims that have been approved.

***Adjustments***

The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim) and the debit transaction (adjusted claim).

***Voids***

The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

### **Pending Claims**

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Recipient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files, or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (\*\*). A previously pended claim is signified by one asterisk (\*).

### **ERRORS**

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are “approved” edits, which identify certain “errors” found in the claim, which do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on the last page(s) of the remittance advice.

### ***Subtotals/Totals***

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by **claim status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by **provider type** are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by **member ID** are provided next to the subtotals for provider type. For pharmacies, these totals are exactly the same as the subtotals by provider type. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

**Grand Totals** for the entire provider remittance advice appear on a separate page following the page containing the **totals by provider type and member ID**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)




**Section Four**

This section has two subsections:

- Financial Transactions
- Accounts Receivable

**Financial Transactions**

The Financial Transactions subsection lists all the recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

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		CYCLE 1563
TO: CITY PHARMACY	<b>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM</b>	ETIN:
111 PARK AVENUE	<b>REMITTANCE STATEMENT</b>	FINANCIAL TRANSACTIONS
ANYTOWN, NEW YORK 11111		PROVIDER ID/NPI: 00123456/0123456798
		REMITTANCE NO: 070806000006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	\$\$\$

NET FINANCIAL TRANSACTION AMOUNT	\$\$\$	NUMBER OF FINANCIAL TRANSACTIONS	XXX
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## Explanation of the Financial Transactions Columns

### **FCN (FINANCIAL CONTROL NUMBER)**

This is a unique identifier assigned to each financial transaction.

### **FINANCIAL REASON CODE**

This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

### **FISCAL TRANSACTION TYPE**

This is the description of the Financial Reason Code. For example: Third-Party Recovery.

### **DATE**

The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

### **AMOUNT**

The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

### ***Totals***

The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

**Accounts Receivable**

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111



**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT**

PAGE 08  
DATE 08/06/07  
CYCLE 1563

ETIN:  
ACCOUNTS RECEIVABLE  
PROVIDER ID/NPI: 001234560123456789  
REMITTANCE NO: 070806000006

REASON CODE	DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
		\$XXX.XX-	\$XXX.XX-	999
		\$XXX.XX-	\$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE \$XXX.XX

***Explanation of the Accounts Receivable Columns***

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

**REASON CODE DESCRIPTION**

This is the description of the Financial Reason Code. For example: Third Party Recovery.

**ORIGINAL BALANCE**

The original amount (or starting balance) for any particular financial reason.

**CURRENT BALANCE**

The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

**RECOUPMENT % AMOUNT**

The deduction (recoupment) scheduled for each cycle.

***Total Amount Due the State***

This amount is the sum of all the **Current Balances** listed above.

**Section Five – Edit Descriptions**

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.



TO: CITY PHARMACY  
111 PARK AVENUE  
ANYTOWN, NEW YORK 11111

PAGE 06  
DATE 08/06/07  
CYCLE 1563

ETIN:  
PHARMACY  
EDIT DESCRIPTIONS  
PROVIDER ID/NPI: 00123456/0123456789  
REMITTANCE NO: 070806000006

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:

- 00127 MEDICARE PAID AMOUNT LESS THAN REASONABLE
- 00142 SERVICE CODE NOT EQUAL TO PA
- 00144 RECIPIENT SEX NOT EQUAL TO FILE
- 00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
- 01154 NO UT SERVICE AUTHORIZATION ON FILE

## Appendix A – Code Sets

### SA EXCEPTION CODE

<b>Code</b>	<b>Description</b>
1	Immediate/urgent care
2	Services rendered in retroactive period
3	Emergency care
4	Client has temporary Medicaid
5	Request from county for second opinion to determine if recipient can work
6	Request for override pending
7	Special handling

**United States Standard Postal Abbreviations**

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

<b><u>American Territories</u></b>	<b><u>Abbrev.</u></b>
American Samoa	AS
Canal Zone	CZ
Guam	GU
Puerto Rico	PR
Trust Territories	TT
Virgin Islands	VI

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