

STATE OF NEW YORK  
DEPARTMENT OF HEALTH



# **eMedNY**

## **MEVS Provider Manual**

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## 1.0 **INTRODUCTION TO THE NEW YORK STATE MEDICAID ELIGIBILITY VERIFICATION SYSTEM** (Rev. 11/02)

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

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

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

Information available through MEVS will provide you with:

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

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

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

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

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

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

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

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## 2.0 **BENEFIT IDENTIFICATION CARDS/FORMS** (Rev. 11/02)

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

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

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

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

### **Temporary Medicaid Authorization Form**

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

Providers should always make a copy of the TMA form for their records. Since an eligibility record is not sent to the eMedNY contractor until the CBIC Card is generated, the MEVS system will not have eligibility data for a recipient in TMA status. Note that any claim submitted for payment may pend waiting for the eligibility to be updated. If the final adjudication of the claim results in a denial for recipient eligibility, please contact the New York State Department of Health, Office of Medicaid Management, Local District Support. The phone number for inquiries on TMA issues for recipients residing Upstate is (518)-474-8216. For New York City recipient TMA issues, the number is (212) 268-6855.

2.1 **Permanent Common Benefit Identification Photo Card** (Rev. 11/02)

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



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

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

2.2 **Permanent Common Benefit Identification Non-Photo Card** (Rev. 11/02)

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



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

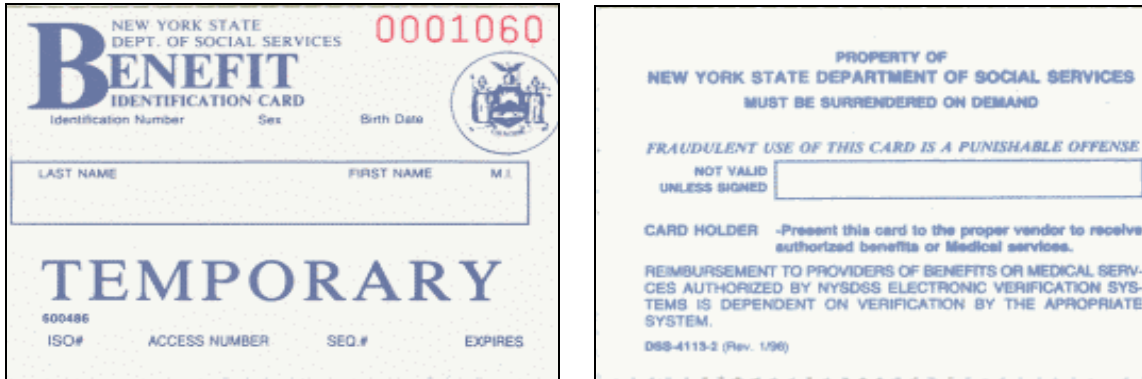


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<b>COMMON BENEFIT IDENTIFICATION NON-PHOTO CARD DESCRIPTION</b>	
Sequence Number	Two-digits at the end of the access number. This is used in the entry process of access number and client number (CIN) verifications.
Magnetic Stripe	Stripe with encoded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

2.3 **Replacement Common Benefit Identification Card** (Rev. 11/02)

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



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

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

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

**3.0 INTRODUCTION TO TELEPHONE (Audio Response Unit) VERIFICATION** (Rev. 11/02)

Verification requests for recipient eligibility may be entered into the MEVS system through a touch-tone telephone. This access method is suggested for providers with very low transaction volume (under 20 transactions per month). For convenience, providers with higher volumes should use the VeriFone Terminal ([see page 4.0.1](#)).

**Access to the Telephone Verification System**

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

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

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

**3.1 Telephone Equipment Specifications** (Rev. 11/02)

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

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

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

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

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

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

### 3.2 Telephone Verification Using the Access Number or Medicaid Number (CIN) (Rev. 11/02)

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

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

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

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

#### ALPHA CONVERSION CHART

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

**Note:** Perform the required conversion before dialing MEVS.

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### 3.3 Telephone Verification Input Section (Rev. 04/03)

#### Instructions for Completing a Telephone Transaction

- If using a CIN, be sure to convert the number before dialing. Refer to the [chart](#) on the previous page.
- Dial 1-800-997-1111.
- Once you have dialed and a connection is made, an Audio Response Unit (ARU) will prompt you for the input data that needs to be entered.
- If you wish to hear a prompt repeated, press \*, (asterisk).
- To bypass a prompt, press #, (the pound key).
- To clear a mistake, press the \* key and re-enter the correct information. This step is only valid if done prior to pressing the # key which registers the entry.
- Once you are familiar with the prompts and wish to make your entries without waiting for the prompts, just continue to enter the data in the proper sequence. As in all transactions (prompted or unprompted), press the # key after each entry.
- For assistance or further information on input or response messages, call the Provider Services staff at 1-800-343-9000.
- For some prompts, if the entry is invalid, the ARU will repeat the prompt. This allows you to correct the entry without re-keying the entire transaction.
- The call is terminated if excessive errors are made.
- If you will be entering co-payment information, be sure to convert the alpha co-payment type to a number, prior to dialing. The Co-payment Type codes and conversion can be found in the Codes Section of this manual.
- The following types of transactions can not be processed via the telephone:
  - Cancel Transactions
  - Authorization Confirmation Transactions
  - Dispensing Validation System Transactions

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

VOICE PROMPT	ACTION/INPUT
	TO BEGIN Dial 1-800-997-1111
NEW YORK STATE MEDICAID	None
IF ENTERING ALPHA/NUMERIC IDENTIFIER, ENTER NUMBER 1  IF ENTERING NUMERIC IDENTIFIER, ENTER NUMBER 2	Enter 1, If using converted CIN.  Enter 2, If using Access Number.
ENTER IDENTIFICATION NUMBER	Enter converted alpha/numeric Medicaid number (CIN) or numeric access number. Press #
ENTER NUMBER 1 FOR SERVICE AUTHORIZATION OR NUMBER 2 FOR ELIGIBILITY INQUIRY	One of the following transaction types must be entered:  <ol style="list-style-type: none"> <li>1 To request a Service Authorization as well as Eligibility Information. This must be used to obtain a service authorization for <u>Post and Clear (P &amp; C) and Utilization Threshold (UT)</u>. Co-payment entries may also be made using this transaction type.</li> <li>2 To request Eligibility Information only. This may also be used to determine if ordered/prescribed services are available for the recipient under the UT program. Co-payment entries can also be made using this transaction type.</li> </ol>
ENTER SEQUENCE NUMBER	If the Identification Number entry was a Medicaid Number (CIN), enter the two-digit sequence number.  No entry is necessary if the numeric Access Number was entered. Press # to bypass the prompt.
ENTER DATE	Press # for today's date or enter MMDDYY for a previous date of service. For all inpatient co-payment entries, the date should equal the discharge date.
ENTER PROVIDER NUMBER	Enter the eight-digit provider identification number assigned at the time of enrollment in the NYS Medicaid Program.



VOICE PROMPT	ACTION/INPUT
<b>ENTER SPECIALTY CODE</b>	<p>Enter the three-digit MMIS specialty code that describes the type of service that will be rendered and press #. If you are providing a service that is exempt from the UT program or you are a clinic or hospital clinic using a transaction type 1, a code MUST be entered.</p> <p>If you do not have a specialty code, press # to bypass this prompt.</p>
<b>ENTER REFERRING PROVIDER NUMBER</b>	<p>Must be entered if the recipient is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press #. If a recipient enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's ID number in response to this prompt.</p> <p>If the recipient is not a referral, press the # key to bypass this prompt.</p>
<b>ENTER FIRST CO-PAYMENT TYPE</b>	<p>Enter the alpha converted co-payment type. Refer to <a href="#">Co-payment Type Code</a> list in the "Codes" section of this manual for the alpha converted number.</p> <p>If the service you are rendering does not require co-payment, or if the recipient is exempt or has met their co-payment maximum responsibility, bypass all the co-payment prompts by pressing #.</p>
<b>ENTER CO-PAYMENT UNITS</b>	<p>Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable.</p> <p>If the first entry is valid, you will be prompted to enter "SECOND CO-PAYMENT TYPE", then a "THIRD CO-PAYMENT TYPE" and finally "FOURTH CO-PAYMENT TYPE". The additional co-payment prompts would be used by a provider who is rendering more than one co-payment type of service. If not applicable, press # to bypass the rest of the co-payment prompts.</p>
<b>ENTER SECOND CO-PAYMENT TYPE</b>	<p>Enter the alpha converted co-payment type for the second co-payment and press #.</p>
<b>ENTER CO-PAYMENT UNITS</b>	<p>Enter the number of units being rendered. Only a one or a two-digit numeric entry is acceptable. Press #</p>
<b>ENTER THIRD CO-PAYMENT TYPE</b>	<p>Enter the alpha converted co-payment type for the third co-payment and press #.</p>

VOICE PROMPT	ACTION/INPUT
<b>ENTER CO-PAYMENT UNITS</b>	Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable. Press #
<b>ENTER FOURTH CO-PAYMENT TYPE</b>	Enter the alpha converted co-payment type for the fourth co-payment and press #.
<b>ENTER CO-PAYMENT UNITS</b>	Enter the number of units being rendered. Only a one or two-digit numeric entry is acceptable. Press #
<b>ENTER NUMBER OF SERVICE UNITS</b>	Enter the total number of service units rendered and press #. If you are performing an eligibility inquiry only, press # to bypass this prompt.
<b>IF YOU ARE A DESIGNATED POSTING PROVIDER, ENTER NUMBER OF LAB TESTS YOU ARE ORDERING</b>	If you are a designated Posting Provider, Enter the total number of Lab tests being ordered and press #, or press # to bypass.
<b>IF YOU ARE A DESIGNATED POSTING PROVIDER ENTER NUMBER OF PRESCRIPTIONS OR OVER THE COUNTER ITEMS YOU ARE ORDERING</b>	If you are a designated Posting Provider, Enter the total number or prescriptions or over the counter items being ordered and press #, or press # to bypass.

VOICE PROMPT	ACTION/INPUT																																					
<b>ENTER ORDERING PROVIDER NUMBER</b>	<p>Enter the MMIS provider ID number of the ordering provider and press #. All providers who fill written orders/scripts must complete this field.</p> <p>If you do not have the provider number of the ordering provider, you may enter the license type and license number. If entering a license number for New York State providers, after entering a license type, enter two zeros and the six-digit license number. If entering out of state license numbers, after entering the license type, enter the two character converted alpha state code (<a href="#">see page 3.2.1</a>), followed by the license number. A Nurse Practitioner must have a "F" preceding their license number in order to prescribe drugs. If entering a NYS nurse practitioner license number, enter the license type followed by 33 (converted F) and then the license number. NYS Optometrists who are allowed to prescribe certain medications will have an alpha character (U or V) preceding their license number. When entering their license number, enter the license type, convert the alpha character to a number (<a href="#">see page 3.2.1</a>) and enter that number followed by the actual license number.</p> <p>Valid license types include:</p> <table data-bbox="802 1100 1425 1388"> <thead> <tr> <th></th> <th><u>In State</u></th> <th><u>Out of State</u></th> </tr> </thead> <tbody> <tr> <td>Physician</td> <td>01</td> <td>11</td> </tr> <tr> <td>Dentist</td> <td>02</td> <td>12</td> </tr> <tr> <td>Physician's Assistant</td> <td>09</td> <td>19</td> </tr> <tr> <td>Optometrist</td> <td>25</td> <td>35</td> </tr> <tr> <td>Podiatrist</td> <td>26</td> <td>36</td> </tr> <tr> <td>Audiologist</td> <td>27</td> <td>37</td> </tr> <tr> <td>Nurse Practitioner</td> <td>29</td> <td>39</td> </tr> <tr> <td>Nurse Midwife</td> <td>29</td> <td>39</td> </tr> </tbody> </table> <p><b>Examples</b></p> <table data-bbox="802 1423 1425 1570"> <tbody> <tr> <td>MMIS Provider ID #</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>0100987654</td> </tr> <tr> <td>Out of State License #</td> <td>116251045678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>2933123456</td> </tr> <tr> <td>NYS Optometrist #</td> <td>2582123456</td> </tr> </tbody> </table> <p><b>Press # to bypass this prompt if you are not a dispensing provider.</b></p>		<u>In State</u>	<u>Out of State</u>	Physician	01	11	Dentist	02	12	Physician's Assistant	09	19	Optometrist	25	35	Podiatrist	26	36	Audiologist	27	37	Nurse Practitioner	29	39	Nurse Midwife	29	39	MMIS Provider ID #	01234567	New York State License #	0100987654	Out of State License #	116251045678	Nurse Practitioner #	2933123456	NYS Optometrist #	2582123456
	<u>In State</u>	<u>Out of State</u>																																				
Physician	01	11																																				
Dentist	02	12																																				
Physician's Assistant	09	19																																				
Optometrist	25	35																																				
Podiatrist	26	36																																				
Audiologist	27	37																																				
Nurse Practitioner	29	39																																				
Nurse Midwife	29	39																																				
MMIS Provider ID #	01234567																																					
New York State License #	0100987654																																					
Out of State License #	116251045678																																					
Nurse Practitioner #	2933123456																																					
NYS Optometrist #	2582123456																																					
<b>NOTE:</b>	When entering a license type and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 2583000867 (License Type + V + Zero fill + License Number).																																					

**THIS IS THE LAST PROMPT YOU WILL HEAR. THE MEVS SYSTEM WILL NOW RETURN YOUR RESPONSE.**

**THIS ENDS THE INPUT DATA SECTION.**

### 3.4 Telephone Verification Response Section (Rev. 04/03)

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

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

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CIN	MEDICAID NUMBER AA22346D	The response begins with the recipient's eight-digit Medicaid CIN.
COUNTY CODE	COUNTY CODE 24	The two-digit code which indicates the recipient's county of fiscal responsibility. Refer to the codes section for a complete listing of <a href="#">county codes</a> .
RECIPIENT'S MEDICAID COVERAGE	ELIGIBLE CAPITATION GUARANTEE	A response of "Eligible Capitation Guarantee" indicates guaranteed status under a Prepaid Capitation Program (PCP). The PCP provider is guaranteed the capitation rate for a period of time after a client becomes ineligible for Medicaid services. Recipients enrolled in some PCPs are eligible for some fee-for-service benefits if referred by the PCP provider. To determine exactly what services are covered, contact the PCP designated in the insurance code field.
	ELIGIBLE EXCEPT LONG TERM CARE	Recipient is eligible to receive all Medicaid services except nursing home services provided in an SNF or inpatient setting and/or waived services provided under the Long Term Health Care Program. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
	ELIGIBLE ONLY FAMILY PLANNING SERVICES	A recipient who was pregnant within the past two years and was on Medicaid while pregnant is eligible for Medicaid covered family planning services for up to 26 months after the end date of pregnancy, regardless of whether the pregnancy ended in a miscarriage, live birth, still birth or an induced termination.
	ELIGIBLE ONLY OUTPATIENT CARE	Recipient is eligible for all ambulatory care, including prosthetics; no inpatient coverage.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
<b>RECIPIENT'S MEDICAID COVERAGE (contd.)</b>	ELIGIBLE PCP	A response of "Eligible PCP" indicates coverage under a Prepaid Capitation Program (PCP). This status means the client is PCP eligible as well as eligible for limited fee-for-service benefits. To determine exactly what services are covered, listen to the PCP services returned in the response. If further clarification is needed, contact the PCP designated in the insurance code field.
	EMERGENCY SERVICES ONLY	Recipient is eligible for emergency services from the first treatment for the emergency medical condition until the condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part.
	FAMILY HEALTH PLUS	Recipient is enrolled in the Family Health Plus Program (FHP) and receives all services through a FHP participating Managed Care Plan. The Medicaid program does not reimburse for any service that is excluded from the benefit package of the FHP Managed Care Plan.
	MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Recipient is eligible to receive all Medicaid services with prescribed limits for physician, psychiatric and medical clinic, laboratory, dental clinic and pharmacy services. A service authorization must be obtained.
	MEDICAID ELIGIBLE	Recipient is eligible for all benefits.
	MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	Recipient is eligible for payment of Medicare coinsurance and deductible only. Deductible and coinsurance payments will be made for Medicare approved services only.

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

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
<b>MEDICARE DATA (contd.)</b>	MEDICARE PARTS A & B & QMB	ABQMB = Recipient has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART A & QMB	AQMB = Recipient has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART B & QMB	BQMB = Recipient has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE QMB Only	QMB = Recipient is a Qualified Medicare Beneficiary (QMB) Only.
	HEALTH INSURANCE CLAIM NUMBER XXXXXXXXXXXX	Actual Health Insurance Claim number consisting of up to twelve-digits. If a number is not available, the following message will be returned.
	HEALTH INSURANCE CLAIM NUMBER NOT ON FILE	Actual Health Insurance Claim number is not on file.
<b>THIRD PARTY INSURANCE AND COVERAGE CODES</b>	INSURANCE COVERAGE CODE 21: DENTAL, PHYSICIAN, INPATIENT	Insurance and Coverage Codes equal the Insurance carrier and the scope of benefits. You will hear a two character insurance code and up to 13 coverage code descriptions. If you hear a third insurance code of ZZ call 1-800-343-9000 to obtain additional insurance and coverage information. Refer to your MMIS Provider Manual for insurance codes. A table of valid coverage codes is located in the Codes Section of this Guide.
<b>EXCEPTION RESTRICTION CODES</b>	EXCEPTION CODE 35	If applicable, a recipient's exception and/or restriction code will be returned. Refer to the <a href="#">Codes Section</a> for the definitions/descriptions.
<b>CO-PAY DATA</b>	NO CO-PAYMENT REQUIRED	This message will be heard if the recipient is under 21 or exempt from co-payment and co-payment data has been entered.
	CO-PAYMENT REQUIREMENTS MET ON MM/DD/YY	Recipient has reached his/her co-payment maximum. The date equals the date of inquiry, which brought the co-payment over the maximum. You should not collect the co-payment until the next co-payment period.



MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
UTILIZATION THRESHOLD POST AND CLEAR DATA	AT SERVICE LIMIT	The recipient has reached his/her limit for that particular service category. No service authorization is created. The service is <b>not</b> approved and payment by Medicaid will <b>not</b> be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.
	DUPLICATE - UT PREVIOUSLY APPROVED	The service authorization request is a duplicate of a previously approved service authorization request for a given provider, recipient, and date of service.
	PARTIAL APPROVAL XX SERVICE UNIT(S) POST AND CLEAR	Indicates that the full complement of requested services relative to Post and Clear processing is not available. The <b>XX</b> represents the number of services approved/available.
	PARTIAL APPROVAL XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S) UTILIZATION THRESHOLD	Indicates that the full complement of requested services relative to Utilization Threshold processing is not available. The <b>XX</b> represents the number of services approved/available.
	SERVICE APPROVED NEAR LIMIT XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The service authorization has been granted and recorded. The recipient has almost reached his/her service limit. For the convenience of the provider and the recipient, this message also indicates that the patient is using services at a rate that could exhaust his/her limit for that particular service category.
	SERVICE APPROVED UTILIZATION THRESHOLD XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The service units requested are approved, as the recipient has not utilized his/her UT limit. A service authorization will be created.
	SERVICES APPROVED POST AND CLEAR XX SERVICE UNIT(S), XX LAB UNIT(S), XX PHARMACY UNIT(S)	The ordering provider has posted services and those service units have been approved. This message will also be returned for a Pharmacy DME (specialty code 307) Card Swipe Transaction Type 1 entry.
DATE OF SERVICE	FOR DATE MMDDYY	This will be heard when the message is complete and reflects the date for which services were requested. <b>You can repeat the message one time by pressing the * key.</b>

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

### 3.5 Telephone Verification Error and Denial Responses (Rev. 11/02)

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

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

RESPONSE	DESCRIPTION/COMMENTS
<b>INVALID CO-PAYMENT</b>	This message is heard at the prompt if the data entered is not in the correct format (invalid number of digits or number doesn't convert to an alpha character). Receiving this message will prohibit the next prompt from being spoken. To proceed, re-enter the data in the correct format.
<b>INVALID CO-PAYMENT, REFER TO MEVS MANUAL</b>	The Data entered is not a valid co-payment value. Refer to the <a href="#">Codes Section</a> of this manual.
<b>INVALID DATE</b>	An illogical date or a date which falls outside of the allowed MEVS inquiry period was entered. The allowed period is 24 months retroactive from the entry date.
<b>INVALID ENTRY</b>	An invalid number of digits was entered for service units. Service units must be one or two-digits.
<b>INVALID IDENTIFICATION NUMBER</b>	The recipient identification number entered was an incorrect length, or an invalid alpha converted number was entered.
<b>INVALID LICENSE TYPE</b>	The License Type entered in the ordering provider field is not a valid value. Refer to the <a href="#">values listed</a> in the ordering provider field in Section 3.3 of this manual.
<b>INVALID MEDICAID NUMBER</b>	An invalid CIN was entered. Refer to the <a href="#">alpha conversion chart</a> in the beginning of this guide. Verify that the CIN was correctly converted to an eleven-digit number.
<b>INVALID MENU OPTION</b>	An invalid entry was made when selecting the identifier type. The entry must be 1 (alphanumeric identifier) or 2 (numeric identifier).
<b>INVALID ORDERING PROVIDER NUMBER</b>	The license number or MMIS Provider ID number that was entered in the ordering provider field was not found on the license or provider files.
<b>INVALID PROVIDER NUMBER</b>	The provider number entered is an invalid eight-digit number.
<b>INVALID REFERRING PROVIDER NUMBER</b>	The referring provider ID number was entered incorrectly or is not a valid MMIS provider ID number. A license number can not be entered in this field.
<b>INVALID SEQUENCE NUMBER</b>	The sequence number entered is not valid or not current. Check the recipient's card for the current sequence number.

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

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

**4.0 INTRODUCTION TO MEVS TERMINAL (VeriFone) VERIFICATION** (Rev. 11/02)

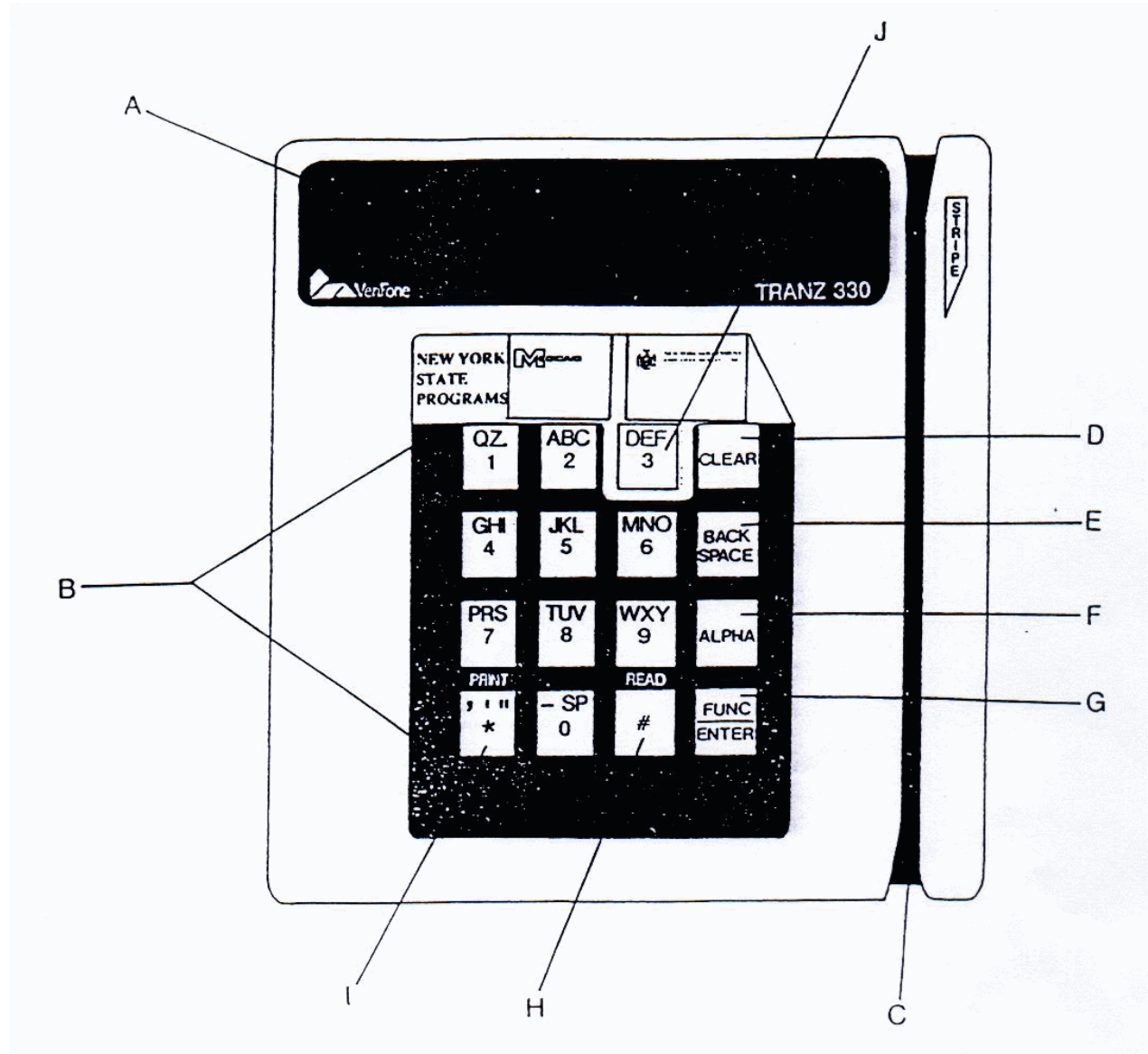
The VeriFone terminal is designed to provide an accurate and timely verification of a recipient's eligibility for Medicaid services. Specific features and conveniences are built into the system to make the verification process easy to learn with a minimum of training time.

Your individual "PROVIDER NUMBER" and the MEVS "TELEPHONE NUMBER" for verification requests are pre-programmed into the VeriFone terminal. Multiple provider identification numbers can be programmed into the VeriFone terminal, which will cause the prompt 'SELECT PROVIDER' to appear. Once programmed, there is no need to enter the full eight-digit Provider ID number, although the two-digit code assigned to that provider number must be selected. Call 1-800-343-9000 for assistance in adding multiple provider numbers to your terminal.

The following section has been divided into two parts: the description of the VeriFone terminal and the procedures for requesting a Medicaid verification using the VeriFone terminal.

4.1 **MEVS Terminal (VeriFone)** (Rev. 11/02)

The VeriFone terminal is a verification device that uses basic telephone outlets to connect with MEVS. These terminals are available from the State of New York and are very easy to use. The features of the VeriFone terminal are described on the following pages.

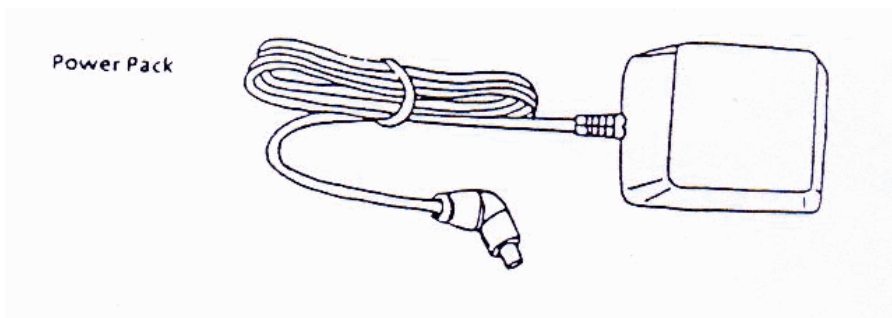
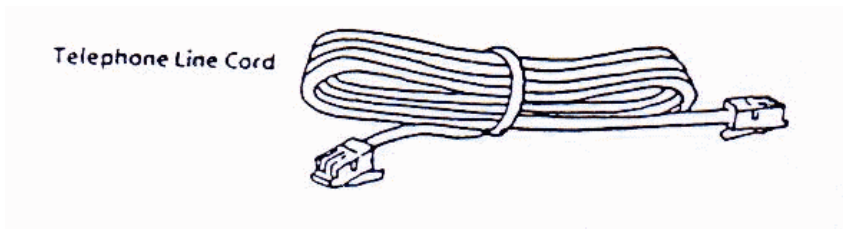
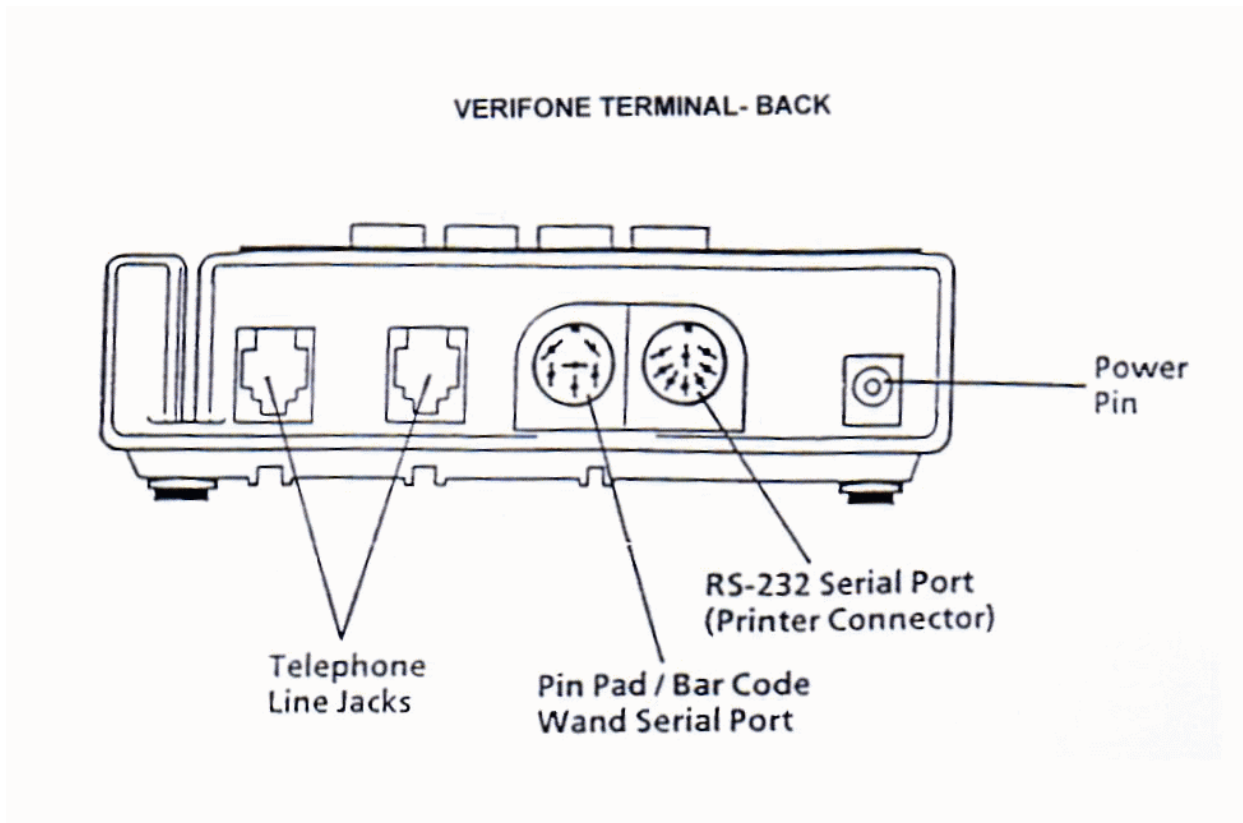




**VERIFONE DESCRIPTION - FRONT**

- A. LED Readout: Sixteen character display screen. The verification response and system messages will be displayed in this area.
- B. Keypad: Area where user enters data needed for the Medicaid verification.
- C. Magnetic Stripe Reader: Slot that reads the magnetic stripe on the back of the card. This allows for quicker entry of verification transactions.
- D. CLEAR Key: Erases all previously entered data and returns to the ready mode.
- E. BACKSPACE Key: Erases the last numeric digit or alphabetic letter entered.
- F. ALPHA Key: Converts numeric digits to alphabetic letters.
- G. FUNC/ENTER Key  
Inputs new data into the system.  
Can also be used to review the last number entered.  
Starts a multiple verification or correction.
- H. # Key: Reads each line of the verification message.
- I. \* Key: Prints the verification message on the optional printer.
- J. 3 Key: Starts a verification transaction through entry of the access number or Medicaid Number (CIN).

VERIFONE TERMINAL – BACK



## 4.2 VeriFone Installation Instructions (Rev. 11/02)

### Connecting the Telephone Line

1. Connect one end of the telephone line cord to one of the two modular jacks at the rear of the terminal. Both jacks perform the same function, so either may be used.
2. Connect the other end of the telephone line cord to your RJ11-type modular telephone wall jack. If you do not have a modular wall jack, obtain an adapter from your local telephone company.

### Connecting a Standard Telephone (Optional)

3. Connect one end of the telephone's line cord to the unused modular jack at the rear of the terminal.
4. If the other end of the telephone's line cord is not already connected to the telephone, connect it at this time.
5. If your telephone requires additional connections, such as a handset or power supply, refer to the instructions supplied with the telephone when connecting these components.

### Connecting the Terminal Power Pack

6. Attach the small plug at one end of the power pack cord to the power pin jack at the rear of the terminal.
7. Plug the two-prong AC power pack into an indoor 120-volt AC outlet.  
WARNING: Do not plug the power pack into an outdoor outlet or operate the terminal outdoors.

### Connecting the Printer (Optional)

8. Connect the 8-pin DIN plug on the printer interface cable to the 8-pin DIN connector at the rear of the terminal.
9. Connect the 25-pin plug on the printer interface cable to the 25-pin connector on the rear of the printer.
10. Plug the printer power cord into a 3-conductor grounded 120-volt AC outlet.

### 4.3 Instructions to Reset Day/Date/Time (Rev. 11/02)

The following information explains the procedure used to set or reset day, date and time.

ACTION	DISPLAY
Press * (asterisk) key and the <b>3</b> key at the same time.	DIAGNOSTICS
Press <b>ALPHA</b> key.  Enter appropriate number corresponding to day of week.  1 = Monday            5 = Friday 2 = Tuesday          6 = Saturday 3 = Wednesday      7 = Sunday 4 = Thursday	(RTC CHIP TEST) DAY OF WEEK =
Press <b>FUNC/ENTER</b> key. Enter last two-digits of year.	YEAR = 20
Press <b>FUNC/ENTER</b> key.  Enter appropriate number corresponding to month of the year 1 = January            7 = July 2 = February          8 = August 3 = March              9 = September 4 = April                10 = October 5 = May                 11 = November 6 = June                12 = December	MONTH =
Press <b>FUNC/ENTER</b> key. Enter Day of Month.	DATE =
Press <b>FUNC/ENTER</b> key. Enter Hour.	HOUR =
Press <b>FUNC/ENTER</b> key. Enter 0 or 1.	AM = 0, PM = 1
Press <b>FUNC/ENTER</b> key. Enter minutes.	MINUTES =
Press <b>FUNC/ENTER</b> key. Enter seconds.	SECONDS =
Press <b>FUNC/ENTER</b> key.	DAY DATE TIME

#### 4.4 VeriFone Verification Input Section (Rev. 11/02)

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

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

##### Instructions for Completing a VeriFone Transaction

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

PROMPT DISPLAYED	ACTION/INPUT
	<b>TO BEGIN:</b> Press the <b>CLEAR</b> key. Press the <b>3</b> key to start the verification.
<b>NY STATE PGRMS</b>	Displayed for one second.

PROMPT DISPLAYED	ACTION/INPUT
<b>ENTER CARD OR ID</b>	<p>If you are using the recipient access number, swipe the card through the reader or key the access number and press the <b>FUNC/ENTER</b> key.</p> <p>Smoothly swipe the card through the magnetic stripe reader from top to bottom. The NY Access # will be displayed for one second.</p> <p><b>Note:</b> The access number must be entered manually if using a replacement paper Benefit Identification Card or if using a plastic card with a damaged magnetic stripe. The six-digit ISO number on the Benefit Identification Card does not need to be entered when manually entering the access number.</p> <p>If you are using the Recipient Medicaid number (CIN), enter the Medicaid number and press the <b>FUNC/ENTER</b> key. The NY Medicaid # will be displayed for one second.</p>
<b>ENTER TRAN TYPE</b>	<p>One of the following must be entered:</p> <ol style="list-style-type: none"> <li><b>1</b> To request a Service Authorization and Eligibility inquiry. This must be used to obtain a service authorization for <u>Post and Clear and Utilization Threshold</u> (UT) programs. Co-payment entries may also be made using Transaction Type 1.</li> <li><b>2</b> To request Eligibility inquiry only. This may also be used to determine if ordered/prescribed services are available for the recipient under the UT program. Co-payment entries may also be made using Transaction Type 2.</li> <li><b>3</b> Authorization Confirmation - To determine if an authorization has already been requested for this patient, for a particular date. To be used with Medicaid Number (CIN) ONLY.</li> <li><b>4</b> Authorization Cancellation - To cancel a previous authorization. Use Medicaid Number (CIN) ONLY. Must be done on the same day of the previous authorization.</li> <li><b>6</b> Dispensing Validation System Request (DVS) - This transaction allows suppliers of predesignated enteral nutrition products; prescription footwear items; certain medical surgical supplies and equipment to request a DVS number (Prior approval). This transaction code is also used to obtain dental DVS Numbers.</li> </ol> <p>Press the <b>FUNC/ENTER</b> key</p>

PROMPT DISPLAYED	ACTION/INPUT
<p><b>NOTE:</b> Depending on which Transaction Type you select, the following prompts may not appear in the order in which they are listed.</p>	
<p><b>ENTER SEQ #</b></p>	<p>If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the <b>FUNC/ENTER</b> key. The sequence number is the last two-digits of the access number.</p> <p>If the Access Number was entered, this prompt will not display.</p>
<p><b>ENTER DATE</b></p>	<p>Press the <b>FUNC/ENTER</b> key for today's date. If you are doing a verification for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the <b>FUNC/ENTER</b> key. DVS transactions require a current date entry or just press <b>FUNC/ENTER</b> key.</p> <p>For all inpatient co-payment entries, the date should equal the discharge date.</p>
<p><b>SELECT PROVIDER</b></p>	<p>If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate number associated with your provider Identification Number or enter an eight-digit MMIS Identification Number and press the <b>FUNC/ENTER</b> key (To add numbers call 1-800-343-9000).</p>
<p><b>ENTER SPEC CODE</b></p>	<p>Enter the three-digit MMIS specialty code that describes the type of service that will be rendered and press the <b>FUNC/ENTER</b> key. If you are providing a service that is exempt from the UT program or you are a clinic or hospital clinic using a Transaction Type 1 or 6, a code <b>MUST</b> be entered.</p> <p>If you do not have a specialty code, press the <b>FUNC/ENTER</b> key to bypass this prompt.</p>
<p><b>REFERRING PRV #</b></p>	<p>Must be entered if the recipient is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the Medicaid provider number of the primary provider and press the <b>FUNC/ENTER</b> key. If a recipient enrolled in the Managed Care Coordinator Program (MCCP) is referred to you by the primary provider, you must enter that provider's Medicaid ID number in response to this prompt.</p> <p>If the recipient is not restricted or in MCCP, press the <b>FUNC/ENTER</b> key to bypass this prompt.</p>

PROMPT DISPLAYED	ACTION/INPUT																																					
ORDERING PRV #	<p>Enter the MMIS provider ID number of the ordering provider and press the <b>FUNC/ENTER</b> key. All providers who fill written orders/scripts must complete this field.</p> <p>If you do not have the provider number of the ordering provider, you may enter the license type and license number. If entering a license number for New York State providers, first enter a license type, followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the license type, followed by the two-digit alpha character state code then the six-digit license number. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have an alpha character (U or V) preceding their license number. When entering their license number, enter the license type followed by a zero, the alpha character and the six-digit license number.</p> <p>Valid license types include:</p> <table data-bbox="808 1003 1383 1312"> <thead> <tr> <th></th> <th><u>In State</u></th> <th><u>Out of State</u></th> </tr> </thead> <tbody> <tr> <td>Physician</td> <td>01</td> <td>11</td> </tr> <tr> <td>Dentist</td> <td>02</td> <td>12</td> </tr> <tr> <td>Physician's Assistant</td> <td>09</td> <td>19</td> </tr> <tr> <td>Optometrist</td> <td>25</td> <td>35</td> </tr> <tr> <td>Podiatrist</td> <td>26</td> <td>36</td> </tr> <tr> <td>Audiologist</td> <td>27</td> <td>37</td> </tr> <tr> <td>Nurse Practitioner</td> <td>29</td> <td>39</td> </tr> <tr> <td>Nurse Midwife</td> <td>29</td> <td>39</td> </tr> </tbody> </table> <p><u>Examples:</u></p> <table data-bbox="808 1438 1323 1585"> <tbody> <tr> <td>MMIS Provider ID #</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>0100987654</td> </tr> <tr> <td>Out of State License #</td> <td>11NJ345678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>290F121212</td> </tr> <tr> <td>NYS Optometrist #</td> <td>250U452749</td> </tr> </tbody> </table> <p><b>NOTE:</b> When entering a license type and license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is V867 would be: 250U000867 (License Type + 0U + Zero fill + License Number).</p>		<u>In State</u>	<u>Out of State</u>	Physician	01	11	Dentist	02	12	Physician's Assistant	09	19	Optometrist	25	35	Podiatrist	26	36	Audiologist	27	37	Nurse Practitioner	29	39	Nurse Midwife	29	39	MMIS Provider ID #	01234567	New York State License #	0100987654	Out of State License #	11NJ345678	Nurse Practitioner #	290F121212	NYS Optometrist #	250U452749
	<u>In State</u>	<u>Out of State</u>																																				
Physician	01	11																																				
Dentist	02	12																																				
Physician's Assistant	09	19																																				
Optometrist	25	35																																				
Podiatrist	26	36																																				
Audiologist	27	37																																				
Nurse Practitioner	29	39																																				
Nurse Midwife	29	39																																				
MMIS Provider ID #	01234567																																					
New York State License #	0100987654																																					
Out of State License #	11NJ345678																																					
Nurse Practitioner #	290F121212																																					
NYS Optometrist #	250U452749																																					



PROMPT DISPLAYED	ACTION/INPUT
<p><b>NOTE:</b> The following three prompts are <u>required</u> for DVS transactions only and will only appear when <b>Transaction Type 6</b> is entered.</p>	
<p><b>ENTER COS</b></p>	<p>For DVS transactions only: Enter the four-digit Category of Service number assigned to you at the time of enrollment in the NYS Medicaid Program. Be sure to enter the same COS that you will put on your claim when billing for the service.</p>
<p><b>ENTER ITEM/NDC #</b></p>	<p>For DVS transactions only: Enter the five-digit New York State alpha/numeric item code of the item being dispensed. For some items, <u>if instructed by New York State</u>, the eleven-digit National Drug Code may be entered.</p> <p>For Dental DVS: Enter a constant value of D; the five character Dental procedure code and a two-digit tooth number, or one character primary tooth or two-character tooth quadrant/arch.</p>
<p><b>ENTER QUANTITY</b></p>	<p>For DVS transactions only: Enter the total number of units dispensed for the current date of service only. For enteral products, enter caloric units. For example: if the prescription is for Regular Ensure 1 - 8 oz. can daily, 30 cans, with 5 refills, there are 75 caloric units per 30 cans (one month supply). The correct entry is 75 for the current date of service. Do not include refills.</p> <p>For Dental DVS: Enter the number of times the procedure was performed.</p>
<p><b>NOTE:</b> If performing a <u>DVS transaction</u>, the Enter Quantity prompt will be the last to appear. <u>Co-payment amounts</u> will be taken from the New York State Drug Plan file and added to the recipient's file for cap calculation unless the recipient has already met their co-pay or is exempt. No co-payment amounts can be entered with the DVS transaction.</p>	
<p><b>COPAY TYPE/UNT 1</b></p>	<p>Enter a co-payment type and the number of units. Refer to the <a href="#">Co-payment Type Code</a> list in the "Codes" Section in this manual for the alpha code to be entered in the co-pay type field. The entry in the "UNT" field must be numeric. (One or two-digit number equal to service units you are rendering). If the service you are rendering does not require co-payment, or if the recipient is exempt or has met their co-payment maximum responsibility, bypass all the prompts by pressing enter.</p> <p>If the first entry is valid, you will be prompted to enter "COPAY TYPE/UNT 2" then a "COPAY TYPE/UNT 3" and finally "COPAY TYPE/UNT 4". The additional co-pay prompts would be used by a provider who is rendering more than one "COPAY TYPE" of service.</p>

PROMPT DISPLAYED	ACTION/INPUT
<b>COPAY TYPE/UNT 2</b>	Enter co-payment type and number of units OR Press enter to bypass the rest of the co-payment prompts.
<b>COPAY TYPE/UNT 3</b>	Enter co-payment type and number of units OR Press enter to bypass the rest of the co-payment prompts.
<b>COPAY TYPE/UNT 4</b>	Enter co-payment type and number of units OR Press enter to bypass the rest of the co-payment prompts.
<b># SERVICE UNITS</b>	Enter the total number of service units and press the <b>FUNC/ENTER</b> key. If you are performing an Eligibility Inquiry only, press the <b>FUNC/ENTER</b> key to bypass this prompt.
<b>NOTE:</b> If you are a POST and CLEAR Provider, enter the appropriate data for the following two prompts. These prompts will only appear for a Post and Clear provider and an entry is required.	
<b># LAB TESTS</b>	Enter the number of lab tests you are ordering and press the <b>FUNC/ENTER</b> key. If no lab tests are required, bypass by pressing the <b>FUNC/ENTER</b> key.
<b># RX/OTC</b>	Enter the number of prescriptions or over the counter items you are ordering and press the <b>FUNC/ENTER</b> key. If no RX/OTC are required, bypass by pressing the <b>FUNC/ENTER</b> key.
<b>THIS ENDS THE INPUT DATA SECTION.</b> The VeriFone will now dial into the MEVS system and display these processing messages:	
<b>DIALING, WAITING FOR ANSR, CONNECTED, TRANSMITTING, RECEIVING, and PROCESSING</b>	These processing messages are displayed.

#### 4.5 VeriFone Verification Response Section (Rev. 04/03)

If you have a printer and would like to print the response data, press the \*(asterisk) key. If you would like to print all responses automatically, call Provider Services staff at 1-800-343-9000 for instructions.

An eligibility/service authorization response that contains no errors will be returned in the following sequence.

**NOTE:** After each Response Field display, press the # key for the next display. Also, although all types of eligibility coverages are listed below, only one will be displayed.

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS
<b>CIN</b>	AA22345D 04	The first line of the response will display the eight-digit Medicaid Number (CIN) and the recipient's two-digit county code. Press the # key to display each line of the message.
<b>RECIPIENT'S MEDICAID COVERAGE</b>	ELIG CAPITATION GUARANTEE	A response of "Eligible Capitation Guarantee" indicates guaranteed status under a Prepaid Capitation Program (PCP). The PCP provider is guaranteed the capitation rate for a period of time after a client becomes ineligible for Medicaid service. Recipients enrolled in some PCPs are eligible for some fee-for-service benefits if referred by the PCP provider. To determine which services are covered by the PCP, review the coverage codes returned in the response. The Coverage Code definitions can be found in the Codes section of this manual. If further clarification of exact coverage is needed, contact the PCP.
	ELIG EXCEPT LTC	Recipient is eligible to receive all Medicaid services except nursing home services provided in an SNF, nursing home services received in an inpatient setting and/or waived services received under the Long Term Health Care Program. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS
<b>RECIPIENT'S MEDICAID COVERAGE (contd.)</b>	ELIGIBLE ONLY FAMILY PLAN SRVC	A recipient who was pregnant within the past two years and was on Medicaid while pregnant is eligible for Medicaid covered family planning services for up to 26 months after the end date of pregnancy, regardless of whether the pregnancy ended in a miscarriage, live birth, still birth or an induced termination.
	ELIGIBLE ONLY OUTPATIENT CARE	Recipient is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
	ELIGIBLE PCP	A response of "Eligible PCP" indicates coverage under a Prepaid Capitation Program (PCP). This status means the recipient is enrolled in a managed care plan as well as eligible for limited fee-for-service benefits. To determine which services are covered by the PCP, review the coverage codes returned in the response. The Coverage Code definitions can be found in the Codes section of this manual. If further clarification of exact coverage is needed, contact the PCP.
	EMERGENCY SRVCS	Recipient is eligible for emergency services from the time first given treatment for the emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part.
	FAM HEALTH PLUS	Recipient is enrolled in the Family Health Plus Program (FHP) and receives all services through a FHP participating Managed Care Plan. The Medicaid program does not reimburse for any service that is excluded from the benefit package of the FHP Managed Care Plan.

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS
<b>RECIPIENT'S MEDICAID COVERAGE (contd.)</b>	MA ELIG-HR/UT	Recipient is eligible to receive all Medicaid services within set limits for physician, psychiatric and medical clinics, laboratory, dental clinic and pharmacy services. A Utilization Threshold service authorization must be obtained.
	MA ELIGIBLE	Recipient is eligible for all benefits.
	MDCRE COIN/DEDUC	Recipient is eligible for payment of Medicare coinsurance and deductibles. Deductible and coinsurance payments will be made for <u>Medicare</u> approved services only.
	PERINATAL FAMILY	Recipient is eligible to receive a limited package of benefits. The following services are excluded: podiatry, long term home health care, long term care, hospice, ophthalmic services, DME, therapy (physical, speech, and occupational), abortion services, and alternate level care.
	PRESUMPTIVE ELIG LONGTERM/HOSPICE	Recipient is eligible for all Medicaid services except hospital based clinic services, hospital emergency room services, hospital inpatient services, and bed reservation.
	PRESUMPTIVE ELIG PRENATAL A	Recipient is eligible to receive all Medicaid services except inpatient care, institutional long term care, alternate level care, and long term home health care.
	PRESUMPTIVE ELIG PRENATAL B	Recipient is eligible to receive only ambulatory prenatal care services. The following services are excluded: inpatient hospital services, long term home health care, long term care, hospice, alternate level care, ophthalmic services, DME, therapy (physical, speech, and occupational), abortion services, and podiatry.

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS														
<b>RECIPIENT MISCELLANEOUS DATA</b>	10 F959 S 06 500	<p>The descriptions that follow are in the order in which the data is returned.</p> <p>The anniversary month is the beginning month of the patient's benefit year. October in example.</p> <p>Valid Sex codes are:  F = Female  M = Male  U = Unborn (Infant)</p> <p>959 = Year of birth is displayed showing the century and year of the recipient's birth.</p> <p>Example: 1959 will appear as 959.</p> <p>S = Category of assistance, SSI.</p> <p>06 = Month client is due for re-certification. June in example.</p> <p>500 = Valid NYC office code.</p> <p>See table of <a href="#">Valid Office Codes</a> in the "Codes" section of this manual.</p>														
<b>MEDICARE DATA</b>		<p>Identifies Medicare coverage recipient is eligible for.</p> <table border="1" data-bbox="634 1157 1430 1896"> <tbody> <tr> <td data-bbox="634 1157 932 1251">MEDICARE A</td> <td data-bbox="932 1157 1430 1251">A = Recipient has only Part A Medicare (inpatient hospital).</td> </tr> <tr> <td data-bbox="634 1251 932 1346">MEDICARE B</td> <td data-bbox="932 1251 1430 1346">B = Recipient has only Part B Medicare (outpatient).</td> </tr> <tr> <td data-bbox="634 1346 932 1440">MEDICARE AB</td> <td data-bbox="932 1346 1430 1440">AB = Recipient has both Parts A and B Medicare Coverage.</td> </tr> <tr> <td data-bbox="634 1440 932 1556">MEDICARE ABQMB</td> <td data-bbox="932 1440 1430 1556">ABQMB = Recipient has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).</td> </tr> <tr> <td data-bbox="634 1556 932 1682">MEDICARE AQMB</td> <td data-bbox="932 1556 1430 1682">AQMB = Recipient has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).</td> </tr> <tr> <td data-bbox="634 1682 932 1808">MEDICARE BQMB</td> <td data-bbox="932 1682 1430 1808">BQMB = Recipient has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).</td> </tr> <tr> <td data-bbox="634 1808 932 1896">MEDICARE QMB Only</td> <td data-bbox="932 1808 1430 1896">QMB = Recipient is a Qualified Medicare Beneficiary (QMB) Only.</td> </tr> </tbody> </table>	MEDICARE A	A = Recipient has only Part A Medicare (inpatient hospital).	MEDICARE B	B = Recipient has only Part B Medicare (outpatient).	MEDICARE AB	AB = Recipient has both Parts A and B Medicare Coverage.	MEDICARE ABQMB	ABQMB = Recipient has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).	MEDICARE AQMB	AQMB = Recipient has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).	MEDICARE BQMB	BQMB = Recipient has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).	MEDICARE QMB Only	QMB = Recipient is a Qualified Medicare Beneficiary (QMB) Only.
MEDICARE A	A = Recipient has only Part A Medicare (inpatient hospital).															
MEDICARE B	B = Recipient has only Part B Medicare (outpatient).															
MEDICARE AB	AB = Recipient has both Parts A and B Medicare Coverage.															
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MEDICARE AQMB	AQMB = Recipient has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).															
MEDICARE BQMB	BQMB = Recipient has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).															
MEDICARE QMB Only	QMB = Recipient is a Qualified Medicare Beneficiary (QMB) Only.															

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS
MEDICARE DATA (contd).	HIC XXXXXXXXXXXXX	Health Insurance Claim number consisting of up to twelve digits. If a number is not available, the following message will be displayed.
	HIC NOT ON FILE	Health Insurance Claim number is not on file.
THIRD PARTY INSURANCE AND COVERAGE CODES	21 BEJK	Insurance and Coverage Codes equal the insurance carrier and the scope of benefits. You will see a two character insurance code and up to 13 coverage codes or the word all. If you see an insurance code of <b>ZZ</b> call 1-800-343-9000 to obtain additional insurance and coverage information. Refer to your MMIS Provider Manual for insurance codes. See table of valid <a href="#">coverage codes</a> in the "Codes" Section of this manual.
EXCEPTION RESTRICTION CODES	EXCP 35 46 ZZ	If applicable, a recipient's exception and/or restriction code will be displayed. Refer to the <a href="#">Codes Section</a> for the definitions/descriptions.
COPAY DATA	NO COPAY REQD	This message will be returned if the recipient is under 21 or exempt from co-payment and co-payment data has been entered.
	COPAY MET MMDDYY	Recipient has reached his/her co-payment maximum. The date equals the date of inquiry which brought the co-payment over the maximum. You should <u>not</u> collect the co-payment until the next co-payment period.
UTILIZATION THRESHOLD POST AND CLEAR DATA	APRVD NEAR LIMIT	The service authorization has been granted and recorded. The recipient has almost reached his/her service limit. For the convenience of the provider and the recipient, this message also indicates that the patient is using services at a rate that could exhaust his/her limit for that particular service category.
	AT SERVICE LIMIT	The recipient has reached his/her limit for that particular service category. No service authorization is created. The service is <u>NOT</u> approved and payment by Medicaid will <u>NOT</u> be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.

FIELD DATA	RESPONSE	DESCRIPTION/COMMENTS
UTILIZATION THRESHOLD POST AND CLEAR DATA (contd.)	DUP UT AUTH	The service authorization request is a duplicate of a previously approved service authorization request for a given provider, recipient, and date of service.
	PARTIAL APPROVAL NN/XX/XX PC	Indicates that the full complement of requested services relative to Post and Clear processing is <b>NOT</b> available. The <b>NN</b> represents the number of services approved/available. An authorization will be created for that number only.
	PARTIAL APPROVAL NN/XX/XX UT	Indicates that the full complement of requested services relative to Utilization Threshold processing is <b>NOT</b> available. The <b>NN</b> represents the number of services approved/available. An authorization will be created for that number only.
	SERVICE APRVD PC	The ordering provider has posted the service and it has been approved. An authorization will be created.
	SERVICE APRVD UT	The service units requested are approved as the recipient has not utilized their UT service limit. A service authorization will be created.
DVS RESPONSES	Refer to <a href="#">Section 4.7</a> for a list of responses, which may be returned here.	This Response Field will only be returned when a Dispensing Validation System (DVS) transaction has been submitted. If the transaction is approved, a co-pay amount (if applicable) and a DVS# will be returned. If the transaction is rejected, a reject message will be returned. Refer to <a href="#">Section 4.7</a> of this manual.
DATE OF SERVICE	FOR MMDDYY END	This prompt will be displayed when the message is complete and reflects the date for which services were requested. <b>You can repeat the message by pressing the # key.</b> No time limit has been placed on the length of time the verification message will be displayed. You can view the message as long as it is necessary to gather the information displayed.



#### 4.6 VeriFone Error and Denial Responses (Rev. 11/02)

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

<b>RESPONSE</b>	<b>DESCRIPTION/COMMENTS</b>
<b>BAD TX COMMUN</b>	Bad transmission communication exists with the network. Try the transaction again.
<b>CALL 800 3439000</b>	When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
<b>CAN NOT CANCEL</b>	Provider not allowed to cancel the previous authorization. The allowable time to cancel the authorization has passed.
<b>CANCELLED SS/XX/XXUT SS/XX/XXPC</b>	The transaction has been cancelled. SS = The number of units cancelled UT = Utilization Threshold PC = Post and Clear.
<b>CONNECTED</b>	This message is displayed until transmission to the host computer begins.
<b>DECEASED ORDERER</b>	The License Number or eight-digit MMIS Provider Number that was entered in the ordering provider field is in a deceased status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct license type/license number combination and format was entered.
<b>DISQUALIFIED ORDERER</b>	The License Number or eight-digit MMIS Provider Number that was entered in the ordering provider field is in a disqualified status on the Master file and cannot prescribe. Check the number entered. If a license number was entered, make sure the correct license type/license number combination and format was entered.
<b>DOWNLOAD DONE</b>	This message is displayed when the download function process is complete.
<b>DOWNLOAD REQUIRD</b>	The VeriFone software is obsolete and must be updated. This message is displayed once a day until the download is completed.

RESPONSE	DESCRIPTION/COMMENTS
<b>INV PRV SELECTED</b>	<p>A provider number selection was made that is not programmed into the terminal.</p> <p>For example: If your terminal is programmed with three provider numbers and you select the number 4, this message will be returned.</p>
<b>INV REF PRV#</b>	<p>The referring provider ID number was entered incorrectly or is not a valid MMIS provider ID number. A license number can not be entered in this field.</p>
<b>INV SPEC CODE</b>	<p>The specialty code was either entered incorrectly, or not associated with the provider's category of service, or the provider is a clinic and a required specialty was not entered.</p>
<b>INV TERM ACCESS</b>	<p>The received transaction is classified as a Provider Type/Transaction Type Combination that is not allowed to be submitted through the POS VeriFone terminal. Additionally, this message will be returned if a pharmacy submits a DVS transaction for an NDC code through the POS VeriFone terminal because DVS required NDC codes must be submitted through the online NCPDP DUR format. Pharmacies are only allowed to submit DVS transactions through the POS VeriFone terminal for Item/APC codes (five-digit alpha/numeric codes).</p> <p>For example: a Pharmacy can submit an eligibility transaction via the Terminal but cannot submit a Service Authorization Transaction unless exempt from the ProDUR Program.</p>
<b>INV TRANS TYPE</b>	<p>An invalid transaction type other than 1-4 or 6 was entered.</p>
<b>INVALID ACCESS #</b>	<p>An incorrect access number was entered.</p>
<b>INVALID CARD THIS RECIPIENT</b>	<p>Recipient has used an invalid card. Check the number you have entered against the recipient's Common Benefit Identification Card. If they agree, the recipient has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.</p>
<b>INVALID DATE</b>	<p>An illogical date or a date which falls outside the MEVS inquiry period. (Dates up to 24 months retroactive will be supported.)</p>
<b>INVALID LIC TYPE</b>	<p>The License Type entered in the ordering provider field is not a valid value. Refer to the <a href="#">values listed</a> in the ordering provider field in Section 4.4 of this manual.</p>
<b>INVALID MDCAID #</b>	<p>The Medicaid number (CIN) entered is not valid.</p>
<b>INVALID ORDERING PROVIDER</b>	<p>The license number or MMIS Provider ID number that was entered in the ordering provider field was not found on the license or provider files.</p>
<b>INVALID PRV #</b>	<p>An incorrect provider number was entered.</p>

RESPONSE	DESCRIPTION/COMMENTS
<b>INVALID SEQ #</b>	The sequence number entered is not valid or not current. Check the recipient's card for the current sequence number.
<b>LOADING APPLN</b>	This message is displayed if a download function is in process. Please wait for DOWNLOAD DONE response and then press CLEAR.
<b>LOST/STOLEN TERM</b>	The terminal serial ID is indicated as being a lost or stolen terminal. Call 1-800-343-9000 for assistance.
<b>MCCP REC NO AUTH</b>	Services must be provided, ordered or referred by the primary provider. In the referring provider field, enter the MMIS provider number of the primary provider to whom the recipient is restricted.
<b>NO ANSWER</b>	The VeriFone is unable to connect with the network. Repeat the transaction.
<b>NO AUTH FOUND</b>	No matching transaction found for the authorization confirmation transaction or cancellation request.
<b>NO COV:EXCESS</b>	Recipient has income in excess of the allowable levels. All other eligibility requirements have been satisfied. This individual will be considered eligible for Medicaid reimbursable services only at the point his or her excess income is reduced to the appropriate level. The individual may reduce his or her excess income by paying the amount of the excess to the Local Department of Social Services, or by submitting bills for the medical services that are at least equal to the amount of the excess income. Medical services received prior to meeting the excess income amount can be used to reduce the amount of the excess.
<b>NO COVERAGE: PENDING FHP</b>	Recipient is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
<b>NO DEVICE ACCESS</b>	The received Transaction Type is not allowed to be submitted through the POS VeriFone Terminal by any Provider Type.
<b>NO ENQ FROM HOST</b>	No enquiry received from host. A problem exists with the network. Repeat the transaction.
<b>NO PROV ACCESS</b>	The provider is not authorized to access the system using a social security number. The Medicaid Number (CIN) or Access Number must be entered.
<b>NO RESP FRM HOST</b>	No response received from host. A problem exists with the network. Repeat the transaction.
<b>NO UNITS ENTERED</b>	No entry was made and the units are required for this transaction.

RESPONSE	DESCRIPTION/COMMENTS
<b>NOT MA ELIGIBLE</b>	Recipient is not eligible for benefits on the date requested. Contact the recipient's Local Department of Social Services for eligibility discrepancies.
<b>PAYMENT PAST DUE</b>	The terminal serial ID is indicated as having past due payments. Call 1-800-343-9000 for assistance.
<b>PLEASE TRY AGAIN</b>	The card swipe was unsuccessful because you partially swiped the card, the card was damaged, or the equipment malfunctioned. Re-swipe or manually enter the access number.
<b>PRESCRIBING PRV LICENSE INACTIVE</b>	The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.
<b>PROCESSING</b>	This message is displayed until the host message is ready to be displayed.
<b>PRV INELIG SERVC ON DATE PERFORMD</b>	The Category of Service for the provider number submitted in the transaction is inactive or invalid for the entered Date of Service. This message will also be returned if Specialty Codes 760 (Clinic Pharmacy) or 307 (DME) are entered in the transaction and the associated Category of Service is not on file or is invalid for the entered Date of Service.
<b>PRV NOT ELIG</b>	The verification was attempted by an inactivated or disqualified provider.
<b>PRV NOT ON FILE</b>	The provider number entered is not identified as a Medicaid enrolled provider. Either the number is incorrect or not on the provider master file.
<b>RCIP NOT ON FILE</b>	Recipient identification number (CIN) is not on file. The number is either incorrect or the recipient is no longer eligible and the number is no longer on file.
<b>RECEIVING</b>	This message is displayed until the host message is received by the VeriFone.
<b>REENTER COPAY</b>	An invalid COPAY TYPE code (any alpha character other than A-I or X) was entered or an invalid numeric UNT (blank or 0 with codes A-I) was entered. Refer to the <a href="#">Co-payment Type Codes</a> in the "Codes" section of the manual.
<b>REENTER ORD PRV</b>	The license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
<b>RST RECP NO AUTH</b>	This recipient is restricted to services from a specific provider. In the referring provider field, enter the MMIS provider number of the primary provider to whom the recipient is restricted.

RESPONSE	DESCRIPTION/COMMENTS
<b>RETRY TRANS</b>	After a successful Transaction has been completed, this message will be received during the Review Function if an invalid sequence of keys is pressed or an Access Number is entered which differs in length from the original number.
<b>SRVC NOT ORDERED</b>	The ordering provider did not post the services you are trying to clear. Contact the ordering provider.
<b>SSN ACCESS NOT ALLOWED</b>	The provider is not authorized to access the system using a social security number. The Medicaid Number (CIN) or Access Number must be entered.
<b>SSN NOT ON FILE</b>	The entered nine-digit number is not on the Recipient Master File.
<b>SYS ERROR XXX</b>	A network problem exists. Call Provider Services at 1-800-343-9000 with the error number.
<b>TRANSMITTING</b>	This message is displayed until the host computer acknowledges the transmission.
<b>UNREADABLE CARD</b>	Will be displayed after three unsuccessful attempts to swipe the card.
<b>WAITING FOR ANSR</b>	This message is displayed until connection is made with the network.
<b>WAITING FOR LINE</b>	The VeriFone terminal is not plugged in or the terminal is on the same line as a telephone which is off the hook or in use.

#### 4.7 Dispensing Validation System Responses (Rev. 11/02)

The responses listed in this section will only be returned when a DVS transaction (Tran Type 6) is submitted. Please note that most of the responses are reject messages and require the transaction to be resubmitted.

RESPONSE	DESCRIPTION/COMMENTS
<b>AGE EXCEEDS MAX</b>	The recipient's age exceeds the maximum allowable age on the NYS Drug Plan file for the item/NDC code entered.
<b>AGE PRECEDES MIN</b>	The recipient's age is below the minimum allowable age on the NYS Drug Plan file for the item/NDC code entered.
<b>COPAY \$ _ _ _ _ _</b>	The amount returned is the co-payment amount for the item submitted taken from the NYS Drug Plan file. If the recipient is not exempt and has not met their co-payment maximum, the amount will be added to the recipient's copay file for Cap calculation. The copay amount will only be returned when applicable.
<b>COS/ITEM INVALID</b>	The entered category of service is not a reimbursable COS on the NYS formulary file for the item/NDC code entered.
<b>CURRENT DATE REQ</b>	A DVS transaction requires a current date entry. The date entered was NOT today's date.
<b>DUPLICATE DVS</b>	The entered transaction is a duplicate of a previously submitted and approved DVS transaction.
<b>DVS # _ _ _ _ _</b>	The DVS transaction is approved. The eight-digit DVS number returned in the response must be entered on your paper/magnetic media claim form when submitted for payment. Pharmacy providers who obtain the DVS number via the VeriFone must enter the DVS number in the NCPDP PA/MC Code Field (416), if submitting the claim through the online NCPDP ECCA process.
<b>DVS NOT INVOKED</b>	The transaction has not been processed through the Dispensing Validation System. If further clarification is required, call (800) 343-9000.
<b>DVS NOT REQUIRED</b>	The entered item/NDC code was not designated by the Dept. of Health to receive a DVS number through MEVS.
<b>EXCEEDS FREQ LMT</b>	The recipient has already received the allowable quantity limit of the item/NDC code entered in the time frame resident on the NYS Drug Plan file or the quantity you requested will exceed that limit.
<b>FHP DENIAL</b>	The recipient is enrolled in the Family Health Plus Program (FHP) and receives all services through a FHP participating Managed Care Plan. The Medicaid program does not reimburse for any service that is excluded from the benefit package of the FHP Managed Care Plan.

RESPONSE	DESCRIPTION/COMMENTS
<b>ITEM/GENDER INV</b>	The item/NDC code entered is not reimbursable for the recipient's gender resident on the eligibility file.
<b>ITEM NOT COVERED</b>	The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.
<b>M/I COS</b>	The entered Category of Service is invalid or missing or is not on the provider's file. COS is required for a DVS request. The number must be four-digits in length.
<b>M/I DVS QUANTITY</b>	The entered quantity's format is invalid or missing and is required.
<b>M/I ITEM CODE</b>	The Item/NDC code entered was either an invalid format or missing and is required. Item code format is one alpha character followed by four numeric digits. The NDC code format is eleven numeric digits. Refer to page 4.4.5 for the correct format of a <a href="#">dental procedure code</a> .
<b>M/I TOOTH/QUAD</b>	The tooth number, tooth quadrant, or arch was not entered and is required, or was entered incorrectly.
<b>MAX QTY EXCEEDED</b>	The quantity entered exceeds the maximum allowable quantity resident on the NYS Drug Plan file. Make sure the quantity entered is for the current date of service only. (no refills).
<b>PROC CD NOT COV</b>	The procedure code entered was either entered incorrectly or is not a NYS reimbursable code, or has been discontinued.

#### 4.8 VeriFone Download Procedure (Rev. 11/02)

A download function is performed when MEVS needs to update information in your terminal. The download procedure is a simple transaction requiring minimal effort and time. The terminal will display one of the following messages: **DOWNLOAD REQUIRED, NO MERCHANT ID, INV PROV #, PROGRAMMING ERROR 0 (ZERO)**. These messages serve as a reminder to you that new information needs to be entered by MEVS. If your terminal displays one of the first three messages stated above, perform the download transaction steps listed below. If you receive the **PROGRAMMING ERROR 0** message, call Provider Services at 1-800-343-9000 for special assistance.

#### DOWNLOAD INSTRUCTIONS

DISPLAY	STEPS/COMMENTS
	Press the <b>CLEAR</b> key.
	Press the <b>FUNC/ENTER</b> key.
<b>FUNCTION?</b>	Press the <b>0</b> (zero) key.
<b>DOWNLOAD?</b>	Press the <b>FUNC/ENTER</b> key.
<b>DIALING</b>	Wait. The terminal is dialing the download computer. If the terminal displays <b>WAITING FOR LINE</b> , check the telephone connection. If the cord is properly connected, the line may be busy. Press the <b>CLEAR</b> key to abandon the call, or wait until the line is free.
<b>WAITING FOR ANSWER</b>	Wait. The terminal is waiting for the download computer to answer.
<b>COMMUNICATING</b>	Wait. The download computer is sending the requested data to your terminal.
<b>LOADING APPLN</b>	Wait for approximately 5 - 7 minutes for the new application to update your terminal.
<b>DOWNLOAD DONE</b>	The terminal has successfully completed the download. Press the <b>CLEAR</b> key to return to the day, date and time display.  This response must be displayed before continuing. Entering any information before <b>DOWNLOAD DONE</b> is displayed will terminate this procedure.



If one of the messages listed below is displayed prior to **LOADING APPLN** or **DOWNLOAD DONE**, call Provider Services at 1-800-343-9000.

DISPLAY	STEPS/COMMENTS
LOST CARRIER	Call Provider Services at 1-800-343-9000
NO RESP FROM HOST	
HOST SENT EOT	
CANNOT CONNECT	
DOWNLOAD ERR XXX	
INV TERM ACCESS	
NO ENQ FROM HOST	

## 5.0 **ALTERNATE ACCESS TO MEVS** (Rev. 11/02)

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

- **CPU-CPU LINK**

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

CPU-CPU link is suggested for service bureaus and high volume (2,000 or more transactions per month) providers.

- **PC-HOST LINK**

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

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

PC based software for providers to use is available through the MEVS contractor.

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

**6.0 CODES SECTION** (Rev. 11/02)**6.1 Co-payment Type Codes** (Rev. 11/02)

Codes used to designate the type of co-payment service you are rendering. Select the alpha code which corresponds to the type of service being rendered. These codes are the only valid codes to be entered in the co-payment type field. Telephone (ARU) users must enter the alpha converted number (right column). VeriFone terminal and Alternate Access Users must enter the alpha code (left column).

<b>CODES</b>	<b>DESCRIPTION</b>	<b>ALPHA CONVERTED NUMBER</b>
A	Inpatient Hospital	21
B	Emergency Room - non-emergency, non-urgent	22
C	Clinic	23
D	Prescription Drugs - brand name	31
E	Prescription Drugs - generic	32
F	Non-prescription Drugs (OTC)	33
G	Sickroom Supplies	41
H	Laboratory	42
I	X-Ray	43
X	No Co-pay	92

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**6.2 County/District Codes** (Rev. 11/02)

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

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

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### 6.3 Exception Codes (Rev. 11/02)

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

- Code 30 This code identifies a recipient who is to receive Long Term Home Health Care (LTHHC) Services from a designated primary provider. This recipient is not eligible to receive Personal Care Services (PCS) and/or Home Health (HH) from other than the designated primary provider. All other Medicaid covered services are subject to Utilization Threshold and Co-payment requirements.
- Code 35 This recipient is enrolled in a Comprehensive Medicaid Case Management (CMCM) program and is exempt from Co-payment and Utilization Threshold processing. The recipient's participation in CMCM does not affect eligibility for other Medicaid services.
- Code 38 The recipient is resident in an ICF-DD facility. As such, the individual is exempt from Co-payment and Utilization Threshold requirements and may be eligible for some fee-for-service Medicaid coverage. You should contact the ICF-DD to find out if the service is included in their per diem rate. If it is not, the claim can be submitted to the NYS Medicaid Program.
- Code 39 This code identifies a recipient in the Aid Continuing program. As such, the recipient is subject to Utilization Threshold and exempt from Co-payment requirements.
- Code 46 This code identifies a recipient in a Home and Community Based Services (HCBS) Waiver who resides in Family Care (FC) or at Home. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
- Code 47 This code identifies a recipient in a Home and Community Based Service (HCBS) Waiver who resides in a Community Residence (CR) and participates in a Subchapter A Program. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
- Code 48 This code identifies a recipient in a Home and Community Based Service (HCBS) Waiver who resides in Community Residence (CR). As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
- Code 49 This code identifies a recipient in the Home and Community Based Services (HCBS) who resides in an Individual Residential Alternative (IRA) and is authorized to receive IRA residential habilitation services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.

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Code 50	This recipient has Connect services, plus is eligible for the service package available to all individuals with Perinatal Family. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements. For a Definition of <a href="#">Perinatal Family</a> , see the section on Eligibility Responses.
Code 51	This recipient has Connect services, plus is eligible for the services described in the Eligibility Response associated with the recipient. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements. For the range of possibilities, see the section on <a href="#">Eligibility Responses</a> .
Code 54	This code designates a recipient whose outpatient Medicaid coverage is limited to Home Health and Personal Care Services benefits. As such, the recipient is subject to Utilization Threshold and Co-payment requirements.
Code 62	This code identifies a recipient in the Care At Home I program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 63	This code identifies a recipient in the Care At Home II program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 64	This code identifies a recipient in the Care At Home III program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 65	This code identifies a recipient in the Care At Home IV program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 66	This code identifies a recipient in the Care At Home V program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 67	This code identifies a recipient in the Care At Home VI program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 68	This code identifies a recipient in the Care At Home VII program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 69	This code identifies a recipient in the Care At Home VIII program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.

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Code 70	This code identifies a recipient in the Care At Home IX program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 71	This code identifies a recipient in the Care At Home X program. As such this individual is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 81	This code identifies a recipient in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI). As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 83	This code identifies a recipient who has been mandated by the local social services district to receive certain alcohol and substance abuse services as a condition of eligibility for public assistance or Medicaid as a result of welfare reform requirements. For managed care enrollees, the presence of this code allows certain substance abuse services to be paid on a fee for service basis. The code may be used to trigger prior approval requirements.
Code NH	This code identifies a recipient in a Nursing Home facility. The majority of the recipient's care is provided by the Nursing Home and is included in their Medicaid per diem rate. If you provide a service to a NH recipient, you must contact the Nursing Home to find out if the service is included in their rate. If it is not, the claim can be submitted to the NYS Medicaid Program.
Code CC	This code identifies a recipient in a Child Care program facility. As such this individual has all of their care provided for by the Child Care facility provider on a per-diem basis. Any Medicaid services provided to the recipient by any other provider than the designated facility provider are not reimbursable.
Code ZZ	This code indicates that more Exception codes are applicable than can be displayed. Call 1-800-343-9000 to obtain additional Exception code information.

#### 6.4 Insurance Codes (Rev. 11/02)

Insurance codes are two character codes which, if returned in the MEVS response, identifies the recipient's insurance carrier. Refer to the billing section of your MMIS Provider Manual for a list of codes and descriptions.

#### Insurance Coverage Codes

These codes identify which services are covered by the recipient's insurance carrier.

<u>COVERAGE CODES</u>	<u>DESCRIPTION</u>	<u>EXPLANATION</u>
A	Inpatient Hospital	All inpatient services are covered except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory.
D	Clinic	Both hospital based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory.
F	Psychiatric Outpatient	Self-Explanatory.
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self-Explanatory.
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you <b>may not</b> request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a major medical policy.



<b><u>COVERAGE CODES</u></b>	<b><u>DESCRIPTION</u></b>	<b><u>EXPLANATION</u></b>
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory.
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory.
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare which require a coinsurance or deductible payment should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Svcs.	All substance abuse services, regardless of where they are provided are covered.
W	Substance Abuse Outpatient	Self-Explanatory.
X	Substance Abuse Inpatient	Self-Explanatory.
Y	Durable Medical Equipment	Self-Explanatory.
Z	Optical	Self-Explanatory.
All	All of the above	All services listed in coverage codes A-Z are covered by the recipient's insurance carrier.

## 6.5 New York City Office Codes (Rev. 11/02)

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

### Public Assistance

#### Manhattan

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

#### Bronx

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

#### Queens

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

#### Brooklyn

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

#### Staten Island

099	Richmond
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### Medical Assistance

500-593	34 <sup>th</sup> Street Manhattan
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**Special Services for Children (SSC)**

DOP Division of Placement  
OPA Office of Placement and Accountability

**Field Offices**

071 Bronx  
072 Brooklyn  
073 Manhattan  
074 Queens  
075 Staten Island

**Office of Direct Child Care Services**

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

**PCP Plan Codes**

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