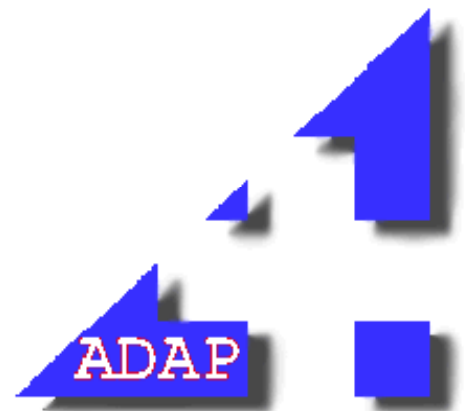


**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

**UNINSURED CARE PROGRAMS
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
PHARMACY PROVIDER MANUAL**

**Uninsured Care Programs
Empire Station
P.O. Box 2052
Albany, NY 12220-0052
1-800-832-5305**



PHARMACY PROVIDER MANUAL HIV UNINSURED CARE PROGRAMS AIDS DRUG ASSISTANCE PROGRAM (ADAP)

PURPOSE

The AIDS Drug Assistance Program (ADAP) - herein referred to as the program - provides reimbursement for medications (specific formulary) for New York State residents who meet program eligibility criteria. The program Formulary may change as new drugs are approved by the FDA and available resources allow. Any program change which decreases covered medications will be sent in writing to participants and providers. The most current ADAP Formulary can be found at the Department of Health Website:

http://www.nyhealth.gov/health_care/

BACKGROUND

The program is a partnership between New York State, and the HIV Planning Councils of the New York City, Long Island, Lower Hudson and Dutchess County regions. The enrollment and claims processing functions of this program are integrated with that of ADAP Plus and Home Care for improved coordination and efficiency.

FUTURE DIRECTIONS

The program's Clinical Advisory Workgroup is continually investigating current and new medications in an effort to provide access to medications useful to all participants, while using scarce resources to the fullest extent possible. Requests for formulary additions or changes should be addressed in writing to the program at:

**ADAP
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052**

POPULATION SERVED

ADAP serves HIV-infected New York State residents who are uninsured or under-insured and who meet established eligibility criteria. Applicants who have partial insurance or limitations on their insurance may be eligible. Applicants who are enrolled in Medicaid and approved with a Medicaid Spenddown or Surplus are also eligible when Medicaid is not active. Participants who are eligible to enroll in Medicare Part D and who do not have existing "creditable" prescription coverage will be required to enroll in Medicare Part D. Pharmacies providing service to participants will need to verify Medicare Part D plan enrollment and submit claims to the Medicare plan before submitting claims to ADAP. The program will coordinate benefits with Medicare Prescription Drug Plans (PDP). Applicants who meet program eligibility criteria receive a program eligibility card. If a participant is underinsured, the program may issue a Secondary Coverage eligibility card, background color light green with the phrase "Secondary Coverage" is listed next to the ADAP eligibility date. If a participant has no insurance or insurance that provides insufficient coverage the participant will be issued a standard eligibility card with a light blue background. Participants are required to present their ADAP card at a participating pharmacy along with a prescription to receive the approved medication(s).

PARTICIPANT ELIGIBILITY

- (1) Residency - New York State
- (2) Medical - HIV Infection (Chronic medical dependency due to HIV illness and physician's orders to be eligible for Home Care services)
- (3) Financial - Income for a household of one \$44,000 per year; \$59,200 for two; and \$74,400 for three or more; liquid assets less than \$25,000

PARTICIPANT ENROLLMENT PROCESS

- Applicants apply to the program, providing proof of residency, income, assets, and insurance, if applicable.
- A Medical Application completed by a physician is required, verifying HIV-infection and indicating medical/disease status.
- Upon determination of eligibility, an ADAP eligibility card is sent to the applicant that may be used to receive prescriptions from an enrolled pharmacy provider for covered medications. There is **NO co-payment** requirement for participants.

IDENTIFICATION OF PARTICIPANT ELIGIBILITY

ADAP assigns a unique identification number to every participant at the time of enrollment. Each participant is issued an ADAP eligibility card listing their unique 11 character identification number, and the date of eligibility. At the time they are approved for the program and whenever a new eligibility card is warranted due to changes in enrollment status, the identification number will change. Participants receive an eligibility card with a light blue background; **or** if they have other medication coverage, they'll receive an eligibility card with a light green background and "Secondary Coverage" next to the ADAP eligibility date. Participants enrolled in ADAP must present their most recent eligibility card whenever they have a prescription filled at an ADAP enrolled pharmacy. The unique identification number on the ADAP eligibility card is presented in this format: 555999999-Ø-A. To avoid transaction rejections, enter all digits when submitting claims, omitting the dashes: 555999999ØA. ADAP will verify that all online pharmacy transactions are submitted using the correct version of the participant's eligibility card. Pharmacies must submit all claims electronically, using NCPDP version 5.1 including the COB segment of the transaction if appropriate. Utilization of the Point of Sale system will verify the participant's eligibility and specific drug coverage as well as process and adjudicate claims.

MEDICARE PART D

Effective January 1, 2006 ADAP participants who are eligible for Medicare Part D must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). Participants with income or assets in excess of low-income subsidy assistance or "Extra Help" thresholds (income in excess of 150 percent of poverty Federal Level or assets in excess of \$6,000) may encounter a monthly premium. If a participant requires medication and presents an ADAP ID Card, you **must** also ask for a Medicare Prescription Drug Plan Card and first use their **Medicare Card. ADAP will be a secondary payer to Medicare part D plans except in cases when the participant has a Medicaid Spenddown and is not Medicaid active (See below, Medicare Part D and Medicaid Spenddown).**

Pharmacy procedures and coordination of benefits between Medicare Part D and ADAP will be updated regularly. Please contact the program at 1-800-832-5305 for updated information or look for mailings sent with processed claim remittance statements.

MEDICAID

Since Medicaid covers the cost of prescription drugs, individuals enrolled in Medicaid are not eligible for this program. Individuals awaiting Medicaid eligibility determination, or who have Medicaid Spenddown requirements **are** eligible. ADAP assistance may be provided on a short-term basis to persons eligible for, or pending Medicaid approval. Once other assistance becomes available, the client will no longer receive ADAP coverage for prescription drugs. ADAP reserves the right to deny any claims for individuals who have active Medicaid eligibility covering prescription drugs. The program will interface with Medicaid to prevent duplication of enrollment and billing. The program will seek to identify individuals who are potentially eligible for Medicaid at eligibility determination and at periodic intervals; and encourage them to apply to Medicaid. Providers are also required to identify and encourage potentially eligible participants to enroll in Medicaid.

MEDICAID SPENDDOWN ELIGIBILITY VERIFICATION

ADAP has received a directive from the New York State Department of Social Services that requires the program to assist individuals who are in a Medicaid Spenddown situation, in meeting their spenddown amounts (91-ADM-11 NYS DSS). In order to respond to this directive and to expedite the process, the following procedures have been established;

ADAP participants who have an income Spenddown will receive an ADAP identification card that has an "**M**" as the last character of the ADAP ID# and the words "**MEDICAID SPENDDOWN**" printed on the card.

If a participant requires medication and presents an ADAP ID card identified as Medicaid Spenddown, you **must** first try to use their **Medicaid card or Medicaid Identification #** to determine that they are in fact **not** eligible under Medicaid to receive the medication.

If they are not eligible for Medicaid, ADAP can be used to provide the medication and seek reimbursement as usual from ADAP. You **must** verify eligibility through the ADAP Point of Sale system. **IN THIS INSTANCE ONLY**, you will issue a standard receipt or statement of expenditures incurred to the participant in the amount of the ADAP billing. The participant is responsible for bringing the receipt to their local Medicaid office to have that amount applied to their Spenddown requirements. If the system denies the prescription, **and** the participants Medicaid is not active, call the program at 1-800-832-5305.

The first time a Medicaid Spenddown ADAP participant uses this process they must provide you with a copy of the letter issued to them by this office describing their Spenddown amounts and the process for meeting them. If they cannot provide a copy of this letter, please contact ADAP eligibility staff at 1-800-542-2437 for clarification and approval if necessary or appropriate.

MEDICARE PART D AND MEDICAID SPENDDOWN

One of the goals of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 is to provide access to comprehensive health care for people living with HIV and AIDS. In order to accomplish this goal for individuals who are Medicare active and have a Medicaid Spenddown,

ADAP will institute a Medicaid Spenddown verification letter. The letter will be sent to participants who need to meet their Medicaid Spenddown. The letter will state the amount of the Medicaid Spenddown to be met. Billing ADAP as Primary Payer in these instances will

allow ADAP to meet the participant's Medicaid Spenddown to ensure comprehensive health care coverage.

ADAP will only pay for the medication or medications required to meet the amount of the Medicaid Spenddown. Claims submitted for medications exceeding the Medicaid Spenddown will be denied with the denial code 41 stating Bill Primary Payer.

Example – John Jones, an ADAP participant with Medicare Part D coverage and a Medicaid Spenddown arrives at the pharmacy with his Medicaid Spenddown verification letter stating his Spenddown is \$240. Mr. Jones needs to fill prescriptions for pain medication and heart medication. Either prescription refill exceeds the \$240 dollar Spenddown, therefore after the first medication is submitted and approved for payment by ADAP, the second medication will need to be billed through the participant's Medicare Part D Plan.

PROVIDER ELIGIBILITY & ENROLLMENT

All licensed New York State pharmacies are eligible to enroll as ADAP providers if actively enrolled in New York State Medicaid, the New York State Elderly Pharmaceutical Insurance Coverage (EPIC) Program, enrolled with one or more Medicare Prescription Drug Plans, and able to submit claims electronically. ADAP will utilize the Pharmacies' EPIC enrollment status and NABP (National Association of Board Pharmacies) identification number or NPI (National Provider Identification) number to verify pharmacy eligibility. Pharmacies must recertify with EPIC periodically to maintain payment eligibility. Pharmacy providers who do not maintain active EPIC, New York State Medicaid, and one or more Medicare Prescription Drug Plan enrollment will be terminated as an ADAP provider.

Pharmacies outside New York State **must** be enrolled with NYS Medicaid, maintain a valid pharmacy license in their appropriate state, and be able to submit claims electronically, utilizing both current NCPDP standards and a NABP identification number or NPI number. Pharmacies outside of New York State must request to participate as an enrolled provider with ADAP in writing; complete a pharmacy enrollment form; and provide documentation of NYS Medicaid enrollment, Medicare Prescription Drug Plan participation, and current pharmacy license.

Pharmacies must complete an enrollment form from the HIV Uninsured Care Programs (ADAP) as part of the enrollment process, and must be actively enrolled as a provider with EPIC before enrolling with ADAP. Pharmacies will be allowed to submit claims to ADAP for up to 90 days while their application to enroll with Medicaid is being processed. The pharmacy must inform the Uninsured Care Programs in writing of any changes to their pharmacy information.

ADAP DISPENSING AND BILLING PROCEDURES

REIMBURSEMENT

ADAP will adhere to the Medicaid reimbursement methodology for all medications covered by the Program. In the case of generics versus brand name medications where an Orange book rated equivalent is available; no dispense as written override is available unless the medication is specifically precluded from a mandatory generic category by NYS Medicaid. ADAP also limits prescription refills to five.

If the drug dispensed is a Federal source prescription drug or a brand-name prescription drug for which no specific Federal upper limit has been set, payment will be made based on the package size dispensed as reported by the prescription drug pricing service used by the Program, less 16.25 percent. The program's prescription drug pricing service is currently "Medispan." Drug prices are updated weekly. ADAP will not make retroactive adjusting payments for drug price changes occurring during the week.

Pharmacies eligible to purchase drugs under the Public Health Service (PHS) Section 340b discount program are required to enter their acquisition cost in the ingredient cost field. Acquisition cost will be the reimbursable amount provided it is lower than either the Federal upper limits price or AWP less 16.25 percent effective July 22, 2008 for brand name medications and AWP less 25.0 percent for generics. Pharmacies designated as a HIV specialty pharmacy by NYS Medicaid will be paid at AWP less 12.0 percent for brand and generic medications.

If the drug dispensed is a multiple source prescription drug for which a specific Federal upper limit has been established, the program will make payment based on the Federal upper limit.

Dispensing Fees

Generic - Multiple source	\$4.50
Brand products	\$3.50

Generally, reimbursement will be made to pharmacies within 21 days of electronic claim submission.

If you have questions regarding our Point of Sale system, please call Ray Martin. If you have questions regarding program policy, please call Ann Burnett or Christine Rivera.

CLAIM SUBMISSION

Providers must be certified to submit claims electronically to the EPIC Program in order to receive ADAP certification. Please contact your claim submission software vendor when you first enroll in ADAP. The software vendor will require the following information:

ANSI BIN Number: 610490 / State: New York / ADAP Destination: Albany, N.Y.

Participating pharmacies are required to submit ADAP claims on-line using industry standard Point of Sale procedures. ADAP will accept claims in NCPDP V5.1 format. Up to four claims may be submitted within a single transaction. The ADAP system is available seven days a week between the hours of 7:00 am and 10:00 pm. All Point of Sale transactions for ADAP are routed through both of the following commercial switching companies: Relay Health and Emedeon.

Claims must be submitted within fourteen days of dispensing medication. Claims may be reversed up to the time that they are processed for payment, within 1 to a maximum of 7 days. Late claims and reversals may be submitted manually on universal claim forms within 90 days of service. Late claims and reversals submitted manually **must** be accompanied by a letter of explanation detailing why the claim could not be submitted timely and/or electronically.

Prescriptions should be filled for a one month supply. Partial prescription claim submission, in the event the pharmacy does not have adequate supply on hand, are supported under

NCPDP v5.1. Current program limitations preclude prescriptions for longer than a 30 day period unless a prior approval is processed. In cases where serious hardships would result for the participant, please contact ADAP at **1-800-832-5305**.

MANUAL CLAIMS

On rare occasions, ADAP will direct the pharmacy to submit a manual claim. No other manual claims will be accepted unless the date of service is greater than 14 days, but less than 90 days, and a letter explaining why the claim was not submitted through the Point of Sale system is provided to the program. Manual claims submitted in excess of 90 days will be denied. Bulk submissions of manual claims will not be processed.

In order to ensure timely reimbursement, submit claims promptly. All claims made under this program shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the date of service. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

All reimbursement is issued by Health Research, Incorporated (HRI), and accompanied by a remittance statement detailing all payments and denials. When inquiring about a claim submission or payment amount please have the **authorization number** or **batch number** and the detailed explanation of payment available for discussion.

Submit all claims to:

**ADAP
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052**

Questions regarding claim submission or dispensing of ADAP medications may be referred to ADAP's toll-free Hotline at **1-800-832-5305**. If you are calling from out of New York State please call 1-518-459-1641.

CLAIM DENIALS

ADAP utilizes both prospective and retrospective utilization review interventions. Prospective reviews may cause claim denials. Each time a claim is submitted, a series of systemic edits are performed:

- Verification of NDC to determine if the medication is covered;
- Determination of prescription refill period - refills will be denied unless a minimum of 75 percent of the last days supply period has occurred;
- Quantity verification to insure monthly maximum is not exceeded;
- Number of days supply the program standard limit is 30 days;
- Maximum Anti-Retroviral/Protease Inhibitor Combination;
- Client eligibility verification including Date of Birth and complete 11 character identification number;
- Some medications require prior approval, a claim will be denied if the claim is submitted without first receiving prior approval;
- Provider eligibility verification including EPIC enrollment; and
- Other Primary Drug Coverage.

When a claim is denied please verify the denial code to determine if a data entry error has occurred.

Retrospective Utilization reviews include, but are not limited to:

- Excessive submission of early refills
- Acquisition cost review for PHS entities – ADAP periodically conducts reviews of medications billed to the program. This analysis compares the price billed to current PHS prices. Recoveries will be made based on the price difference between billed amount and acquisition cost. PHS price recoveries will either be direct payment to the program or withheld from future payments to the pharmacy until such time as all over-payments are recovered.
- Out of state shipping - Participants **must** reside in New York State. On occasion, participants may visit or work in locations out of New York State for extended periods of time. Prescriptions may not be shipped to non-New York state addresses for multiple months unless the program has approved either an extended supply or made provisions on behalf of the participant.

PROBLEMS, COMPLAINTS, AND BILLING ISSUES

If you have a problem with payment or other administrative aspects of the program, please contact the Director of Operations or Fiscal Services at **1-800-832-5305**, or write to the program at Empire Station P.O. Box 2052, Albany, N.Y. 12220.

CONFIDENTIALITY

ADAP requires that all pharmacy staff observe the highest standards of confidentiality in providing services. The Health Care Portability and Accountability Act (HIPAA) defines personal identifiers and requires a detailed notice of privacy practices be given to patients no later than April 14, 2003 and at least once every three years thereafter. HIPAA also holds the provider accountable for non-specifically authorized disclosures. State Education Law as it relates to professional licensing specifically prohibits revealing personally identifiable facts, data or other information obtained in a professional capacity without the prior consent of the patient or client, except as authorized by law.

It is essential that you, as a provider for ADAP, are sensitive to the need of ADAP participants to have their prescriptions filled with complete confidentiality.

UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW

Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of medications and supplies provided to ADAP participants. Pharmacy providers must furnish information regarding any payment claimed to authorized officials upon request of the State Department of Health.

For audit purposes, records on participants must be maintained and be available to authorized ADAP officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as an ADAP provider.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York or Federal statute or regulation which relates to the provision of medication and or the fiscal integrity of the program. Examples of unacceptable practices include, but are not limited to the following:

- Knowingly making a claim for an improper amount or for unfurnished, unnecessary medications or supplies;
- Practicing a profession fraudulently beyond its authorized scope, including the provision of medications or supplies while one's license to practice is suspended or revoked;
- Failing to maintain records necessary to fully disclose the extent of the medications or supplies furnished;
- Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing an ADAP participant to either utilize or refrain from utilizing any particular source of medication or supplies; and
- Knowingly demanding or collecting any compensation in addition to claims made under ADAP.

Audit and Claim Review

- (a) Providers shall be subject to audit by the Department of Health or its designee's. With respect to such audits, the provider may be required:
 1. To reimburse the department for overpayments discovered by audits; and
 2. To pay restitution for any direct or indirect monetary damage to the program resulting from their improperly or inappropriately furnishing covered services.
- (b) The Department of Health may conduct audits and claim reviews, and investigate potential fraud or abuse in a provider's conduct. The Department of Health may pay or deny claims; or delay claims for audit review.
- (c) When audit findings indicate that a provider has provided covered services in a manner which may be inconsistent with regulations governing the program, or with established standards for quality, or in an otherwise unauthorized manner, the Department of Health may summarily suspend a provider's participation in the program and/or payment of all claims submitted and all future claims may be delayed or suspended. When claims are delayed or suspended, a notice of withholding payment or recoupment shall be sent to the provider by the department. This notice shall inform the provider that within 30 days he/she may request in writing an administrative review of the audit determination before a designee of the Department of Health. The review must occur and a decision rendered within a reasonable time after a request for recoupment is warranted, or if no request for review is made by the provider within the 30 days provided, the department shall continue to recoup or withhold funds pursuant to the audit determination.
- (d) Where investigation indicates evidence of abuse by a provider, the provider may be fined, suspended, restricted or terminated from the program.

Audits and Recovery of Overpayments

- (a) Recovery of overpayments shall be made only upon a determination by the Department of Health that such overpayments have been made, and recovery shall be made of all money paid to the provider to which it has no lawful right or entitlement.
- (b) Recovery of overpayments pursuant to this subject shall not preclude the Department of Health or any other authorized governmental body or agency from taking any other action with respect to the provider, including auditing or reviewing other payments, or claims for payment for the same or similar periods, imposing program sanctions, or taking any other action authorized by law.
- (c) The Department of Health may utilize any lawful means to recover overpayments, including civil lawsuit, participation in a proceeding in bankruptcy, common law settlement, or such other actions or proceedings authorized or recognized by law.
- (d) All fiscal and statistical records and reports of providers and all covered services which are used for the purpose of establishing the provider's right to payment under the program and any underlying books, records, documentation which formed the basis for such fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation including all covered services provided shall be kept and maintained by the provider for a period of not less than six years from the date of completion of such reports, or the date upon which the fiscal and statistical records were required to be filed, whichever is later, or the date the service was provided.
- (e) All claims made under the program shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the date of service. Time frame limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

Fraud

Examples of fraud include when a person knowingly:

- Makes a false statement or representation which enables any person to obtain medical services to which he/she is not entitled;
- Presents for payment any false claim for furnishing services or merchandise;
- Submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Termination - Disenrollment

Either ADAP or the pharmacy may terminate a pharmacy enrollment with 30 days written notice. ADAP reserves the right to terminate or suspend pharmacies with less than 30 days written notice for any of the following practices.

- Violation of participant confidentiality
- Unacceptable practices
- Fraud
- Failure to comply with audit requirements
- Failure to maintain EPIC and New York State Medicaid enrollment

NYS Uninsured Care Programs ADAP Specifications for NCPDP 5.1 Transactions

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	ADAP ID number from card – see notes

Claim Segment: Mandatory

Note: Partial fill transactions are supported, compound transactions are not supported.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx number
436-E1	Product/Service ID Qualifier	Ø3 = NDC	M	
4Ø7-D7	Product/Service ID		M	11-Digit NDC
403-D3	Fill Number		R	
405-D5	Days Supply		R	
408-D8	Dispense As Written		R	
414-DE	Date Prescription Written		R	
415-DF	Number Of Refills Authorized		R	
442-E7	Quantity Dispensed		R	
454-EK	Scheduled Prescription ID Number	Required when available. Use the same coding as NYS Medicaid when not available ZZZZZZZZ = out of State EEEEEEEE = electronic 99999999 = oral HHHHHHHH = hospital	R	The prescription pad serial number from the official New York State prescription form is required as of 2/1/2007.
308-C8	Other Coverage Code	0 = Not specified 1 = No other coverage 2 = Other coverage exists – payment collected* 3 = Other coverage exists – claim not covered* 4 = Other coverage exists – payment not collected* 5 = Managed care plan denial* 6 = Other coverage denied – not participating provider* 7 = Other coverage exists – not in effect on date of service* 8 = Claim is billing for copay * * COB segment required	RW	Required for all copay/coinsurance transactions

343-HD	Dispensing Status	P = Partial fill C = Completed partial fill	RW	Required for all partial fill transactions
456-EN	Associated Prescription/Service Reference #		RW	Required for partial fill completion
457-EP	Associated Prescription/Service Reference Date		RW	Required for partial fill completion
344-HF	Quantity Intended To Be Dispensed		RW	Required for all partial fill transactions
335-HG	Days Supply Intended To Be Dispensed		RW	Required for all partial fill transactions

Prescriber Segment: Required for ADAP

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	12 = DEA #	R	
411-DB	Prescriber ID		R	DEA #

COB/Other Payments Segment: Required for copay/coinsurance transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	
338-5C	Other Payer Coverage Type		M (Repeating)	
339-6C	Other Payer ID Qualifier		O (Repeating)	
340-7C	Other Payer ID		O (Repeating)	
443-E8	Other Payer Date		O (Repeating)	
341-HB	Other Payer Amount Paid Count		RW	Required when other coverage code indicates that payment was collected.
342-HC	Other Payer Amount Paid Qualifier		O (Repeating)	
431-DV	Other Payer Amount Paid		RW (Repeating)	Required when other coverage code indicates that payment was collected.
471-5E	Other Payer Reject Count		RW	Required when other coverage code indicates that claim was denied.
472-6E	Other Payer Reject Code		RW (Repeating)	Required when other coverage code indicates that a claim was denied.

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted		R	
412-DC	Dispensing Fee Submitted		R	
426-DQ	Usual And Customary		O	
433-DX	Patient Paid Amount Submitted		O	
430-DU	Gross Amount Due		R	New requirement as of 11/01/2005.
478-H7	Other Amount Claimed Submitted Counter		RW	See note on copay only
479-H8	Other Amount Claimed Submitted Qualifier		RW (Repeating)	Required for copay only
480-H9	Other Amount Claimed Submitted		RW (Repeating)	Required for copay only

ELIGIBILITY VERIFICATION REQUEST:

****SEGMENTS****

Transaction Header Segment: Mandatory for All Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø49Ø	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø4-A4	Processor Control Number	ADAPØ1	M	
1Ø9-A9	Transaction Count	Ø1	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	Blank fill	M	Not used

Patient Segment: Required for ADAP

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	M	Patient Segment
304-C4	Date of Birth		R	

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	ADAP ID number from card – see notes

REVERSAL TRANSACTION REQUEST:

****SEGMENTS****

Transaction Header Segment: Mandatory for All Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø49Ø	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number	ADAPØ1	M	
1Ø9-A9	Transaction Count	Ø1 = One occurrence Ø2 = Two occurrences Ø3 = Three occurrences Ø4 = Four occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	Blank fill	M	Not used

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx number
436-E1	Product/Service ID Qualifier	Ø3 = NDC	M	
4Ø7-D7	Product/Service ID		M	11-Digit NDC

REBILL TRANSACTION REQUEST:

****SEGMENTS****

Note: Rebill Transaction Requests are identical to Claim Transaction Requests. The only difference is in field 1Ø3-A3 (Transaction Type).

ADAP RESPONSE SEGMENTS

Transmission Rejected Response

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	
103-A3	Transaction Code	Same value as in request billing	M	
109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	R	M	
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R	M	
501-FA	Reject Count		R	
511-FB	Reject Code		R	
526-FQ	Response Message		R	
549-7F	Help Desk # Qualifier	03 = Processor/PBM	R	ADAP help desk
550-8F	Help Desk Number		R	

Billing Accepted Response – Transaction PAID or Duplicate of Paid

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	
103-A3	Transaction Code	Same value as in request billing	M	
109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	A	M	
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	P = Paid D = Duplicate of Paid	M	
503-F3	Authorization Number		R	ADAP Transaction racking

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx Number

Response Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	23	M	Response Pricing Segment
5Ø5-F5	Patient Pay Amount		R	
5Ø6-F6	Ingredient Cost Paid		R	
5Ø7-F7	Dispensing Fee Paid		R	
563-J2	Other Amount Paid Count	1	RW	Used for Copay Only Billing Response
564-J3	Other Amount Paid Qualifier	99	RW	Used for Copay Only Billing Response
565-J4	Other Amount Paid		RW	Used for Copay Only Billing
566-J5	Other Payer Amount Recognized		RW	Used for COB transactions when ADAP is secondary
5Ø9-F9	Total Amount Paid		R	
522-FM	Basis of Reimbursement Determination		R	
346-HH	Basis of Calculation – Dispensing Fee	Ø2 = Quantity Intended Ø4 = Waived Due to Partial	RW	Used for partial fill
347-HJ	Basis of Calculation – Copay	Ø2 = Quantity Intended Ø4 = Waived Due to Partial	RW	Used for partial fill

Response DUR/PPS Segment: Situational

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	24	M	Response DUR/PPS Segment
567-J6	DUR/PPS Response Counter Code		RW (repeating)	
439-E4	Reason for service code		RW (repeating)	
528-FS	Clinical Significance Code		RW (repeating)	
529-FT	Other Pharmacy Indicator		RW (repeating)	
530-FU	Previous Date of Fill		RW (repeating)	
531-FV	Quantity of Previous Fill		RW (repeating)	
532-FW	Database Indicator		RW (repeating)	
533-FX	Other Prescriber Indicator		RW (repeating)	
544-FY	DUR free text message		RW (repeating)	

Billing Accepted Response – Transaction Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	Same value as in request billing	M	
1Ø3-A3	Transaction Code	Same value as in request billing	M	
1Ø9-A9	Transaction Count	Same value as in request billing	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request billing	M	
2Ø1-B1	Service Provider ID	Same value as in request billing	M	
4Ø1-D1	Date of Service	Same value as in request billing	M	

Message Segment: Situational - Used when additional information is needed

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	20	M	Message Segment
504-F4	Message		RW	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
5Ø3-F3	Authorization Number		R	ADAP Transaction Tracking #
5Ø1-FA	Reject Count		R	
511-FB	Reject Code		R	
526-FQ	Response Message		R	
549-7F	Help Desk # Qualifier	Ø3 = Processor/PBM	R	ADAP help desk
55Ø-8F	Help Desk Number		R	

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx Number

Response DUR/PPS Segment: Situational

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	24	M	Response DUR/PPS Segment
567-J6	DUR/PPS Response Counter Code		RW (repeating)	
439-E4	Reason for service code		RW (repeating)	
532-FW	Database Indicator		RW (repeating)	
544-FY	DUR free text message		RW (repeating)	

Eligibility Verification Response – Accepted

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø9-A9	Transaction Count	1	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	A = Approved	M	
5Ø3-F3	Authorization Number		R	ADAP Transaction Tracking #

Eligibility Verification Response – Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø9-A9	Transaction Count	1	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7= NCPDP Provider ID #	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
5Ø3-F3	Authorization Number		R	ADAP Transaction Tracking #
5Ø1-FA	Reject Count		R	
511-FB	Reject Code		R	
526-FQ	Response Message		R	
549-7F	Help Desk # Qualifier	Ø3 = Processor/PBM	R	ADAP help desk
55Ø-8F	Help Desk Number		R	

**Reversal Response Accepted –
Transaction Approved or Duplicate of Approved**

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	A = Approved S = Duplicate of Approved	M	
5Ø3-F3	Authorization Number		R	

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx Number

Reversal Response Accepted - Transaction Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7= NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		R	
501-FA	Reject Count		R	
511-FB	Reject Code		R	
526-FQ	Response Message		R	
549-7F	Help Desk # Qualifier	03 = Processor/PBM	R	ADAP help desk
550-8F	Help Desk Number		R	

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	01 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	Rx Number

REBILL TRANSACTION RESPONSE

****SEGMENTS****

Note: Rebill Transaction Responses are identical to Billing Transaction Responses. The only difference is in field 103-A3 (Transaction Type). Additionally, there is no duplicate status for rebill transactions.

Notes on ADAP 5.1

ADAP accepts NCPDP 5.1 transactions:

B1 – Billing

Compound prescription types are not supported

Partial fill transactions are supported

B2 – Reversal

E1 – Eligibility Verification

B3 – Rebill

ADAP accepts claims for processing between the hours of 7:00 AM and 10:00 PM seven days a week. Billing transactions must be submitted within 14 days of the date of service. Claims may be reversed up until the time that they are processed for payment. Claims are processed for payment on a weekly basis.

ADAP Cardholder ID: The cardholder ID (3Ø2-C2) is an 11-digit field. On the card, it has the format: 999999999-Ø-A. When this field is sent, omit the dashes and use the format: 999999999ØA. ADAP will verify that all online pharmacy transactions are submitted using the correct version of the participant's eligibility card.

Pharmacy providers must be registered with ADAP prior to submitting claims electronically. There is no formal testing process for 5.1; however, providers may call and request ADAP to monitor the initial transmission of 5.1 transactions.

Copay Only Billing: For copay only billings, the value of Other Coverage Code (308-C8) must be "8". No COB segment is required. The pricing segment should contain Other Amount Claimed Submitted Count (478-H7) with a value of "1", along with Other Amount Claimed Submitted Qualifier (479-H8) with a value of "99", and Other Amount Claimed Submitted (480-H9) with the amount of the copay. In this situation, Ingredient Cost Submitted (409-D9) and Dispensing Fee Submitted (412-DC) should be 0 and Gross Amount Due (430-DU) should reflect the amount for the copay only.

Medicare Part D – TrOOP and COB: ADAP will be participating in coordination of benefits (COB) with Medicare Part D programs. ADAP must be billed as a secondary payer for individuals who have active Part D coverage. This means that Other Coverage Code (308-C8) must contain a value between 2 and 8. Claims that do not indicate that ADAP is being billed after the primary (based on the value of 308-C8) will be denied with a code of 41 ('Submit bill to other processor or primary payer'). ADAP has established a Processor Control Number (PCN) that is to be used for all claim transactions where the participant has active Part D coverage. In these cases, the PCN must be "TROOPUCP". Using the incorrect PCN will result in a claim denial with the error code M1 ('Patient not covered in this aid category'). It is necessary to use the correct PCN so that TrOOP can be calculated accurately in real time. The PCN "ADAP01" should continue to be used for all other cases. A COB segment is required when ADAP is billed as a secondary payer (with the exception of copay only transactions).

Recent Changes

01/04/2007

- 454–EX Scheduled Prescription ID Number is now required as of 2/1/2007 to be consistent with NYS Medicaid policy.
- DUR/PPS Response Segment specifications added in advance of possible use.

05/10/2007

- Service Provider ID Qualifier (202-B2) may now have the values of 01 (NPI) or 07 (NABP). ADAP will accept either NPI or NABP in Service Provider ID (201-B1) . ADAP will continue to accept NABP number as long as NYS EPIC accepts NABP.
- ADAP will continue to use DEA number as Prescriber ID (411-DB). NPI number will be accepted in this field when a verification source becomes available for prescriber NPI numbers.

08/04/2008

- Both NPI and DEA may now be used for Prescriber ID (411-DB). Prescriber ID Qualifier (466-EZ) must be one of these two values: 01=NPI, 12=DEA. Pharmacies are currently encouraged to use NPI. ADAP will notify providers a minimum of 60 days prior to mandatory NPI.

Questions Should Be Directed to:

**NYS Uninsured Care Programs
P.O. Box 2052
Empire Station
Albany, NY 12220**

**Inside New York State - (800) 832-5305
Outside New York State – (518) 459-1641
adap@health.state.ny.us**

HIV Uninsured Care Programs

Troubleshooting Guide to Online Claims Processing

Common Error Codes and Corrective Actions

Code: M2 Recipient Locked In

Explanation: The participant is restricted to a single pharmacy and the claim is not from that pharmacy.

Correction: Call ADAP to confirm restriction. Instruct the participant go to assigned pharmacy. In certain situations, ADAP may change or remove the restriction.

Code: M4 Prescription Number/Time Limit Exceeded

Explanation: ADAP will pay for a total of five concurrent antiretroviral medications with no more than two of these being protease inhibitors.

Correction: This error can occur when claims are received for more than five concurrent antiretroviral medications. In some cases, there has been a regimen change and the pharmacist will need to verify the patient's *current* regimen. Once the regimen has been confirmed, pharmacists can call 800-732-9503 and an ADAP pharmacy representative will make the corrections in the ADAP concurrent treatment system allowing the new claim to go through. Low dose Norvir and Kaletra as part of an ARV regimen can be overridden by an ADAP pharmacy representative if it puts the regimen over the limit. In other cases, a physician has deemed that more than five full dose antiretrovirals are required. The prescribing physician must sign an Exception to ADAP Antiretroviral Combination Limit form. Once this form is received by ADAP, an entry will be made in the ADAP concurrent treatment system that will allow more than five antiretroviral drugs for a given period.

Code: 07 Invalid/Missing Cardholder ID Number

Explanation: This code is generated when the incorrect cardholder ID number is entered.

Correction: Ask the participant for their most recent ADAP eligibility card. Be sure to omit the dashes and use the format: 99999999ØA.

Code: 09 Invalid/Missing Date of Birth

Explanation: This code is generated when the date of birth field is missing or does not match the date of birth on file with ADAP.

Correction: Ask the participant for their date of birth. If this does not match the participant must contact ADAP.

Code: 17 Invalid/Missing Refill Date

Explanation: The first fill of a new prescription must be entered as refill 0.

Correction: Enter "0" as the refill number

Code: 19 Missing/Invalid Days Supply

Explanation: This code is generated when the days supply field (NCPDP # 405) is blank or is greater than 40 days (100 days in the case of vitamins or supplements).

Correction: Adjust the days supply to fit within ADAP limits where applicable, otherwise, an extended supply approval is required. A 90 day extended supply can be approved without written justification. Requests for an extended supply beyond 90 days or for a subsequent extended supply require a written justification.

Code: 25 Missing/Invalid Prescriber ID

Explanation: All claims require a valid DEA number in the prescriber ID field (NCPDP # 411). DEA numbers have a total of nine characters. The first two characters are alphanumeric and the remaining seven are numeric.

Correction: Enter a valid DEA number. If the prescribing physician's DEA number is not available, the pharmacy DEA number can be used.

Code: 28 Missing/Invalid Date Prescription Written

Explanation: The first fill of a new prescription must occur within 60 days from the date on the prescription.

Correction: Verify that the correct date has been entered. If the prescription date is past the 60 day allowable window, contact the doctor's office for a new prescription.

Code: 41 Submit Bill to Other Processor or Primary Payer

Explanation: This code is generated when an individual has Medicaid spenddown. ADAP will pay claims for individuals on spenddown. After the spenddown amount has been met and a seven day grace period has passed, claims will be denied with code 41.

Correction: Bill Medicaid

Code: 65 Patient Is Not Covered

Explanation: Individual is not covered by ADAP on the date of service.

Correction: Call ADAP to verify eligibility.

Note: Many individuals are terminated from ADAP once they become eligible for Medicaid. Verify Medicaid eligibility and bill Medicaid if approved.

Code: 70 NDC Not Covered

Explanation: **This error code does not indicate that a drug is not covered by ADAP.** NDC codes are specific to a medication manufacturer, dosage, and package size. A code 70 is generated when an active price for a NDC is not located in the ADAP system. This code is often generated in conjunction with a code 54 (Non-Matched NDC Number).

Correction: Call ADAP to verify that the drug is not covered.

Code: 75 Prior Authorization Required

Explanation: A number of medications covered by ADAP require prior approval before dispensing. Medications requiring prior approval are indicated on the ADAP Formulary. A current Formulary can be found the Department of Health website: http://www.nyhealth.gov/health_care/

Correction: Prescribing physician must sign a Prior Authorization Request form or use the automated prior authorization line for some drugs. Currently prior authorizations for Mepron (atovaquone), Fuzeon (enfuvirtide), and Aptivus (tipravavir) can be obtained by calling 800-832-5305. For other prior authorizations a prior authorization form must be requested. When this form is received by ADAP, an entry will be made in the prior approval system that will approve the medication for a given time period.

Code: 76 Plan Limitations Exceeded

Explanation: The quantity of all medications and devices is limited to a maximum supply for a 30 day period. This limit is prorated based on the days supply field (NCPDP # 405). The quantity of the drug or device dispensed divided by the days supply cannot exceed the maximum daily limit.

Correction: The days supply field may be adjusted to fall within ADAP limits. However, a physician may deem that it is clinically necessary to exceed ADAP limits. In this case, the physician must sign a Medication Limit Override form. Once this form is received by ADAP, an entry will be made in the drug limit override system that will allow a new limit for a designated participant for a specified time period.

Code: 79 Early Refill

Explanation: A prescription cannot be refilled until 75 percent of the supply has been used.

Correction: A reasonable justification for an early refill is required. This may include a dispensing error, lost or damaged prescription, or a patient use error. An entry will be made in the ADAP early refill system that will allow a refill for a designated participant for the specified NDC on a given day.

Code: 88 DUR Reject Error

Explanation: Needles/syringes require a prior approved claim for an injectable medication within one day prior to the claim. Antiretroviral combinations deemed to be sub-optimal or contra-indicated will generate a DUR error.

Correction: If dispensing an injectable medication and syringe at the same time, submit the medication first. If no injectable medication is being dispensed, a needle/drug proximity override is required. If a needle/drug proximity override is required, call ADAP. In the case of a sub-optimal ARV DUR error, please contact the ADAP pharmacy hotline at 1-800-832-5305.

Questions regarding claim rejections should be directed to:
From Within New York State: **(800) 542-2437**
From Outside New York State: **(518) 459-1641**