New York State
eMedNY Billing Guidelines

PHARMACY

Version 2022 - 01

8/15/2022

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and eMedNY. More information about eMedNY can be found at www.emedny.org.

TABLE OF CONTENTS

***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. 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.

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

2. Claims Submission

Pharmacies can submit claims using either electronic or paper formats.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and Certification Statement before submitting claims to NYS Medicaid.

Providers are asked to update their Certification Statement on an annual basis. Providers are sent renewal information when their Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking: eMedNY Trading Partner Information Companion Guide.

2.1 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) D.0 electronic format.

Direct billers should also refer to the sources listed below to comply with the NYS Medicaid requirements:

- NCPDP Standard Version D.0 Implementation Guide explains the proper use of the standards and program specifications. This document is available at www.ncpdp.org.
- NYS Medicaid NCPDP 5.1 Request and Response Companion Guide (CG) provide instructions for the specific requirements of NYS Medicaid for the NCPDP 5.1. This document is available at www.emedny.org by clicking: eMedNY 5010/D.0 Transaction Instructions.
- eMedNY Prospective Drug Utilization Review/ Electronic Claims Capture and Adjudication ProDUR/ECCA Provider Manual.

Further information on the D.0 transaction is available at www.emedny.org by clicking: eMedNYHIPAASupport.

Further information about electronic claim prerequisites is available at www.emedny.org by clicking: eMedNY Trading Partner Information Companion Guide.

2.2 Paper Claims

Pharmacies that choose to submit claims on paper forms must use the New York State eMedNY-000301 claim form.

To view the eMedNY-000301 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

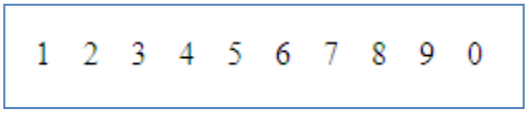
An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking: eMedNY Trading Partner Information Companion Guide.

2.2.1 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:

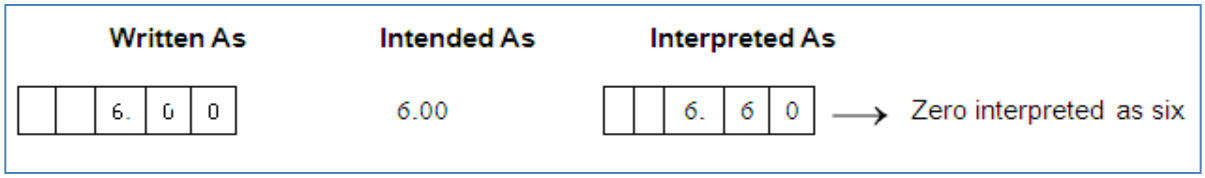
- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1



- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2



- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

Written As	Intended As	Interpreted As
2	2	7 → Two interpreted as seven
3	3	2 → Three interpreted as two

- Characters should not touch each other as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

Written As	Intended As	Interpreted As
23	23	illegible → Entry cannot be interpreted properly

- Do not write 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, such as 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:

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

2.3 Claim Form A – eMedNY-000301

To order the eMedNY-000301 claim form, please contact the eMedNY call center at 1-800-343-9000.

2.4 Pharmacy Services Billing Instructions

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 to find out what information they need to provide in their claims. For further electronic claim submission information, refer to the NCPDP D.0 Request and Response Companion Guide which is available at www.emedny.org by clicking: NCPDP D.0 Companion Guide.

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.

2.4.1 Claim Form – eMedNY-00301 Field Instructions

Header Section: Fields 1 through 13A

The information entered in the Header Section of the claim form (fields 1 through 13A) applies to all claim lines entered in the Procedure Section of the form.

Provider ID Number (Field 1)

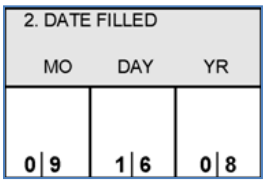
Enter the provider's 10-digit National Provider Identifier (NPI), name and address using the full 9 digit ZIP code.

NOTE: 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, which can be found at www.emedny.org by clicking: Inquiry.

Date Filled (Field 2)

Enter the date the prescription/order is filled in the format MM/DD/YY. See Exhibit 2.4.1-1 for an example.

Exhibit 2.4.1-1



SA EXCP Code [Service Authorization Exception Code] (Field 3)
837P Ref: Loop 2300 REF03 when REF01 = 4N

If applicable, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix B - Code Sets.

NOTE: If the services being claimed require special claim handling (see list of exempted specialties in Appendix A-Codes), the value '7' must be entered.

If not applicable leave this field blank.

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' in the 'A' box.
- If submitting a void to a previously paid claim, enter 'X' 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 document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record.

2.4.1.1 Adjustment

An adjustment may be submitted to correct any information on a previously paid claim other than:

- The billing provider
- The member ID.

Exhibit 2.4.1.1-1 and Exhibit 2.4.1.1-2 illustrate an example of a claim with an adjustment being made. TCN 0826019876543200 is shared by three individual claim lines. TCN 0826067890123456 was paid on October 1, 2008. After receiving payment, the provider determines that an incorrect item code has been reported. An adjustment must be submitted to correct the claim records. Exhibit 2.4.1.1-1 shows the claim as it was originally submitted and Exhibit 2.4.1.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.1.1-1

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 09 DAY 16 YR 08

3. SA EXCP CODE:

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

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 (F 2)
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith

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

PRIOR APPROVAL/AUTHORIZATION NO.:
12.
12A. LINE
FOR OFFICE USE ONLY
13.
13A.
14 1

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	09 16 08	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y 1 X	1 5.0 0					
2	6 0 0 0 6 0 0	09 16 08	B 4 1 8 9	1 0.0 0	1 0	1	0	Y 1 X	7 5.0 0					
3	6 0 0 0 1 6 0	09 16 08	A 6 2 4 7	6 0.0 0	3 0	0	0	Y 1 X	2 0.0 0					
4								Y 1 N						
5								Y 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 09 DAY 16 YR 08

*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

[redacted]

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	$.

Exhibit 2.4.1.1-2

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: 7 V
4A. ORIGINAL CLAIM NUMBER: 0 8 2 6 0 6 7 8 9 0 1 2 3 4 5 6

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 (F 2)
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

PRIOR APPROVAL/AUTHORIZATION NO.: LINE: FOR OFFICE USE ONLY

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith
11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:
12.
12A.
13.
13A.
14: 1

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 6 0	0 9 / 1 6 / 0 8	A 6 2 4 6	3 0.0 0	3 0	0	0	Y 1 X	1 0.0 0					
2								Y 1 N						
3								Y 1 N						
4								Y 1 N						
5								Y 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 1 0 DAY 0 6 YR 0 8

*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

[redacted]

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	$.

2.4.1.2 Void

A void is submitted to nullify the original claim in its entirety.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form.
- The void must contain the TCN and the originally submitted Billing Provider ID and Member ID.

Exhibit 2.4.1.2-1 and Exhibit 2.4.1.2-2 illustrate an example of a claim being voided. TCN 082609865432123 was paid on October 1, 2008. Later, the provider became aware that the patient was covered by other 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. Exhibit 2.4.1.2-1 shows the claim as it was originally submitted and Exhibit 2.4.1.2-2 shows the claim being submitted as voided.

Exhibit 2.4.1.2-1

NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

2. DATE FILLED (MO DAY YR): 0 9 1 6 0 8

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 11111-1111

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

6. DATE OF BIRTH: 0 4 1 9 1 9 5 5

7. SEX: X (1) F (2)

8. OTHER RECIPIENT INSURANCE CODE:

9. RECIPIENT NAME: LAST Brandon FIRST John

PRIOR APPROVAL/AUTHORIZATION NO. | LINE | FOR OFFICE USE ONLY

10. PROF CD | 10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6 | 10B. NAME: Peter Smith | 12. | 12A. | 14: 1

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

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED (MO DAY YR)	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	0 9 1 6 0 8	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y (1) X	1 5.0 0					
2								Y (1) N						
3								Y (1) N						
4								Y (1) N						
5								Y (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 9 1 6 0 8

*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

[redacted]

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

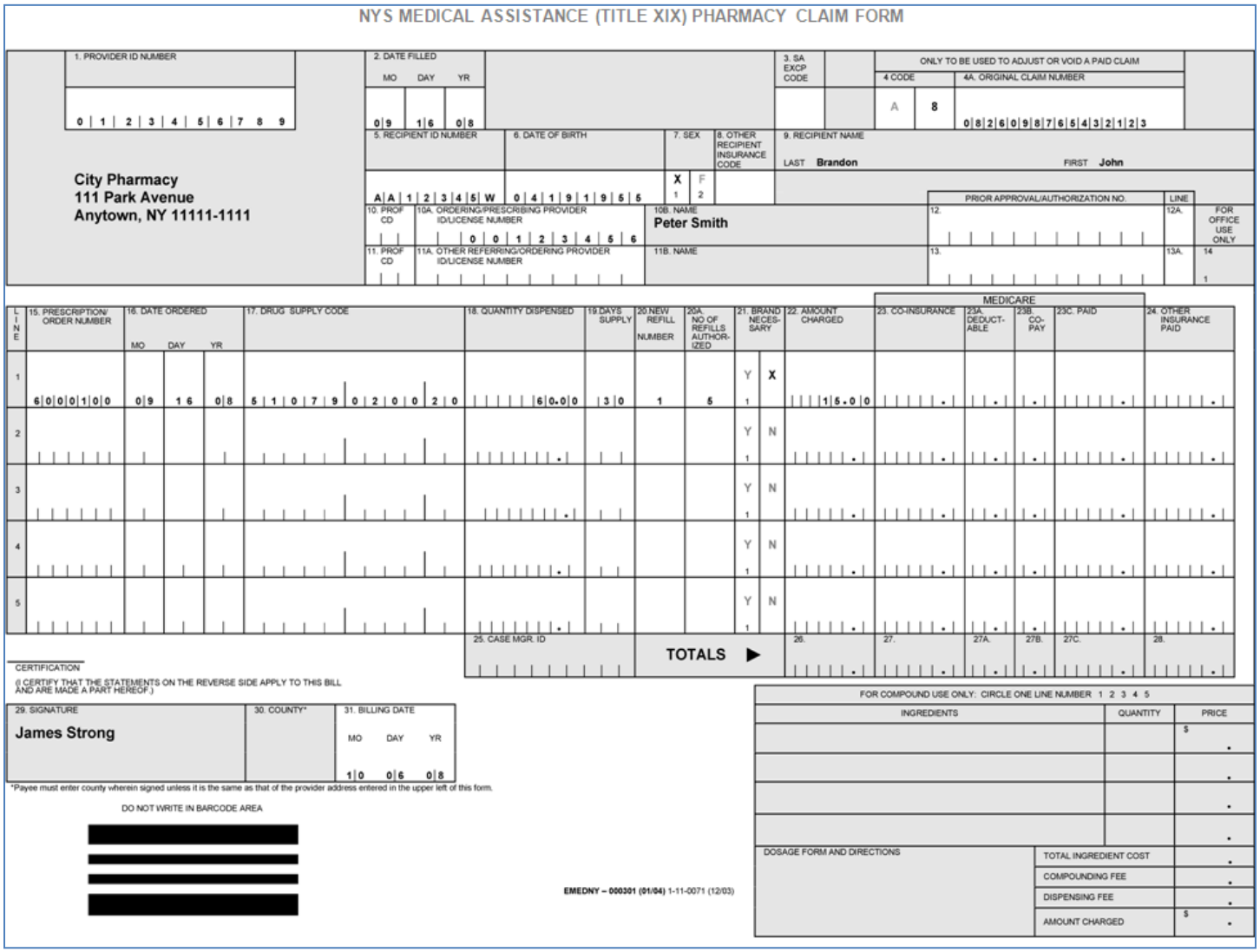
FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.
		.

DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

Exhibit 2.4.1.2-2



NYS MEDICAL ASSISTANCE (TITLE XIX) PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7 8 9

City Pharmacy
111 Park Avenue
Anytown, NY 11111-1111

2. DATE FILLED: MO 0 9 DAY 1 6 YR 0 8

3. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
4 CODE: A 8
4A. ORIGINAL CLAIM NUMBER: 0 8 2 6 0 9 8 7 6 5 4 3 2 1 2 3

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 M, F 2
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 0 0 1 2 3 4 5 6
10B. NAME: Peter Smith

PRIOR APPROVAL/AUTHORIZATION NO.:
LINE:
12.
12A.
FOR OFFICE USE ONLY
14 1

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

MEDICARE

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20 NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	23. CO-INSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE PAID
1	6 0 0 0 1 0 0	0 9 1 6 0 8	5 1 0 7 9 0 2 0 0 2 0	6 0.0 0	3 0	1	5	Y 1 X	1 5.0 0					
2								Y 1 N						
3								Y 1 N						
4								Y 1 N						
5								Y 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 1 0 DAY 0 6 YR 0 8

*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

[redacted]

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	$.

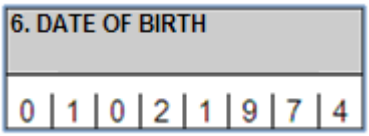
Recipient ID Number (Field 5)

Enter the member ID. This information may be obtained from the member's Common Benefit ID Card (CBIC).

Date of Birth (Field 6)

Enter the member's birth date. This information may be obtained from the CBIC. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.1-3.

Exhibit 2.4.1-3



Sex (Field 7)

Place an 'X' in the appropriate box to indicate the member's sex. This information may be obtained from the CBIC.

Recipient Other Insurance Code (Field 8)

If the member is exempt from co-pay, enter the value Z9 in this field. For information on co-pay exemptions, refer to the Policy Guidelines which can be found at www.emedny.org by clicking on the link: Policy Guidelines.

Recipient Name (Field 9)

Enter the member's last name followed by the first name as they appear on the CBIC.

PROF Code [Profession Code – Ordering/Prescribing Provider] (Field 10)

Leave this field blank.

Ordering/Prescribing Provider ID/License Number (Field 10A)

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 NPI should be entered in this field.

Prescriptions from All Others

Enter the NPI of the prescribing professional.

NOTE: If the NPI of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.

Prescriptions for Restricted Members

When filling prescriptions/orders for a member who is restricted to a primary provider (physician, clinic, podiatrist or dentist) and the primary provider is the prescribing/ordering provider, the NPI of this provider must be entered in this field.

If the restricted member was referred by the primary provider to another provider and the referred-to provider is the ordering/prescribing provider, the pharmacy provider must enter the referred-to provider's NPI. The primary provider's NPI must be entered in field 11A.

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 Members

If a restricted member was referred by his/her primary provider to another provider and this provider is the prescriber/orderer, enter the NPI of the member's primary care provider.

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

Enter the name of the member's primary provider, if an NPI 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 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".

Prior Approval/Authorization No. (Field 13)

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.

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 submit a DVS transaction, please refer to the Medicaid Eligibility Verification System (MEVS) and Dispensing Validation System (DVS) Provider Manual available at www.emedny.org by clicking on the link:*** MEVS/DVS Provider Manual***.***
- ***For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules available at www.emedny.org by clicking on the link:*** List of OTC Categories and Supply Codes.

Procedure Section: Fields 15 to 24

Prescription/Order Number (Field 15)

Enter the pharmacy prescription/order number.

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.

Drug/Supply Code (Field 17)

For Prescription Drugs

Enter the National Drug Code (NDC) displayed on the package.

For OTC Drugs

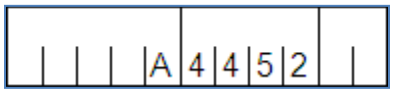
Enter the 11-digit NDC.

NOTE: Do not use the UPC 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. See exhibit 2.4.1-5 for an example of proper entry for supply items.

Exhibit 2.4.1-5



Procedure Codes and Fee Schedules are available at www.emedny.org by clicking on the link: Pharmacy Manual.

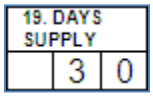
Quantity Dispensed (Field 18)

The quantity dispensed is the total number of Metric units dispensed for the prescription.

Days Supply (Field 19)

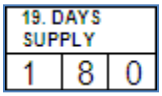
Enter the days' supply as written on the prescription/order. Exhibit 2.4.1-6 shows an example of a proper entry of a 30-day supply.

Exhibit 2.4.1-6



If the prescription/order directs the member "to take when necessary," enter ***180*** in this field as shown in Exhibit 2.4.1-7.

Exhibit 2.4.1-7



New /Refill Number (Field 20)

Original Prescription/Order

Enter 0 in this field.

Refill

Indicate the number of the 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.

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” on the order/prescription in their own handwriting, 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 appropriate price. 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.

Medicare Co-Insurance (Field 23)

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

NOTES:

- ***Fields 23, 23A, 23B, and 23C are only applicable if the member is also a Medicare beneficiary.***
- ***It is the responsibility of the provider to determine whether Medicare covers the service being billed. 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 Deductible (Field 23A)

When applicable, enter the Medicare deductible amount for this drug/supply. Otherwise, leave this field blank.

Medicare Co-Pay (Field 23B)

When applicable, enter the Medicare co-pay amount for this drug/supply. Otherwise, leave this field blank.

Medicare Paid (Field 23C)

When applicable, enter the amount paid by Medicare for the drug/supply. If Medicare denied payment, enter 0.00 in this field. Otherwise, leave this field blank.

Other Insurance Paid (Field 24)

This field must be completed if the member is covered by insurance other than Medicare.

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

Leave this field blank if the member 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 billed for. 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.

Pharmacy Claim Form-Certification Section: Fields 29 to 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 where 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 where the claim form is signed.

Date (Field 31)

Enter the date on which the provider or an authorized representative of the provider 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 Information for All Providers, General Billing section, which can be found at www.emedny.org by clicking on the link: General Billing.

For Compound Use Only (Field 35)

As of the D.0 mandate, compound drugs must be submitted by electronic claims only. Please refer to the Procedure Codes, which can be found at www.emedny.org by clicking on the link: List of OTC Categories and Supply Codes.

DIAGNOSIS CODE (Electronic Claims Only)

New York Medicaid policy requires the prescriber to provide a valid diagnosis code on all fiscal orders for durable medical equipments, prosthetics, orthotics, and supplies (DMEPOS).

A valid diagnosis code is a minimum requirement for all DMEPOS fiscal orders.

The diagnosis code must be submitted on all NCPDP pharmacy DMEPOS claims. The diagnosis code on the fiscal order must match the diagnosis code reported on the claim. Providers that bill using the 837 format should already be submitting the diagnosis code on all DMEPOS claims.

Exhibit 2.4.1-4 contains the NCPDP 5.1 fields utilized to report diagnosis code:

Exhibit 2.4.1-4

NCPDP FIELD	DESCRIPTION
Diagnosis Code Count (491-VE)	Count of diagnosis occurrences. 1-5 'Diagnosis Codes' may be sent.
Diagnosis Code Qualifier (492-WE)	Code qualifying the 'Diagnosis Code' sent. '01'= International Classification of Diseases (ICD-9).
Diagnosis Code (424-DO)	Code Identifying the diagnosis of the patient.

NOTE: Diagnosis Code can only be reported on NCPDP format.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals (by category, status and member ID) and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

APPENDIX A
CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

Pharmacy – Sample Claim
NYS MEDICAL ASSISTANCE (TITLE XIX)
PHARMACY CLAIM FORM

1. PROVIDER ID NUMBER: 1 2 3 4 5 6 7 8 9 0

2. DATE FILLED: MO 0 5 DAY 1 3 YR 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:

5. RECIPIENT ID NUMBER: A A 1 2 3 4 5 W
6. DATE OF BIRTH: 0 4 1 9 1 9 5 5
7. SEX: X 1 F 2
8. OTHER RECIPIENT INSURANCE CODE:
9. RECIPIENT NAME: LAST Brandon FIRST John

City Pharmacy
111 Park Avenue
Anytown, NY 11111

10. PROF CD:
10A. ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 1 2 3 4 5 6 7 8 9 0
10B. NAME: Peter Smith
11. PROF CD:
11A. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
11B. NAME:

PRIOR APPROVAL/AUTHORIZATION NO.:
12.
12A. LINE:
13.
13A.
FOR OFFICE USE ONLY 14 1

LINE	15. PRESCRIPTION/ ORDER NUMBER	16. DATE ORDERED MO DAY YR	17. DRUG SUPPLY CODE	18. QUANTITY DISPENSED	19. DAYS SUPPLY	20. NEW REFILL NUMBER	20A. NO OF REFILLS AUTHORIZED	21. BRAND NECESSARY	22. AMOUNT CHARGED	MEDICARE 23. COINSURANCE	23A. DEDUCTABLE	23B. CO-PAY	23C. PAID	24. OTHER INSURANCE 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 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 0	1 0	1	0	Y 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	Y 1 X	2 0 . 0 0					
4								Y 1 N						
5								Y 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 0 5 DAY 1 3 YR 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

[redacted]

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

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

INGREDIENTS	QUANTITY	PRICE
		$.
		.
		.

DOSAGE FORM AND DIRECTIONS

TOTAL INGREDIENT COST	.
COMPOUNDING FEE	.
DISPENSING FEE	.
AMOUNT CHARGED	$.

APPENDIX B
CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of SA Exception Codes.

SA Exception Codes

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