

STATE OF NEW YORK
DEPARTMENT OF HEALTH



eMedNY
MEVS Provider Manual
NPI Edition

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1.0 INTRODUCTION TO THE NEW YORK STATE MEDICAID ELIGIBILITY VERIFICATION SYSTEM (Rev. 10/03)

New York State operates a Medicaid Eligibility Verification System (MEVS) as a method for providers to verify client eligibility prior to provision of Medicaid services. The Identification Card does not constitute full authorization for provision of medical services and supplies. A client 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 client'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, PC-Host link and ePACES).

Information available through MEVS will provide you with:

- The eligibility status for a Medicaid client for a specific date (today or prior to today).
- The county having financial responsibility for the client (used to determine the contact office for prior approval and prior authorization.)
- Any Medicare, third party insurance or HMO coverage that a client may have for the date of service.
- Any limitations on coverage which may exist for the client 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 client'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 client.

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 clients 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.

ALTERNATE ACCESS TO MEVS (Rev. 02/05)

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.

- **ePACES**

Refer to ePACES on <http://www.emedny.org/HIPAA/SupportDocs/ePACES.html>

- **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 (5,000 to 10,000 transactions per day) providers.

- **eMedNY eXchange**

This method allows users to transfer files from their computer via a web-based interface. Users are assigned an "inbox" and are able to send and receive transaction files in an email-like fashion. Transaction files are "attached" and sent to eMedNY for processing. Responses are delivered to the user's inbox, and can be downloaded to the user's computer.

- **Batch Transmission**

This method is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer (upload) or from another computer to their computer (download). Each batch file transmission sent to the eMedNY contractor is required to be completed within two hours. Any transmission exceeding two hours will be disconnected.

- **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.

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

1.1 **National Provider Identifier (NPI)** (Rev. 3/09)

As per the Administrative Simplification provision (Standard for Unique Health Identifier for Health Care Providers), of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the National Provider Identifier (NPI) was adopted as the standard (unique health identifier) for health care providers for use in the health care system.

The New York State Department of Health (NYSDOH) implemented the NPI system changes on September 1, 2008. Temporarily, NYS Medicaid Provider ID's and license numbers will continue to be accepted for processing in addition to the NPI.

NYSDOH will notify the Provider community when we will no longer accept Proprietary Identifiers from Providers that require an NPI (excludes atypical providers).

2.0 **BENEFIT IDENTIFICATION CARDS/FORMS** (Rev. 10/05)

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 client 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 client 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.

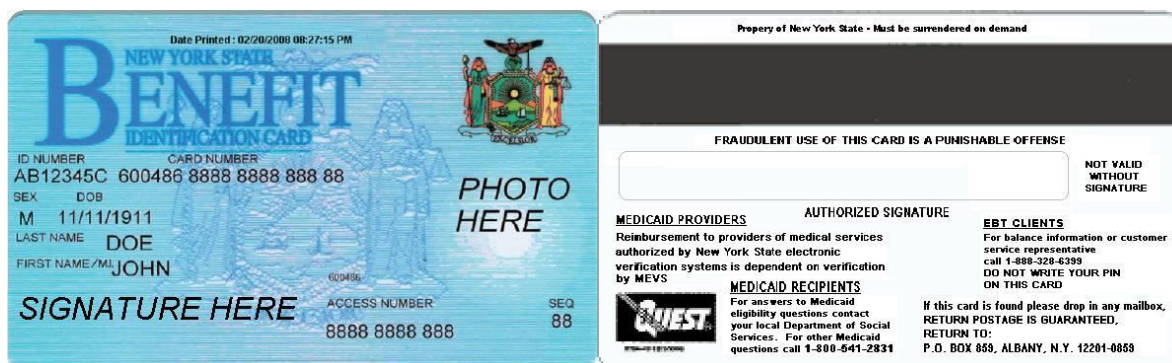
Temporary Medicaid Authorization Form

In some circumstances, the client 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 client has an immediate medical need and a permanent plastic card has not been received by the client. 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 client 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 client 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 client eligibility, please contact the New York State Department of Health, Office of Health Insurance Programs, Local District Support. The phone number for inquiries on TMA issues for clients residing Upstate is (518)-474-8887. For New York City client TMA issues, the number is (212) 417-4500.

2.1 Permanent Common Benefit Identification Photo Card (Rev. 06/09)

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

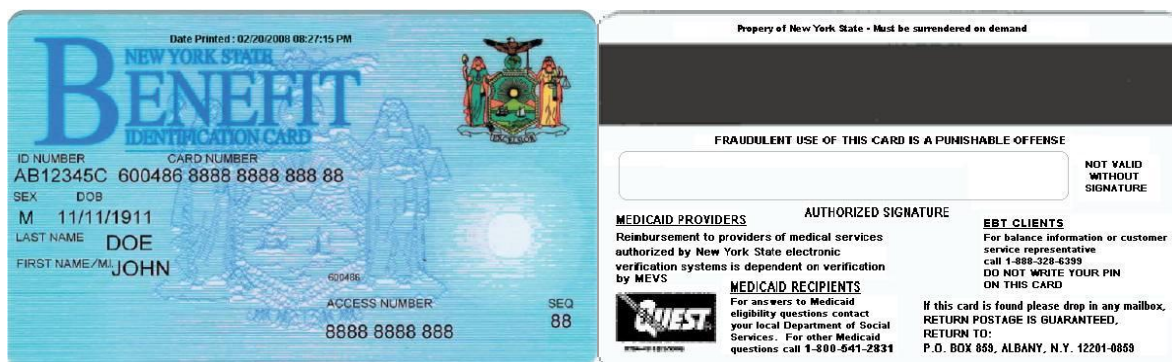


COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
ID Number	Eight-digit number assigned by the State of New York which identifies each individual Medicaid client. This number contains both alpha and numeric digits. <u>This is the Client Identification Number (CIN) to be used for billing purposes.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

COMMON BENEFIT IDENTIFICATION PHOTO CARD DESCRIPTION	
Access Number	Thirteen-digit number (including the 2 digit sequence 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.
Date Printed	<p>Located at top of the Benefit Card. This information may be used, by the Medicaid client, to help identify the most recent benefit card that was issued. <i>Hint: Always use the Card with the most recent date/time stamp.</i></p> <p>Date Printed Format: MM/DD/CCYY HH:MM:SS (AM/PM)</p>

2.2 Permanent Common Benefit Identification Non-Photo Card (Rev. 06/09)

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

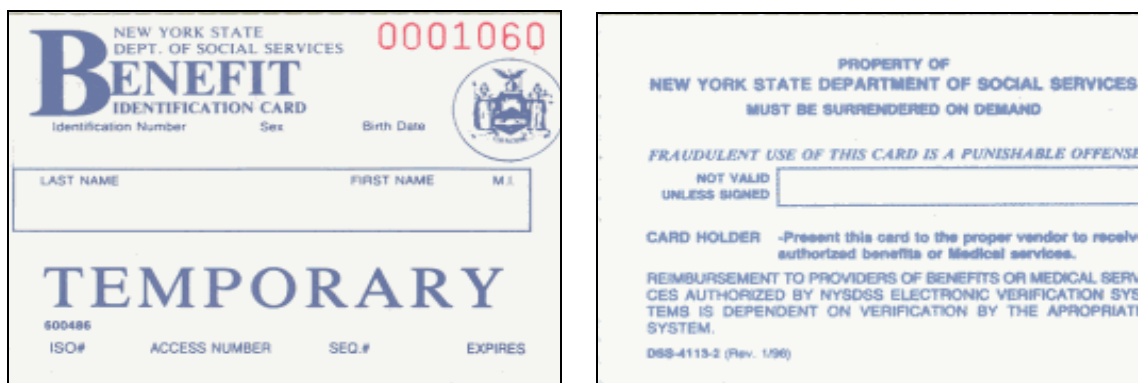


COMMON BENEFIT IDENTIFICATION NON-PHOTO CARD DESCRIPTION	
ID Number	Eight-digit number assigned by the State of New York, which identifies each individual client. <u>This is the Client Identification Number (CIN) to be used for billing purposes. Client ID # must be two alpha, five numeric and one alpha.</u>
Sex	One letter character indicating the sex of the client. This character is located on the same line as date of birth. M = Male F = Female U = Unborn (Infant)
Date of Birth	Client's date of birth, presented in MM/DD/YY 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 client who will use this card for services.
First Name/ 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 (including the 2 digit sequence number) used for entry into the Medicaid Eligibility Verification System. The access number is <u>not</u> used for billing.

COMMON BENEFIT IDENTIFICATION NON-PHOTO CARD DESCRIPTION	
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.
Date Printed	Located at top of the Benefit Card. This information may be used, by the Medicaid client, to help identify the most recent benefit card that was issued. <i>Hint: Always use the Card with the most recent date/time stamp.</i> Date Printed Format: MM/DD/CCYY HH:MM:SS (AM/PM)

2.3 Replacement Common Benefit Identification Card (Rev. 10/03)

The Replacement Common Benefit Identification Card is a temporary paper card issued by the Local Department of Social Services to a client. 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 client. <u>This is the Client Identification Number (CIN) to be used for billing purposes. Client ID # must be two alpha, five numeric and one alpha.</u>
Sex	One letter character indicating the sex of the client. This character is located on the same line as date of birth. M = Male F = Female U = Unborn (Infant)
Date of Birth	Client's date of birth, presented in MM/DD/YY format. Example: August 15, 1980 is shown as 08/15/1980. Unborns (Infants) are identified by 00000000.
Name	Name of the client 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 (including the 2 digit sequence number) used for entry into the Medicaid Eligibility Verification System. The access number is <u>not</u> used for billing.

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 client'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. 10/03)

Verification requests for client 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 50 transactions per month). For convenience, providers with higher volumes should use the VeriFone Terminal or refer to [Alternate Access to MEVS](#) on page [1.0.2](#).

Access to the Telephone Verification System (Rev. 02/05)

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 wish to be transferred directly to an eMedNY Provider Services Representative, you may press "0" on the telephone keypad at any time during the first four prompts.

The following message will be heard:

"The ARU Zero Out Option"

You will then be connected to the eMedNY Provider Services Helpdesk.

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 Audio Response Unit (ARU). 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. 10/03)

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 client'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.

3.3 Telephone Verification Input Section (Rev. 06/09)

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.
 - To be transferred to an eMedNY Provider Services Representative, press “0” on the telephone keypad at any time during the first four prompts. The following message will be heard: “The ARU Zero Out Option”. You will then be transferred to the eMedNY Provider Services Helpdesk.
 - If you will be entering co-payment information, be sure to convert the alpha co-payment type to a number, prior to dialing. Refer to Section 13.1 on page [13.0.1](#) for [Co-payment Type codes](#).
 - The following types of transactions cannot 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"> 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 & C)</u> and <u>Utilization Threshold (UT)</u>. Co-payment entries may also be made using this transaction type. 2 To request Eligibility Information only. This may also be used to determine if ordered/prescribed services are available for the client under the UT program. Co-payment entries can also be made using this transaction type.
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 ten-digit National Provider Identifier (NPI) and press #. For atypical providers enter the eight-digit MMIS provider identification number assigned at the time of enrollment in the NYS Medicaid Program and press #.

VOICE PROMPT	ACTION/INPUT
ENTER SPECIALTY CODE	<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>
ENTER REFERRING PROVIDER NUMBER	<p>Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the ten-digit National Provider Identifier (NPI) or the eight-digit MMIS provider number of the primary provider and press #. If a client 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 client is not a referral, press the # key to bypass this prompt.</p>
ENTER FIRST CO-PAYMENT TYPE	<p>Enter the alpha converted co-payment type. Refer to Section 13.1 on page 13.0.1 for Co-payment Type codes.</p> <p>If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, bypass all the co-payment prompts by pressing #.</p>
ENTER CO-PAYMENT UNITS	<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>
ENTER SECOND CO-PAYMENT TYPE	<p>Enter the alpha converted co-payment type for the second co-payment and press #.</p>
ENTER CO-PAYMENT UNITS	<p>Enter the number of units being rendered. Only a one or a two-digit numeric entry is acceptable. Press #.</p>
ENTER THIRD CO-PAYMENT TYPE	<p>Enter the alpha converted co-payment type for the third co-payment and press #.</p>

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

VOICE PROMPT	ACTION/INPUT												
<p>ENTER ORDERING PROVIDER NUMBER</p>	<p>Enter the ten-digit National Provider Identifier (NPI) and press #.</p> <p>For atypical providers enter the eight-digit MMIS Provider ID 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 (for atypical providers ONLY), you may enter the profession code and license number. If entering a license number for New York State providers, after entering a profession code, enter two zeros and the six-digit license number. If entering out of state license numbers, after entering the profession code, enter the two character converted alpha state code (see page 3.2.1), 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 profession code 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 profession code, convert the alpha character to a number (see page 3.2.1) and enter that number followed by the actual license number.</p> <p style="text-align: center;">Examples</p> <table data-bbox="808 1226 1364 1409"> <tbody> <tr> <td>National Provider ID (NPI)</td> <td>0123456789</td> </tr> <tr> <td>MMIS Provider ID</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>06000987654</td> </tr> <tr> <td>Out of State License #</td> <td>0606251345678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>04233421212</td> </tr> <tr> <td>NYS Optometrist #</td> <td>05683452749</td> </tr> </tbody> </table> <p>Press # to bypass this prompt if you are not a dispensing provider.</p>	National Provider ID (NPI)	0123456789	MMIS Provider ID	01234567	New York State License #	06000987654	Out of State License #	0606251345678	Nurse Practitioner #	04233421212	NYS Optometrist #	05683452749
National Provider ID (NPI)	0123456789												
MMIS Provider ID	01234567												
New York State License #	06000987654												
Out of State License #	0606251345678												
Nurse Practitioner #	04233421212												
NYS Optometrist #	05683452749												
<p>NOTE: When entering a profession code 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: 05683000867 (Profession Code + V + Zero fill + License Number).</p>													

**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. 06/09)

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 client's eight-digit Medicaid CIN.
COUNTY CODE	COUNTY CODE XX	The two-digit code which indicates the client's county of fiscal responsibility. Refer to Section 13.4 on page 13.4.1 for county codes .
CLIENT'S MEDICAID COVERAGE	COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Client is eligible to receive most Medicaid services. Client is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Client is not eligible for managed long-term care in a SNF, hospice in a SNF or intermediate care facility services. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
<p>CLIENT'S MEDICAID COVERAGE (contd.)</p>	<p>COMMUNITY COVERAGE WITHOUT LONG TERM CARE</p>	<p>Client is eligible for acute inpatient care, care in a psychiatric center, some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency services except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting, intermediate care facility services, residential treatment facility services and services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.</p> <p>Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	<p>ELIGIBLE CAPITATION GUARANTEE</p>	<p>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. Clients 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.</p>

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	ELIGIBLE EXCEPT NURSING FACILITY SERVICES	Client is eligible to receive all Medicaid services except nursing home services provided in an SNF or inpatient setting. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
	ELIGIBLE ONLY FAMILY PLANNING SERVICES	The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% of the federal poverty level. Eligible recipients (males and females) have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.
	ELIGIBLE ONLY OUTPATIENT CARE	Client 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 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.
CLIENT'S MEDICAID COVERAGE (contd.)	EMERGENCY SERVICES ONLY	Client 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.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
	FAMILY HEALTH PLUS	Client is enrolled in the Family Health Plus Program (FHP) and receives most services through a FHP participating Managed Care Plan.
	MEDICAID ELIGIBLE	Client is eligible for all benefits.
	MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Client 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.
	MEDICARE COINSURANCE AND DEDUCTIBLE ONLY	Client is eligible for payment of Medicare coinsurance and deductible only. Deductible and coinsurance payments will be made for Medicare approved services only.
	OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Client is eligible for most ambulatory care, including prosthetics, and one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Client is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	<p>Client is eligible for some ambulatory care, including prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services. Client is not eligible for inpatient coverage other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.</p> <p>Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	<p>Client is eligible for all ambulatory care, including prosthetics. Client is not eligible for inpatient coverage.</p> <p>Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	PERINATAL FAMILY	<p>Client 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.</p>

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
CLIENT'S MEDICAID COVERAGE (contd.)	PRESUMPTIVE ELIGIBLE LONG-TERM/HOSPICE	Client 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	Client 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	Client 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.
ANNIVERSARY MONTH	ANNIVERSARY MONTH OCTOBER	This is the beginning month of the client's benefit year.
CATEGORY OF ASSISTANCE	CATEGORY OF ASSISTANCE "S"	The code S signifies that the client is enrolled in the SSI assistance program.
MEDICARE DATA	Identifies the Medicare coverage for which the client is eligible, for the date of service entered.	
	MEDICARE PART A	Client has only Part A Medicare (inpatient hospital).
	MEDICARE PART B	Client has only Part B Medicare (outpatient).
	MEDICARE PARTS A and B	Client has both Parts A and B Medicare Coverage.
	MEDICARE PARTS A & B & QMB	Client has Part A and B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART A & QMB	Client has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART B & QMB	Client has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
MEDICARE DATA (contd.)	MEDICARE QMB Only	Client is a Qualified Medicare Beneficiary (QMB) Only.
	MEDICARE PART D	Client has only Part D Medicare coverage (prescription drugs).
	MEDICARE PARTS A & D	Client has both Part A and Part D Medicare coverage (inpatient hospital and prescription drugs).
	MEDICARE PARTS B & D	Client has both Part B and Part D Medicare coverage (outpatient and prescription drugs).
	MEDICARE PARTS A & B & D	Client has Part A and Part B and Part D Medicare coverage (inpatient hospital, outpatient and prescription drugs).
	MEDICARE PARTS A & B & D & QMB	Client has Part A and Part B and Part D Medicare coverage (inpatient hospital, outpatient and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PARTS A & D & QMB	Client has Part A and Part D Medicare coverage (inpatient hospital and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PARTS B & D & QMB	Client has Part B and Part D Medicare coverage (outpatient and prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	MEDICARE PART D & QMB	Client has Part D Medicare coverage (prescription drugs) and is a Qualified Medicare Beneficiary (QMB).
	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.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
THIRD PARTY INSURANCE AND COVERAGE CODES	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. Refer to Section 13.6 on page 13.6.1 , for the Codes Section for definitions/descriptions.
EXCEPTION RESTRICTION CODES	EXCEPTION CODE 35	If applicable, a client's exception and/or restriction code will be returned. Refer to Section 13.5 on page 13.5.1 , for the Exception Codes for the definitions/descriptions.
CO-PAY DATA	NO CO-PAYMENT REQUIRED	This message will be heard if the client is under 21 or exempt from co-payment and co-payment data has been entered.
	CO-PAYMENT REQUIREMENTS MET ON MM/DD/YY	Client 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.
UTILIZATION THRESHOLD POST AND CLEAR DATA	AT SERVICE LIMIT	The client has reached his/her limit for that particular service category. No service authorization is created. The service is not approved and payment by Medicaid will not be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.
UTILIZATION THRESHOLD POST AND CLEAR DATA (contd.)	DUPLICATE - UT PREVIOUSLY APPROVED	The service authorization request is a duplicate of a previously approved service authorization request for a given provider, client, 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 XX represents the number of services approved/available.

MESSAGE SEQUENCE	RESPONSE	DESCRIPTION/COMMENTS
	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 XX 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 client has almost reached his/her service limit. For the convenience of the provider and the client, 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 client 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 all providers who are designated card swipers, except pharmacy, for Tran 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. You can repeat the message one time by pressing the * key.

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. 06/08)

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
CALL 800-343-9000	When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
DECEASED ORDERING PROVIDER	The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
DISQUALIFIED ORDERING PROVIDER	The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
EXCESSIVE ERRORS, REFER TO MEVS MANUAL OR CALL 800-343-9000 FOR ASSISTANCE	Too many invalid entries have been made during the transaction. Refer to Section 3.3 on page 3.3.1 for the input data section , or call 800-343-9000 .
INVALID ACCESS METHOD	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.
INVALID ACCESS NUMBER	An invalid access number was entered. Check the number and retry the transaction.

RESPONSE	DESCRIPTION/COMMENTS
INVALID CARD THIS RECIPIENT	Client has used an invalid card. Check the number you have entered against the client's Common Benefit Identification Card. If they agree, the client has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.
INVALID CO-PAYMENT	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.
INVALID CO-PAYMENT, REFER TO MEVS MANUAL	The Data entered is not a valid co-payment value. Refer to Section 13.0 on page 13.0.1 for the Codes Section .
INVALID DATE	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.
INVALID ENTRY	An invalid number of digits was entered for service units. Service units must be one or two-digits.
INVALID IDENTIFICATION NUMBER	The client identification number entered was an incorrect length, or an invalid alpha converted number was entered.
INVALID PROFESSION CODE	The Profession Code entered in the ordering provider field is not a valid value. Refer to the eMedNY website at http://www.emedny.org for a list of valid Profession Codes.
INVALID MEDICAID NUMBER	An invalid CIN was entered. Refer to the alpha conversion chart on page 3.2.1 in the beginning of this manual. Verify that the CIN was correctly converted to an eleven-digit number.
INVALID MENU OPTION	An invalid entry was made when selecting the identifier type. The entry must be 1 (alphanumeric identifier) or 2 (numeric identifier).
INVALID ORDERING PROVIDER NUMBER	The National Provider Identifier (NPI), license number or MMIS Provider ID number that was entered in the ordering provider field was not found on the license or provider files.
INVALID PROVIDER NUMBER	The National Provider Identifier (NPI) entered is invalid, or for atypical providers, the MMIS provider ID entered is an invalid eight-digit number.

RESPONSE	DESCRIPTION/COMMENTS
INVALID REFERRING PROVIDER NUMBER	The referring provider NPI or the eight-digit MMIS provider ID was entered incorrectly or is not a valid. A license number cannot be entered in this field.
INVALID SEQUENCE NUMBER	The sequence number entered is not valid or not current. Check the client's card for the current sequence number.
INVALID SPECIALTY CODE	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.
MCCP RECIPIENT NO AUTHORIZATION	Services must be provided, ordered, or referred by the primary provider. Enter the ten-digit NPI or the eight-digit MMIS Provider ID of the primary provider to whom the client is restricted.
NO COVERAGE EXCESS INCOME	Client 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.
NO COVERAGE PENDING FAMILY HEALTH PLUS	Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
NO SERVICE UNITS ENTERED	No entry was made and the units are required for this transaction.
NOT MEDICAID ELIGIBLE	Client is not eligible for benefits on the date requested. Contact the client's Local Department of Social Services for eligibility discrepancies.
PRESCRIBING PROVIDER LICENSE NOT IN ACTIVE STATUS	The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.

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

4.0 **INTRODUCTION TO THE VERIFONE OMNI 3750 MEVS TERMINAL** (Rev. 10/03)

The VeriFone terminal is designed to provide an accurate and timely verification of a client's eligibility for Medicaid services. Specific features and conveniences, such as a large LCD screen, ATM style buttons and a built in printer, make the verification process easy to learn and use with a minimum of training time.

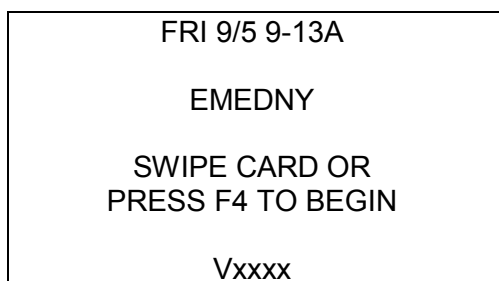
Multiple provider identification numbers can be programmed into the VeriFone terminal in the Provider Menu. When programmed, the two-digit shortcut code assigned to that Provider can be selected, instead of entering the Provider ID number. Refer to Section 7.3 on page [7.3.1](#) for [Instructions for Provider Menu](#) or call 1-800-343-9000 for assistance in adding multiple provider numbers to your terminal.

The Quick Start ([Refer to Section 5.0](#) on page [5.0.1](#)) is a quick and easy way to install the VeriFone Omni 3750 terminal. For step-by-step instructions use the VeriFone Installation Instructions ([Refer to Section 7.0](#) on page [7.0.1](#)).

Initial Screen

When the VeriFone Omni 3750 terminal is not actively being used, the device normally shows its "initial screen" (see below). This screen is referenced often in this manual. To get to this screen in most circumstances, press the red cancel key.

Initial screen example:



```
FRI 9/5 9-13A  
EMEDNY  
SWIPE CARD OR  
PRESS F4 TO BEGIN  
Vxxxx
```

The "xxxx" in "Vxxxx" on the bottom line is the software version the terminal is using. This number may be needed when calling provider services for assistance.

5.0 **QUICK START** (Rev. 10/03)

The Quick Start is an easy way to setup up the VeriFone Omni 3750 terminal. For a full and detailed description of the terminal refer to Section 6.0 on page [6.0.1](#) for the [VeriFone Omni 3750 Terminal](#).

1. Select a location that has access to a power outlet and a telephone line for your terminal. Open the box and unpack the terminal. (Refer to Section 7.0 on page [7.0.1](#) for the [VeriFone Installation Instructions](#) for step-by-step instructions).
2. Connect the telephone line cord into the telephone jack labeled 'H S'. Connect the other end into the wall jack. (Refer to Section 6.2 on page [6.0.3](#) for the [VeriFone Omni 3750 Terminal – Back](#)).
3. Connect the power connector into the power port on the back of the terminal, and the power cord into the power pack. Plug the three-prong power cord into the power outlet. (Refer to Section 6.2 on page [6.0.3](#) for the [VeriFone Omni 3750 Terminal – Back](#)).
4. After the device has gone through its start-up routine, the day, date, and time is displayed on the top line of the terminal.

Note: The terminal uses its internal clock to calculate the date that will be entered on your transaction. Please ensure that the Day, Date and Time are correct. For instructions on resetting Day, Date and Time, please refer to [Section 7.1](#) on page [7.1.1](#).

5. The terminal will arrive with the requestor's Provider number pre-programmed. It is recommended to review the Medicaid Provider number before using the terminal. Press the **P2** key (labeled "Provider") to enter the Provider Menu. "Provider Setup" is briefly displayed. When the Password prompt is displayed, enter the following six-digit number '123456' and press the **ENTER** key. When the terminal displays "ENTER PROVIDER NUMBER", enter the two-digit number '01' and press the **ENTER** key. "PROVIDER NUMBER 01" is displayed with the pre-programmed Provider number below the text.
6. To use the pre-programmed Provider number, press the **CANCEL/CLEAR** key, to return to the initial screen. To change the pre-programmed Provider number, press the **BACKSPACE** key eight times to clear the number. Then enter the eight-digit Medicaid Provider number and press the **ENTER** key. If you have no additional Provider numbers to enter, press the **CANCEL/CLEAR** key. To store additional Provider numbers refer to Section 7.3 on page [7.3.1](#) for [Instructions for Provider Menu](#).
7. If you are required to dial a number to get an outside line (e.g. '9'), press the **P1** key (labeled "Setup") to enter the Setup Menu. When the Password prompt is displayed, enter the following six-digit number '123456' and press the **ENTER** key. The "DIAL PREFIX" is displayed, enter the access code (e.g. single digit "9") and press the **ENTER** key. After the access code has been entered, press the **CANCEL/CLEAR** key to return to the Initial Screen. (Refer to Section 7.2 on page [7.2.1](#) for [Instructions for Setup Menu](#)).
8. Press the **F4** key or swipe the CBIC card in the Magnetic Card Reader to begin processing transactions to eMedNY.

6.0 VERIFONE OMNI 3750 TERMINAL (Rev. 10/03)

The VeriFone Omni 3750 terminal is a verification device that uses basic telephone outlets to connect with Medicaid Eligibility Verification System (MEVS).

6.1 VeriFone Omni 3750 Terminal – Front (Rev. 10/03)



6.1.1 VeriFone Omni 3750 Terminal Description – Front (Rev. 10/03)

A.	INTERNAL THERMAL PRINTER	A dot matrix printer in which heat is applied to the pins of the matrix to form dots on heat-sensitive paper.
B.	INDICATOR LED	Power and Paper Indicator. NOTE: A blinking light indicates to check paper supply or paper is not inserted properly.
C.	PAPER COVER RELEASE	Open the printer paper compartment.
D.	F4 ATM-STYLE FUNCTION KEY	Starts a verification transaction through entry of the access number or Medicaid Number (CIN).
E.	LCD SCREEN	The verification response and system messages will be displayed in this area.
F.	MAGNETIC CARD READER	Slot that reads the magnetic stripe on the back of the card. This allows for quicker entry of verification transactions.
G.	ALPHA KEY	Converts numeric digits to alphabetic letters.
H.	PAPER ADVANCE KEY	Press the 3 Key from the initial screen to advance the paper one line at a time.
I.	TELEPHONE STYLE KEYPAD	Area where user enters data needed for the Medicaid verification.
J.	ENTER KEY	Inputs new data into the system.
K.	BACKSPACE KEY	Erases the last numeric digit or alphabetic letter entered.
L.	CANCEL/CLEAR KEY	Erases <u>all</u> previously entered data and returns to the ready mode.
M.	REPRINT KEY	From the initial screen, prints a duplicate copy of the verification message.
N.	P1 SETUP KEY	Allows modification of the Terminal Settings. (Refer to Section 7.2 on page 7.2.1 for the Instructions for Setup Menu)
O.	P2 PROVIDER KEY	Allows for add, update, delete, and review of multiple provider Ids. (Refer to Section 7.3 on page 7.3.1 for the Instructions for Provider Menu)
P.	P3 SCROLL BACK KEY	Facilitates scrolling to the previous line, if applicable.
Q.	P4 SCROLL FORWARD/REVIEW KEY	Facilitates scrolling to the next line, if applicable. Also is used to review the previous transaction. (Refer to Section 12.0 on page 12.0.1 for the Review Function)

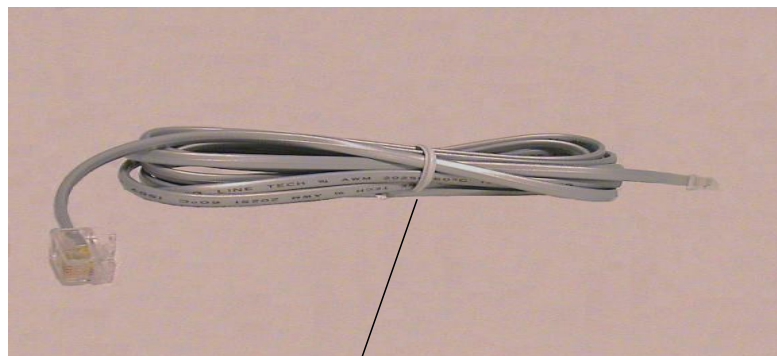
6.2 VeriFone Omni 3750 Terminal – Back (Rev. 10/03)



POWER PORT

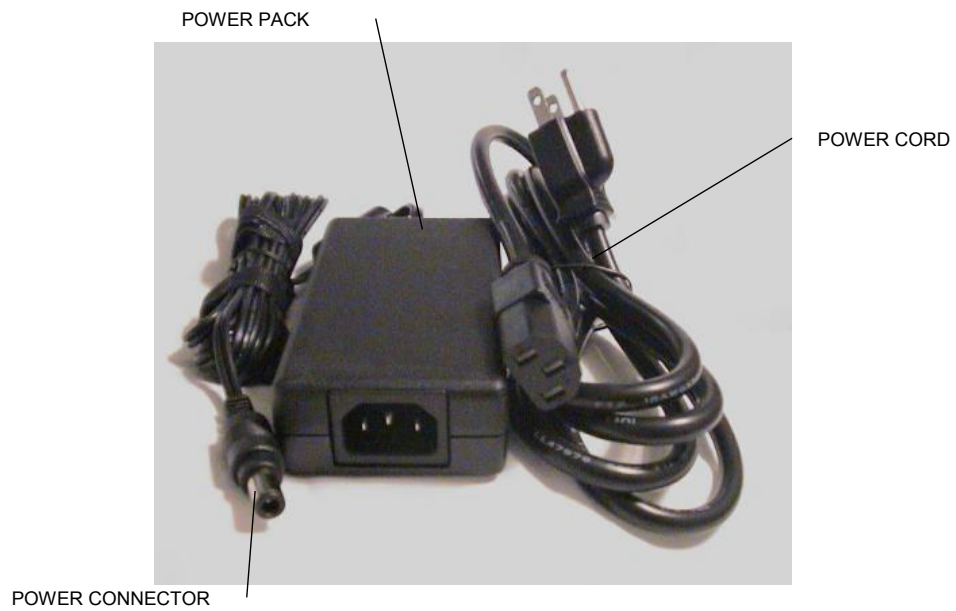
TELEPHONE JACK

Telephone Line Cord



Telephone Line Cord

Power Pack



7.0 **VERIFONE INSTALLATION INSTRUCTIONS** (Rev. 10/03)

These instructions will assist with the setup of the VeriFone Omni 3750 terminal. Select a location that has access to a power outlet and a telephone line for your terminal.

Connecting the Telephone Line

1. Connect one end of the telephone line cord to the telephone jack labeled "H S" on the right hand side at the rear of the terminal
2. Connect the other end of the telephone line cord to your RJ11-type modular telephone wall jack. If you do not have a telephone wall jack, obtain an adapter from your local telephone company.

Connecting the Terminal Power Pack

1. Connect the power connector into the power port.
2. To lock the power connector, align the plastic lock tab pointing up and turn to the left. To unlock the power connector, turn to the right.
3. Connect the power cord into the power pack.
4. Plug the three-prong AC power cord into an indoor 120-volt AC outlet.

WARNING: Do not plug the power pack into an outdoor outlet or operate the terminal outdoors.

Inserting Thermal Paper into the Internal Thermal Printer

1. To open the printer paper compartment, press the Paper Cover Release button located on the right side of the terminal.
2. Insert a roll of thermal paper, and ensure paper feeds from underneath. (See illustration 2b of the Quick Instruction Guide provided with the new device).
3. Press down to close the printer paper compartment.

Ordering Thermal Paper for the Internal Thermal Printer

To order additional thermal paper (2.25 Inches by 85 Feet thermal paper), contact TASQ Technology at 1-800-420-3197 or your nearest office supply store.

7.1 Instructions to Reset Day/Date/Time (REV. 10/03)

To set or reset the day, date, and time follow the Display/Action table.

DISPLAY	ACTION
The Initial Screen is displayed.	Press the F2 and F4 key at the same time
SYSTEM MODE ENTRY PASSWORD	Enter "Z66831" (1-alpha-alpha 66831) and press the ENTER key
SYS MODE MENU 1	Press the F3 key for CLOCK
SYS MODE CLOCK YEAR: YYYY MONTH: MM DAY: DD	Enter the current date as " CCYYMMDD "
	Press the P2 key labeled Provider .
SYS MODE CLOCK HOUR: HH MINUTE: MM	Enter Time as " HHMM " Enter HH in 24-Hour clock format (e.g. 1:00 p.m. HOUR: 13 MINUTE: 00) Press the ENTER key to Save and Exit
SYS MODE MENU 1	Press the F4 key to restart the device
Initial screen	

7.2 Instructions for Setup Menu (P1 Key) (REV. 10/03)

Access this menu by pressing the **P1** key labeled as the Setup Menu. This menu allows the user to modify several variables that the device uses. To edit the Setup Menu follow the Display/Description/Action table.

Press the **CANCEL/CLEAR** key to return to the initial screen.

DISPLAY	DESCRIPTION	ACTION
Initial Screen		Press the P1 key to enter the Setup Menu
Terminal Setup ENTER PASSWORD		Enter the following six-digit number '123456' and press the ENTER key.
DIAL PREFIX ## -----	The Dial Prefix is dialed before the telephone number. If a value has already been entered, it will display on the second line ("##").	If you are required to dial a number (e.g. '9') to get an outside line, enter the access code here (e.g. single digit "9") and press the ENTER key. After the access code has been entered, press the CANCEL/CLEAR key.
ENTER NYM TELE # 1-866-828-4814 -----	This is the number the device will dial to submit transactions.	Press the ENTER key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
ENTER BACKUP # 1-866-828-4815 -----	This is the number the device will dial in case the main number does respond.	Press the ENTER key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
DIAL TYPE TONE TONE PULSE	The type of phone system used. Touchtone is most commonly used. Default is 'Tone'.	The current setting is the word under "DIAL TYPE". If you need to change the setting, press the F1 key for Tone or press the F2 key for Pulse. Otherwise, press the ENTER key to continue.

DISPLAY	DESCRIPTION	ACTION
PRINT ALL YES YES NO	This designates whether the device will automatically print responses. Default is 'YES'.	The current setting is the word under "PRINT ALL". To change the setting, press the F1 key to automatically print responses or press the F2 key to not automatically print responses. NOTE: When the "PRINT ALL" is set to "no", you may print manually by pressing the asterisk "*" key from the initial screen. Press the ENTER key to continue.
KEY BEEP NO YES NO	This designates whether the device will beep when a key is pressed. Default is 'NO'.	The current setting is the word under "KEY BEEP". To change the setting, press the F1 key to beep or press the F2 key to not beep. NOTE: Errors will still cause a beep to sound. Press the ENTER key to continue.
DOWNLOAD TELE # 1-888-843-7160 -----	This is the phone number the device will dial to download a new application to the device.	Press the ENTER key to continue. If you need to change this number, call the Provider Help Desk at 1-800-343-9000.
ENTER NEW PASSWORD -----	This is the password used to access the Setup Menu and the Provider Menu.	<u>WARNING:</u> If you need to have a different password, enter it here. Be advised that if you change it, Provider Services will not be able to reset it for you. Press the ENTER key to return to the initial screen without changing the password.

7.3 Instructions for Provider Menu (P2 key) (REV. 06/08)

Access this menu by pressing the **P2** key labeled as the Provider Menu. The VeriFone Omni 3750 terminal can store up to 20 MMIS Provider ID numbers to quickly process transactions. Each Provider number can be used by entering the two-digit shortcut code that corresponds to the Provider submitting the transaction. To store additional Provider numbers in the terminal follow the Step/Action/Display table.

Press the **CANCEL/CLEAR** key to return to the initial screen.

NOTE: If only one Provider ID is entered in the table, it will automatically be used for each transaction and the prompt "Select Provider" will not be displayed.

DISPLAY	ACTION
Initial Screen	Press the P2 key to enter the Provider Menu
ENTER PASSWORD	Enter the following six-digit number '123456' and press the ENTER key
Provider Setup is displayed	
ENTER PROVIDER NUMBER --	Enter a valid two-digit number (01 – 20). The first shortcut assigned must start with 01. NOTE: It is <u>important</u> to keep track of the shortcuts that correspond with each Provider ID.
PROVIDER NUMBER nn ##### <i>The 'nn' on the first line is the two-digit shortcut number corresponding to the Provider.</i> <i>The "#####" on the second line is the ten-digit NPI or the eight-digit MMIS Provider ID.</i> <i>If a provider number is not associated with 'nn', then a blank line will display instead of the Provider number.</i>	Enter the ten-digit National Provider Identifier (NPI) that you are assigning to that shortcut and press the ENTER key. For all atypical providers, enter the eight-digit MMIS Provider ID that you are assigning to that shortcut and press the ENTER key To change the number currently displayed press the BACKSPACE key to clear the existing Provider number, enter the new number and press the ENTER key OR Press the ENTER key to keep the current value

DISPLAY	ACTION
ENTER PROVIDER NUMBER --	Press the CANCEL/CLEAR key to return to the Initial Screen OR Repeat Steps 2 through 4 to store additional Providers

8.0 **VERIFONE VERIFICATION INPUT SECTION** (Rev. 10/03)

8.1 **VeriFone Verification Using the Access Number or Medicaid Number (CIN)** (REV. 10/03)

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-character alpha/numeric identifier on the Common Benefit Identification Card.

8.2 **Instructions for Completing a VeriFone Transaction** (REV. 10/03)

- **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, refer to Section 7.3 on page [7.3.1](#) for the [Instructions for Provider Menu](#) or call **1-800-343-9000**. (Please maintain a listing of provider numbers and corresponding shortcuts.)
- 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.

8.2.1 Instructions for Completing Tran Type 1 (Rev. 06/09)

Note: Laboratories and Pharmacies should **NOT** use Tran Type 1. Please refer to Section 8.2.6 on page [8.2.6.1](#) for [Tran Type 7](#).

Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs. Co-payment entries will be determined based on the entry in the SERVICE TYPE and/or TAXONOMY and the # SERVICE UNITS prompts.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
<p>ENTER CARD OR ID</p>	<p>If you are using the client access number, swipe the card through the reader or key the access number and press the ENTER key.</p> <p>To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second.</p> <p>Note: 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 Client Medicaid number (CIN), enter the Medicaid number and press the ENTER key. The type of identification used will be displayed for one second.</p>
<p>ENTER TRAN TYPE</p>	<p>1 Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for <u>Post and Clear</u> (PC) and <u>Utilization Threshold</u> (UT) programs.</p> <p>Press the ENTER key.</p>
<p>ENTER SEQ #</p>	<p>If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the ENTER 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>

PROMPT DISPLAYED	ACTION/INPUT
ENTER DATE	<p>Press the ENTER key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the ENTER key.</p> <p>For all inpatient co-payment entries, the date should equal the discharge date.</p>
SELECT PROVIDER	<p>If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).</p>
ENTER TAXONOMY	<p>This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes).</p> <p>Press the ENTER key to bypass if not required.</p>
SERVICE TYPE	<p>Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes).</p> <p>Press the ENTER key to bypass if not required.</p>
ORDERING PRV #	<p>Enter the ten-digit National Provider Identifier (NPI) and press the ENTER key.</p> <p>For all atypical providers enter the eight-digit MMIS Provider ID number of the ordering provider and press the ENTER 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 (for atypical providers ONLY), you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code 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 profession code followed by a zero, the alpha character and the six-digit license number.</p>

PROMPT DISPLAYED	ACTION/INPUT												
ORDERING PRV # (contd.)	<p style="text-align: center;"><u>Examples:</u></p> <table border="0"> <tr> <td>National Provider ID (NPI)</td> <td>0123456789</td> </tr> <tr> <td>MMIS Provider ID</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>06000987654</td> </tr> <tr> <td>Out of State License #</td> <td>060NJ345678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>0420F421212</td> </tr> <tr> <td>NYS Optometrist #</td> <td>0560U452749</td> </tr> </table> <p>NOTE: When entering a profession code 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: 0560U000867 (Profession Code + 0U + Zero fill + License Number).</p>	National Provider ID (NPI)	0123456789	MMIS Provider ID	01234567	New York State License #	06000987654	Out of State License #	060NJ345678	Nurse Practitioner #	0420F421212	NYS Optometrist #	0560U452749
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New York State License #	06000987654												
Out of State License #	060NJ345678												
Nurse Practitioner #	0420F421212												
NYS Optometrist #	0560U452749												
REFERRING PRV #	<p>Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the ten-digit National Provider Identifier (NPI) or the eight-digit MMIS provider ID of the primary provider and press the ENTER key. If a client 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 client is not restricted or in MCCP, press the ENTER key to bypass this prompt.</p>												
<p>NOTE: The system will default the copay type based on the entry of the Service Type and/or Taxonomy.</p>													
COPAY EXEMPT	<p>If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, enter 1 for yes. If the client is not exempt from co-payment, enter 2 for no.</p> <p>NOTE: Bypassing this prompt will enter a 2 for no.</p>												
# SERVICE UNITS	<p>Enter the total number of service units and press the ENTER key.</p> <p>DME Suppliers must use this prompt to clear any DME Supply Items posted by the Ordering Provider.</p>												
<p>NOTE: If you are a POST and CLEAR Provider, enter the appropriate data for the following two prompts. Bypass by pressing the ENTER key.</p>													
# LAB TESTS	<p>Enter the number of lab tests you are ordering and press the ENTER key. If no lab tests are required, bypass by pressing the ENTER key.</p>												

PROMPT DISPLAYED	ACTION/INPUT
# RX/OTC	Enter the number of prescriptions, over the counter items, or DME Supply Items you are ordering and press the ENTER key. If no RX/OTC are required, bypass by pressing the ENTER key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

8.2.2 Instructions for Completing Tran Type 2 (Rev. 06/08)

Eligibility Inquiry only: This transaction may also be used to determine if a client is at limit for the service category you are providing or ordering under the UT program.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
<p>ENTER CARD OR ID</p>	<p>If you are using the client access number, swipe the card through the reader or key the access number and press the ENTER key.</p> <p>To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second.</p> <p>Note: 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 Client Medicaid number (CIN), enter the Medicaid number and press the ENTER key. The type of identification used will be displayed for one second.</p>
<p>ENTER TRAN TYPE</p>	<p>2 Eligibility Inquiry only: This transaction may also be used to determine if a client is at limit for the service category you are providing or ordering under the UT program.</p> <p>Press the ENTER key.</p>
<p>ENTER SEQ #</p>	<p>If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the ENTER 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>ENTER DATE</p>	<p>Press the ENTER key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the ENTER key.</p>

PROMPT DISPLAYED	ACTION/INPUT												
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).												
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the ENTER key to bypass if not required.												
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes) Press the ENTER key to bypass if not required.												
ORDERING PRV #	<p>Enter the ten-digit National Provider Identifier (NPI) and press the ENTER key.</p> <p>For all atypical providers enter the eight-digit MMIS Provider ID number of the ordering provider and press the ENTER 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 (for atypical providers ONLY), you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code, 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 profession code followed by a zero, the alpha character and the six-digit license number.</p> <p style="text-align: center;">Examples:</p> <table data-bbox="808 1766 1339 1946"> <tbody> <tr> <td>National Provider ID (NPI)</td> <td>0123456789</td> </tr> <tr> <td>MMIS Provider ID</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>06000987654</td> </tr> <tr> <td>Out of State License #</td> <td>060NJ345678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>0420F421212</td> </tr> <tr> <td>NYS Optometrist #</td> <td>0560U452749</td> </tr> </tbody> </table>	National Provider ID (NPI)	0123456789	MMIS Provider ID	01234567	New York State License #	06000987654	Out of State License #	060NJ345678	Nurse Practitioner #	0420F421212	NYS Optometrist #	0560U452749
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Out of State License #	060NJ345678												
Nurse Practitioner #	0420F421212												
NYS Optometrist #	0560U452749												

PROMPT DISPLAYED	ACTION/INPUT
ORDERING PRV # (contd.)	NOTE: When entering a profession code 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: 0560U000867 (Profession Code + 0U + Zero fill + License Number).
NOTE: The Referring Provider # prompt will be displayed only if the prompt for the Ordering Provider is bypassed.	
REFERRING PRV #	<p>Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the ten-digit National Provider Identifier (NPI) or the eight-digit MMIS provider ID of the primary provider and press the ENTER key. If a client 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 client is not restricted or in MCCP, press the ENTER key to bypass this prompt.</p>
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

8.2.3 Instructions for Completing Tran Type 3 (REV. 06/08)

Authorization Confirmation: This transaction is used to determine if an authorization has already been requested for this client, for a particular date of service. To be used with Medicaid Number (CIN) ONLY.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
ENTER CARD OR ID	Enter the Medicaid number (CIN) and press the ENTER key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	<p>3 Authorization Confirmation: This transaction is used to determine if an authorization has already been requested for this client, for a particular date of service. To be used with Medicaid Number (CIN) ONLY.</p> <p>Press the ENTER key.</p>
ENTER SEQ #	Enter the two-digit sequence number and press the ENTER key. The sequence number is the last two-digits of the access number.
ENTER DATE	Press the ENTER key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the ENTER key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	<p>This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes).</p> <p>Press the ENTER key to bypass if not required.</p>
SERVICE TYPE	<p>Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes)</p> <p>Press the ENTER key to bypass if not required.</p>

PROMPT DISPLAYED	ACTION/INPUT
# SERVICE UNITS	Enter the total number of service units and press the ENTER key.
# LAB TESTS	Enter the number of lab tests and press the ENTER key. If no lab tests are required, bypass by pressing the ENTER key.
# RX/OTC	Enter the number of prescriptions or over the counter items and press the ENTER key. If no RX/OTC are required, bypass by pressing the ENTER key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

8.2.4 Instructions for Completing Tran Type 4 (Rev. 06/08)

Authorization Cancellation: This transaction is used to cancel an authorization. Use Medicaid Number (CIN) ONLY. Authorizations for DME, prescription footwear, and orthotic/prosthetic devices may be cancelled for up to 90 days. All others must be done within 24 hours of the authorization you are canceling.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
ENTER CARD OR ID	Enter the Medicaid number and press the ENTER key. The type of identification used will be displayed for one second.
ENTER TRAN TYPE	<p>4 Authorization Cancellation: This transaction is used to cancel an authorization. Use Medicaid Number (CIN) ONLY. Authorizations for DME, prescription footwear, and orthotic/prosthetic devices may be cancelled for up to 90 days. All others must be done within 24 hours of the authorization you are canceling.</p> <p>Press the ENTER key.</p>
ENTER SEQ #	Enter the two-digit sequence number and press the ENTER key. The sequence number is the last two-digits of the access number.
ENTER DATE	Press the ENTER key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the ENTER key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	<p>This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes).</p> <p>Press the ENTER key to bypass if not required.</p>

PROMPT DISPLAYED	ACTION/INPUT
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the ENTER key to bypass if not required.
# SERVICE UNITS	Enter the total number of service units and press the ENTER key.
# LAB TESTS	Enter the number of lab tests you are canceling and press the ENTER key. If no lab tests are required, bypass by pressing the ENTER key.
# RX/OTC	Enter the number of prescriptions or over the counter items you are canceling and press the ENTER key. If no RX/OTC are required, bypass by pressing the ENTER key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

8.2.5 Instructions for Completing Tran Type 6 (Rev. 06/08)

Dispensing Validation System (DVS) Request: This transaction allows suppliers of 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.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
<p>ENTER CARD OR ID</p>	<p>If you are using the client access number, swipe the card through the reader or key the access number and press the ENTER key.</p> <p>To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second.</p> <p>Note: 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 Client Medicaid number (CIN), enter the Medicaid number and press the ENTER key. The type of identification used will be displayed for one second.</p>
<p>ENTER TRAN TYPE</p>	<p>6 Dispensing Validation System (DVS) Request: This transaction allows suppliers of 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 for selected Dental Procedure Codes.</p> <p>Press the ENTER key.</p>
<p>ENTER SEQ #</p>	<p>Enter the two-digit sequence number and press the ENTER 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>ENTER DATE</p>	<p>Press the ENTER key for today's date. DVS transactions require a current date entry.</p>

PROMPT DISPLAYED	ACTION/INPUT												
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).												
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the ENTER key to bypass if not required.												
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the ENTER key to bypass if not required.												
ORDERING PRV #	<p>Enter the ten-digit National Provider Identifier (NPI) and press the ENTER key.</p> <p>For all atypical provider enter the eight-digit MMIS Provider ID number of the ordering provider and press the ENTER 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 (for atypical providers ONLY), you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code, followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code 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 profession code followed by a zero, the alpha character and the six-digit license number.</p> <p style="text-align: center;"><u>Examples:</u></p> <table data-bbox="808 1766 1339 1946"> <tbody> <tr> <td>National Provider ID (NPI)</td> <td>0123456789</td> </tr> <tr> <td>MMIS Provider ID</td> <td>01234567</td> </tr> <tr> <td>New York State License #</td> <td>06000987654</td> </tr> <tr> <td>Out of State License #</td> <td>060NJ345678</td> </tr> <tr> <td>Nurse Practitioner #</td> <td>0420F421212</td> </tr> <tr> <td>NYS Optometrist #</td> <td>0560U452749</td> </tr> </tbody> </table>	National Provider ID (NPI)	0123456789	MMIS Provider ID	01234567	New York State License #	06000987654	Out of State License #	060NJ345678	Nurse Practitioner #	0420F421212	NYS Optometrist #	0560U452749
National Provider ID (NPI)	0123456789												
MMIS Provider ID	01234567												
New York State License #	06000987654												
Out of State License #	060NJ345678												
Nurse Practitioner #	0420F421212												
NYS Optometrist #	0560U452749												

PROMPT DISPLAYED	ACTION/INPUT
<p>ORDERING PRV # (contd.)</p>	<p>NOTE: When entering a profession code 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: 0560U000567 (Profession Code + 0U + Zero fill + License Number).</p>
<p>REFERRING PRV #</p>	<p>Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the ten-digit National Provider Identifier (NPI) or the eight-digit MMIS provider ID of the primary provider and press the ENTER key. If a client 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 client is not restricted or in MCCP, press the ENTER key to bypass this prompt.</p>
<p>COPAY EXEMPT</p>	<p>If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, enter 1 for yes. If the client is not exempt from co-payment, enter 2 for no.</p> <p>NOTE: Bypassing this prompt will enter a 2 for no.</p>
<p>ENTER ITEM/NDC #</p>	<p>Enter the five-character HCPCS alpha/numeric item code of the item being dispensed. The following modifiers may be used to further describe certain procedure codes for orthotic and prosthetic devices, and prescription footwear:</p> <ul style="list-style-type: none"> • LT (Left Side) • RT (Right Side) <p>For DVS authorization, enter the modifier immediately following the procedure code, with no spaces between the modifier and code.</p> <p>For DME, prescription footwear and orthotic/prosthetic devices, DVS will be created for an authorization period of 180 days.</p> <p>Note: Date-of-Service entered on the DVS request will be used to begin the authorization period. The actual date of service, which is entered on the claim, can be anytime within the 180 day authorization period.</p> <p>For some items, if instructed by New York State, the</p>

PROMPT DISPLAYED	ACTION/INPUT
	eleven-digit National Drug Code may be entered. 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.
ENTER QUANTITY	Enter the total number of units dispensed for the current date of service only. Do not include refills. For Dental DVS: Enter the number of times the procedure was performed.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

8.2.6 Instructions for Completing Tran Type 7 (Rev. 06/08)

Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs by Pharmacy and Lab providers. Co-payment entries will be determined based on the entry in the number of Lab Tests, Generic/OTC, Brand, and Supplies prompts.

PROMPT DISPLAYED	ACTION/INPUT
	<p>TO BEGIN: Press the CANCEL/CLEAR key.</p> <p>Press the F4 key or swipe the CBIC card in the Magnetic Card Reader to start the verification.</p>
<p>ENTER CARD OR ID</p>	<p>If you are using the client access number, swipe the card through the reader or key the access number and press the ENTER key.</p> <p>To use the card, smoothly swipe it through the magnetic stripe reader from top to bottom. "NY Access #" will be displayed for one second.</p> <p>Note: 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 Client Medicaid number (CIN), enter the Medicaid number and press the ENTER key. The type of identification used will be displayed for one second.</p>
<p>ENTER TRAN TYPE</p>	<p>7 Service Authorization and Eligibility Inquiry: This transaction must be used to obtain a service authorization for Post and Clear (PC) and Utilization Threshold (UT) programs by Pharmacy and Lab providers. Co-payment entries will be determined based on the entry in the number of Lab Tests, Generic/OTC, Brand, and Supplies prompts.</p> <p>Press the ENTER key.</p>
<p>ENTER SEQ #</p>	<p>If your Identification Number entry was a Medicaid ID number (CIN), enter the two-digit sequence number and press the ENTER 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>

PROMPT DISPLAYED	ACTION/INPUT
ENTER DATE	Press the ENTER key for today's date. If you are doing a transaction for a previous date of service, you must enter the eight-digit date, MMDDCCYY, and press the ENTER key.
SELECT PROVIDER	If you see this prompt, there are multiple provider numbers programmed into this terminal. Enter the appropriate shortcut code associated with your provider Identification Number. You may also enter your ten-digit NPI or an eight-digit MMIS Provider ID (for atypical providers ONLY) and press the ENTER key (To add numbers call 1-800-343-9000).
ENTER TAXONOMY	This code is used for classifying health care providers according to provider type or practitioner specialty. (Refer to Section 13.2 on page 13.2.1 for the Taxonomy Codes). Press the ENTER key to bypass if not required.
SERVICE TYPE	Enter the code identifying the type of service you are providing. (Refer to Section 13.2 on page 13.2.1 for the Service Type Codes). Press the ENTER key to bypass if not required.
ORDERING PRV #	<p>Enter the ten-digit National Provider Identifier (NPI) and press the ENTER key.</p> <p>For all atypical providers enter the eight-digit MMIS Provider ID number of the ordering provider and press the ENTER 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 (for atypical providers ONLY), you may enter the profession code and license number. If entering a license number for New York State providers, first enter a profession code, followed by two zeros, then the six-digit license number. If entering out of state license numbers, first enter the profession code, 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 profession code followed by a zero, the alpha character and the six-digit license number.</p> <p style="text-align: right;"><u>Examples:</u></p> <p>National Provider ID (NPI) 0123456789</p>

PROMPT DISPLAYED	ACTION/INPUT
<p>ORDERING PRV # (contd.)</p>	<p>MMIS Provider ID 01234567 New York State License # 06000987654 Out of State License # 060NJ345678 Nurse Practitioner # 0420F421212 NYS Optometrist # 0560U452749</p> <p>NOTE: When entering a profession code 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: 0560U000867 (Profession Code + 0U + Zero fill + License Number).</p>
<p>REFERRING PRV #</p>	<p>Must be entered if the client is in the Restricted Recipient Program and the transaction is not done by the primary provider. Enter the ten-digit National Provider Identifier (NPI) or the eight-digit MMIS provider ID of the primary provider and press the ENTER key. If a client 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 client is not restricted or in MCCP, press the ENTER key to bypass this prompt.</p>
<p>COPAY EXEMPT</p>	<p>If the service you are rendering does not require co-payment, or if the client is exempt or has met their co-payment maximum responsibility, enter 1 for yes. If the client is not except from co-payment, enter 2 for no.</p> <p>NOTE: Bypassing this prompt will enter a 2 for no.</p>
<p>NOTE: The system will default the copay type based on the entry in the number of Lab tests, number of Generic/OTC, number of Brand, and number of Supplies prompts.</p>	
<p># LAB TESTS</p>	<p>Enter the number of lab tests you are performing and press the ENTER key. If no lab tests are required, bypass by pressing the ENTER key.</p>
<p>NOTE: The # GENERIC/OTC, # BRAND and # SUPPLIES prompts will be displayed only if the # LAB TESTS prompt is bypassed.</p>	
<p># GENERIC/OTC</p>	<p>Enter the number of generic prescriptions or over the counter items you are dispensing and press the ENTER key. If no Generic/OTC prescriptions are required, bypass by pressing the ENTER key.</p>

PROMPT DISPLAYED	ACTION/INPUT
# BRAND	Enter the number of brand prescriptions you are dispensing and press the ENTER key. If no brand prescriptions are required, bypass by pressing the ENTER key.
# SUPPLIES	Enter the number of supplies you are dispensing and press the ENTER key. If no supplies are required, bypass by pressing the ENTER key.
THIS ENDS THE INPUT DATA SECTION. The VeriFone will now dial into the MEVS system and display these processing messages:	
DIALING, WAITING FOR ANSR, CONNECT XXXX, WAITING FOR ENQ, TRANSMITTING, and RECEIVING.	These processing messages are displayed.

9.0 VERIFONE VERIFICATION RESPONSE SECTION (Rev. 06/04)

The device will automatically display and print the response data unless you have specified in the setup menu to not automatically print your receipts. To print an additional copy of the response data, press the '*' asterisk key. To advance the paper by a line, press the '3' key from the initial screen. If your device has paper but is not printing a response, refer to the "PRINT ALL" setting in Section 7.2 on page [7.2.1](#) for [Instructions for Setup Menu](#).

Note: The screen will display up to eight (8) lines of text. If the response is longer than eight (8) lines, use the P3 (Scroll Back) and P4 (Scroll Forward/Review) keys.

9.1 Fields on MEVS receipt (Rev. 08/09)

The MEVS receipt presents information in two sections:

- Input: The Input section displays the information entered into the MEVS device for the last transaction and always starts with the **TODAY'S DATE** field which reflects the terminal's internal date and time.
- Response: The Response section only displays fields, which contain data. The fields displayed also vary based on the Tran Type used to conduct the transaction. The Response section always starts with the PROV NO. field.

Some fields are required fields (as stated in the transaction descriptions in [Section 8.2](#) on page [8.0.1](#)), so they will always appear.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
PROV NO.:	The ten-digit National Provider Identifier (NPI), or the eight-digit MMIS Provider ID (for atypical providers ONLY).
DATE SVC:	The date for which services were requested.
MEDICAID ID:	The Medicaid number (CIN) is displayed on the receipt if the client is identified. If the client cannot be identified, the information entered in the MEVS Device will be displayed.
HIC NO.:	Health Insurance Claim number consisting of up to twelve-digits.
DOB:	This field displays the client's date of birth.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
GENDER:	The Client's gender. Values are: M = Male F = Female U = Unborn
CNTY/OFF:	The two-digit county code is displayed for Upstate client's county of fiscal responsibility. The Office code is a three-digit code for Downstate clients. Refer to Section 13.4 on page 13.4.1 for a complete listing of
ANNIV DT:	This is the beginning of the client's benefit year.
MSG:	If applicable, a client's Category of Assistance (COA) and/or exception code(s) will be returned. Refer to Section 13.5 on page 13.5.1 , for the Exception Codes for the definitions/descriptions. 'COA = S' (The code S signifies that the client is enrolled in the SSI assistance program.) The Month that the client is due for Recertification will also be displayed here.
----- ELIG REQUEST REJECT -----	This message is displayed when the eligibility request cannot be validated. The fields listed below provide further information for the validation of the eligibility request.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes .
Folw-Up Act Cd:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Call the telephone number displayed on the receipt for more information.
----- SERV REQUEST REJECT -----	This message is displayed when a Service Authorization (SA) or DVS request cannot be processed or the client is ineligible. The fields listed below provide further information for the validation of the Service request or DVS.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes .

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
Folw-Up Act Cd:	Values are: C = Please Correct and Resubmit P = Please Resubmit Original Transaction
INFO #:	Call the telephone number displayed on the receipt for more information.
----- PLAN ELIG. & BENEFITS -----	The fields listed below display the client's eligibility and benefit information with Medicaid, as well as any other insurance. The client's Medicaid, Medicare and/or other insurance information are separated by dashes (-----).
Plan:	This field displays the name of the plan
Plan Policy Number	This field displays the policy number assigned to the other Third Party Insurance.
Plan Cd:	The field displays a 2-character code for other Third Party Insurance. If you see an Insurance Code of ZZ , call 1-800-343-9000 to obtain additional Insurance and coverage information. For Medicaid PCP only, the 2 character code and coverage codes are displayed. This field is displayed if the plan code is available.
Plan Address	This field displays the Address, City, State and Zip Code of the Managed Care Plan or other Third Party Insurance.
Elig/Ben Info:	This field displays the client's level of medical coverage or other coverages. Refer to Section 10.0 on page 10.0.1 for Accepted Reason Codes .
INFO #:	Call the telephone number displayed on the receipt for more information.

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
Serv Type Cd:	<p>We will return one or more of the following values to further define coverage, exclusions and limitations.</p> <p style="padding-left: 40px;">30 = Health Benefit Plan Coverage</p> <p style="padding-left: 40px;">48 = Hospital Inpatient</p> <p style="padding-left: 40px;">54 = Long Term Care</p> <p style="padding-left: 40px;">82 = Family Planning</p> <p style="padding-left: 40px;">86 = Emergency</p> <p>If the Eligibility Response reads: Exclusions, and Service Types of 48 (Hospital Inpatient) and 54 (Long Term Care) are also displayed, this means the Client's coverage is: (Eligible Only Outpatient Care) OR If a Service Type of 54 (Long Term Care) is also displayed, this means the Client's coverage is: (Eligible Except Nursing Facility Services). If the Eligibility Response reads: Limitations, and a Service Type of 82 (Family Planning) is also displayed, this means the Client's coverage is: (Family Planning Services Only). OR If a Service Type of 86 (Emergency) is also displayed, this means the Client's coverage is: (Emergency Services Only).</p>

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
Insr Type Cd:	Values are: C1 = Commercial MP = Medicare Primary MC = Medicaid QM = Qualified Medicare Beneficiary
Plan Cov Desc:	This field will display a literal that further defines the response with respect to UT limits exceeded, client restrictions and limitations of coverage. If the message "Restricted to following provider" is returned, this field will display the type of restriction. We suggest submitting Tran Type 1 to ensure the ordering/referring provider is correct.
Time Per Qual:	This field displays the time period qualifiers. Values for this field are: 29 = Copay remaining 30 = UT exceeded
Dollar Amt:	This field displays the copay remaining only when 29 is present in the Time Per Qual field.
----- HEALTH CARE SERVICES -----	The fields listed below display information relating to Service Authorization (SA) or DVS requests which can contain several groups of information and are separated by dashes (-----).
Action Cd:	Values are: A1 = Certified in total A3 = Not Certified A6 = Modified CT = Contact Payer NA = No Action Required

Response Fields	
Note: While all possible responses are listed below only those applicable will be returned on your receipt.	
LABEL	DESCRIPTION
INFO #:	Call the telephone number displayed on the receipt for more information.
Ref Id:	This field displays a message or DVS number.
Modified Units:	This field shows the partial units that were approved for the Service Authorization (SA) requested. Indicates that the full complement of requester services relative to Utilization Threshold and/or Post and Clear processing is NOT available. The NN represents the number of services approved/available. An authorization will be created for that number only. This field also shows the number of Utilization Threshold and/or Post and Clear units reversed (canceled) for the
Units: N/X/X	For confirmations, this field shows the approved units, posted lab units and posted Rx/OTC units.
Item/NDC Code:	This field shows the approved Item/NDC code only for a DVS confirmation.
Dental Info:	This field shows the tooth, arch, or quadrant for a DVS confirmation
Quantity Approved:	This field shows the quantity that was approved for a DVS confirmation.
Rej Reason Cd:	This field displays the Reject Reason codes. Refer to Section 11.0 on page 11.0.1 for Reject Reason codes .
- End of Receipt -	

10.0 ACCEPTED REASON CODES (Rev. 08/09)

RESPONSE/RETURN	SERVICE TYPES RETURNED	POSSIBLE CAUSES
1 ACTIVE COVERAGE	30 (Medicaid)	MA ELIGIBLE Client is eligible for all benefits
	30 (Medicaid)	MA ELIGIBLE HR UTILIZATION THRESHOLD Client 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.
B COPAYMENT		COPAYMENT Client has copay remaining if this response is returned.
		ELIGIBLE ONLY OUTPATIENT CARE Client is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
E EXCLUSIONS	48 (Hospital Inpatient) and 54 (Long Term Care)	ELIGIBLE ONLY OUTPATIENT CARE Client is eligible for all ambulatory care, including prosthetics; no inpatient coverage.
	54 (Long Term Care)	ELIGIBLE EXCEPT NURSING FACILITY SERVICES Client is eligible to receive all Medicaid services except nursing home services provided in an SNF or inpatient setting. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.
F LIMITATIONS	30 (Medicaid)	AT SERVICE LIMIT The client has reached his/her limit for that particular service category. No service authorization is created. The service is not approved and payment by Medicaid will not be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.

RESPONSE/RETURN	SERVICE TYPES RETURNED	POSSIBLE CAUSES
<p>F LIMITATIONS (contd.)</p>	<p>30 (Medicaid)</p>	<p>COMMUNITY COVERAGE NO LTC</p>
		<p>Client is eligible for acute inpatient care, care in a psychiatric center, some ambulatory care, prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period up to 29 consecutive days of certified home health agency services. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency services except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting, intermediate care facility services, residential treatment facility services and services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Svcs.</p>
	<p>30 (Medicaid)</p>	<p>COMMUNITY COVERAGE W / CBLTC</p>
		<p>Client is eligible to receive most Medicaid services. Client is not eligible for nursing home services in a SNF or inpatient setting except for short-term rehabilitation nursing home care in a SNF. Short-term rehabilitation nursing home care means one admission in a 12-month period of up to 29 consecutive days of nursing home care in a SNF. Client is not eligible for managed long-term care in a SNF, hospice in a SNF or intermediate care facility services. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	<p>82 (Family Planning)</p>	<p>ELIGIBLE ONLY FAMILY PLANNING SERVICES</p>
		<p>The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% of the federal poverty level. Eligible recipients (males and females) have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.</p>

RESPONSE/RETURN	SERVICE TYPES RETURNED	POSSIBLE CAUSES
<p>F LIMITATIONS (contd.)</p>	<p>86 (Emergency)</p>	<p>EMERGENCY SERVICES ONLY</p> <p>Client 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.</p>
	<p>30 (Medicaid)</p>	<p>MEDICARE COINSURANCE DEDUCTIBLE ONLY</p> <p>Client is eligible for payment of Medicare coinsurance and deductible only. Deductible and coinsurance payments will be made for Medicare approved services only.</p>
	<p>30 (Medicaid)</p>	<p>OUTPATIENT COVERAGE NO LTC</p> <p>Client is eligible for some ambulatory care, including prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency services. Client is not eligible for inpatient coverage other than short-term rehabilitation nursing home care in a SNF. Client is not eligible for adult day health care, Assisted Living Program, certified home health agency except short-term rehabilitation, hospice, managed long-term care, personal care, consumer directed personal assistance program, limited licensed home care, personal emergency response services, private duty nursing, and waiver services provided under the Long Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>

RESPONSE/RETURN	SERVICE TYPES RETURNED	POSSIBLE CAUSES
F LIMITATIONS (contd.)	30 (Medicaid)	<p>OUTPATIENT COVERAGE NO NFS</p> <p>Client is eligible for all ambulatory care, including prosthetics. Client is not eligible for inpatient coverage. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	30 (Medicaid)	<p>OUTPATIENT COVERAGE W / CBLTC</p> <p>Client is eligible for most ambulatory care, including prosthetics, and one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. Client is not eligible for inpatient care other than short-term rehabilitation nursing home care in a SNF. Refer to Appendix Section 14.1 for Attestation of Resources Non-Covered Services.</p>
	30 (Medicaid)	<p>PERINATAL FAMILY</p> <p>Client 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 of care.</p>
	30 (Medicaid)	<p>PRESUMPTIVE ELIGIBILITY LONG-TERM/HOSPICE</p> <p>Client is eligible for all Medicaid services except hospital based clinic services, hospital emergency room services, hospital inpatient services, and bed reservation.</p>
	30 (Medicaid)	<p>PRESUMPTIVE ELIGIBILITY PRENATAL A</p> <p>Client is eligible to receive all Medicaid services except inpatient care, institutional long-term care, alternate level of care, and long-term home health care.</p>
	30 (Medicaid)	<p>PRESUMPTIVE ELIGIBILITY PRENATAL B</p> <p>Client 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 of care, ophthalmic, DME, therapy (physical, speech, and occupational), abortion, and podiatry.</p>

RESPONSE/RETURN	SERVICE TYPES RETURNED	POSSIBLE CAUSES
N SERVICES RESTRICTED TO THE FOLLOWING PROVIDER	30 (Medicaid)	<p>SERVICES RESTRICTED TO THE FOLLOWING PROVIDER</p> <p>For restricted clients, this response is returned if the ordering provider entered is not who the client is restricted to.</p>
R OTHER OR ADDITIONAL PAYER	30 (Medicaid)	<p>ELIGIBLE CAPITATION GUARANTEE</p> <p>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. Clients 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.</p>
	30 (Medicaid)	<p>FAMILY HEALTH PLUS</p> <p>Client is enrolled in the Family Health Plus Program (FHP) and receives most services through a FHP participating Managed Care Plan.</p>
MC MANAGED CARE COORDINATOR	30 (Medicaid)	<p>ELIGIBLE PCP</p> <p>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, 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.</p>

11.0 REJECT REASON CODES (Rev. 06/08)

NOTE: The table below displays the mapping of HIPAA codes to eMedNY codes.

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
CT	CONTACT PAYER	CALL 1-800-343-9000
		When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
I	NON COVERED	NOT MA ELIGIBLE
		Patient does not have Medicaid coverage for the date you are requesting.
		NO COVERAGE PENDING FAMILY HEALTH PLUS
Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.		
U	CONTACT FOLLOWING ENTITY FOR ELIGIBILITY OR BENEFIT INFORMATION	CALL 1-800-343-9000
		When certain conditions are met (ex: multiple responses), you are instructed to call the Provider Services staff for additional data.
Y	SPENDDOWN	NO COVERAGE: EXCESS INCOME
		Client 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.
15	REQUIRED APPLICATION DATA MISSING	NO UNITS ENTERED
		No entry was made and the units are required for this transaction.
33	INPUT ERRORS	ITEM NOT COVERED
		The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
33 INPUT ERRORS (contd.)	MISSING/INVALID DVS QUANTITY
	The entered quantity's format is invalid or missing and is required.
	CURRENT DATE REQUIRED
	A DVS transaction requires a current date entry. The date entered was NOT today's date.
	MISSING/INVALID CATEGORY OF SERVICE
	The entered taxonomy/service type does not map to a valid category of service on the provider's file for the entered Date of Service.
41 AUTHORIZATION/ACCESS RESTRICTIONS	MISSING/INVALID TOOTH/QUADRANT
	The tooth number, tooth quadrant, or arch was not entered and is required, or was entered incorrectly.
	DOWNLOAD REQUIRED
	The VeriFone software is obsolete and must be updated. This message is displayed once a day until the download is completed.
	INVALID TRAN TYPE
An invalid transaction type other than 1-4, 6 or 7 was entered.	
INVALID TERMINAL ACCESS	
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 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 HCPCS codes (five-digit alpha/numeric codes). 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.	

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
41 AUTHORIZATION/ACCESS RESTRICTIONS (contd.)	SERVICE NOT ORDERED
	The ordering provider did not post the services you are trying to clear. Contact the ordering provider.
	LOST/STOLEN TERMINAL
	The terminal serial ID is indicated as being a lost or stolen terminal. Call 1-800-343-9000 for assistance.
	PAYMENT PAST DUE
	The terminal serial ID is indicated as having past due payments. Call 1-800-343-9000 for assistance.
	SSN ACCESS NOT ALLOWED
The provider is not authorized to access the system using a social security number. The Medicaid Number (CIN) or Access Number must be entered.	
42 UNABLE TO RESPOND AT CURRENT TIME	RESUBMIT TRANSACTION
43 INVALID/MISSING PROVIDER INFORMATION	INVALID PROVIDER NUMBER
	The Provider ID entered is not valid.
	REENTER ORDERING PROVIDER
	The National Provider Identifier (NPI), license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
	INVALID PROFESSION CODE
The Profession Code entered in the ordering provider field is not a valid value. Refer to the eMedNY website at http://www.emedny.org for a list of valid Profession Codes.	

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
43	INVALID/MISSING PROVIDER INFORMATION (contd.)	DISQUALIFIED ORDERER
		The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
		DECEASED ORDERER
		The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
		INVALID ORDERING PROVIDER
		The National Provider Identifier (NPI), license number or MMIS Provider ID that was entered in the ordering provider field was not found on the license or provider files.
		INVALID REFERRING PROVIDER NUMBER
		The referring provider ID number was entered incorrectly or is not a valid Provider ID. A license number cannot be entered in this field.
45	INVALID/MISSING PROVIDER SPECIALTY	PRESCRIBING PROVIDER LICENSE INACTIVE
		The license number entered in the ordering provider field is on the license file but is not active for the date of service entered.
48	INVALID/MISSING PROVIDER IDENTIFICATION	INVALID TAXONOMY OR SERVICE TYPE
		The Taxonomy and/or Service Type entered does not map to a specialty or category of service on the provider's file for the entered Date of Service.
48	INVALID/MISSING PROVIDER IDENTIFICATION	REENTER ORDERING PROVIDER
		The National Provider Identifier (NPI), license number or provider number entered in the ordering provider field has the incorrect format (wrong length or characters in the wrong position).
		DISQUALIFIED ORDERER

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
48 INVALID/MISSING PROVIDER IDENTIFICATION (contd.)	The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
	DECEASED ORDERER
	The National Provider Identifier (NPI), License Number or eight-digit MMIS Provider ID 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 profession code/license number combination and format was entered.
	INVALID ORDERING PROVIDER
	The National Provider Identifier (NPI), license number or MMIS Provider ID that was entered in the ordering provider field was not found on the license or provider files.
	INVALID REFERRING PROVIDER ID NUMBER
	The referring provider NPI or eight-digit MMIS number was entered incorrectly or is not a valid Provider ID. A license number cannot be entered in this field.
49 PROVIDER IS NOT PRIMARY PHYSICIAN	RESTRICTED RECIPIENT NO AUTHORIZATION
	This client is restricted to services from a specific provider. In the referring provider field, enter the National Provider Identifier (NPI) or eight-digit MMIS provider ID of the primary provider (physician, clinic, inpatient hospital etc.) to whom the client is restricted.
	MCCP RESTRICTED RECIPIENT NO AUTHORIZATION

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
49	PROVIDER IS NOT PRIMARY PHYSICIAN (contd.)	Services must be provided, ordered or referred by the primary. In the referring provider field, enter the National Provider Identifier (NPI) or the eight-digit MMIS provider ID of the primary provider (physician, clinic, inpatient hospital etc.) to whom the client is restricted.
50	PROVIDER INELIGIBLE FOR INQUIRIES	PROVIDER NOT ELIGIBLE The verification was attempted by an inactivated or disqualified provider.
51	PROVIDER NOT ON FILE	PROVIDER NOT ON FILE The provider number entered is not identified as a Medicaid enrolled provider. Either the number is incorrect or not on the provider master file.
52	SERVICE DATES NOT WITHIN PROVIDER PLAN ENROLLMENT	PROVIDER INELIGIBLE SERVICE ON DATE PERFORMED The Taxonomy and/or Service Type entered does not map to a specialty or category of service on the provider's file for the entered Date of Service. This message will also be returned if Taxonomy code (Clinic Pharmacy) or Service Type (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.
53	INQUIRED BENEFIT INCONSISTENT WITH PROVIDER TYPE	COS NOT VALID FOR ITEM/NDC CODE The entered Taxonomy and/or Service Type does not map to a COS that is valid for the Item/NDC procedure code.
60	DATE OF BIRTH FOLLOWS DATE(S) OF SERVICE	SERVICE DATE PRIOR TO BIRTHDATE A date which occurs before the birthdate.
62	DATE OF SERVICE NOT WITHIN ALLOWABLE INQUIRY PERIOD	INVALID DATE An illogical date or a date which falls outside the MEVS inquiry period. (Dates up to 24 months retroactive will be supported.)
69	INCONSISTENT WITH PATIENT'S AGE	AGE EXCEEDS MAXIMUM The client's age exceeds the maximum allowable age on the NYS Drug Plan file for the item/NDC code entered. AGE PRECEDES MINIMUM

REJECT REASON CODE AND DESCRIPTION		POSSIBLE CAUSES
69	INCONSISTENT WITH PATIENT'S AGE (contd.)	The client's age is below the minimum allowable age on the NYS Drug Plan file for the item/NDC code entered.
70	INCONSISTENT WITH PATIENT'S GENDER	ITEM/GENDER INVALID
		The item/NDC code entered is not reimbursable for the client's gender resident on the eligibility file.
72	INVALID/MISSING SUBSCRIBER/INSURED ID	INVALID CARD THIS RECIPIENT
		Client has used an invalid card. Check the number you have entered against the client's Common Benefit Identification Card. If they agree, the client has been issued a new and different Benefit Identification Card and must produce the new card prior to receiving services.
		INVALID ACCESS NUMBER
		An incorrect access number was entered.
		INVALID MEDICAID NUMBER
		The Medicaid number (CIN) entered is not valid.
		INVALID SEQUENCE NUMBER
		The sequence number entered is not valid or not current. Check the client's card for the current sequence number.
75	SUBSCRIBER/INSURED NOT FOUND	SOCIAL SECURITY NUMBER NOT ON FILE
		The entered nine-digit number is not on the Client Master File.
		RECIPIENT NOT ON FILE
		Client identification number (CIN) is not on file. The number is either incorrect or the client is no longer eligible and the number is no longer on file.
		NO COVERAGE: PENDING FHP
		Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.
		NO MATCH ON FILE
		Client is not found on file.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
76 DUPLICATE SUBSCRIBER/INSURED ID NUMBER	<p>CALL LOCAL DISTRICT</p> <p>When a Name Search transaction is submitted and more than one eligible client identification number (CIN) is found, please contact the client's local county of fiscal responsibility.</p>
84 CERTIFICATION NOT REQUIRED FOR THIS SERVICE	<p>PA NOT REQ/MEDIA TYPE INVALID</p> <p>The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through MEVS or this is not the appropriate access for obtaining a Prior Approval number for this item/NDC. This response will be returned except on the OMNI 3750. For those developing their own software, refer to the NYS Medicaid HIPAA Companion Documents, 278 Request and Response.</p> <p>DVS NUMBER NOT REQUIRED</p> <p>The entered item/NDC was not designated by the Dept. of Health to receive a DVS number through MEVS. This response will be returned for the Verifone OMNI 3750 Terminal.</p>
87 EXCEEDS PLAN MAXIMUMS	<p>AT SERVICE LIMIT</p> <p>The client has reached his/her limit for that particular service category. No service authorization is created. The service is NOT approved and payment by Medicaid will NOT be made. Refer to your MMIS manual if the patient has either an emergency or medically urgent situation.</p> <p>EXCEEDS FREQUENCY LIMIT</p> <p>The client 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.</p> <p>MAXIMUM QUANTITY EXCEEDED</p> <p>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).</p>

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
88 NON-COVERED SERVICE	PROCEDURE CODE NOT COVERED
	The procedure code entered was either entered incorrectly or is not a NYS reimbursable code, or has been discontinued.
	ITEM NOT COVERED
	The entered Item/NDC code is not a reimbursable code on the New York State Drug Plan file or has been discontinued.
89 NO PRIOR APPROVAL	NO AUTHORIZATION FOUND
	No matching transaction found for the authorization confirmation transaction or cancellation request.
91 DUPLICATE REQUEST	DUPLICATE – UT PREVIOUSLY APPROVED
	The service authorization request is a duplicate of a previously approved service authorization request for a given provider, client, and date of service.
	DUPLICATE DVS
	The entered transaction is a duplicate of a previously submitted and approved DVS transaction.
95 PATIENT NOT ELIGIBLE	NOT MEDICAID ELIGIBLE
	Client is not eligible for benefits on the date of service requested.
	FAMILY HEALTH PLUS
	Client has Family Health Plus.
	NO COVERAGE: PENDING FHP
	Client is waiting to be enrolled into a Family Health Plus Managed Care Plan. No Medicaid services are reimbursable.

REJECT REASON CODE AND DESCRIPTION	POSSIBLE CAUSES
95 PATIENT NOT ELIGIBLE (contd.)	NO COVERAGE: EXCESS INCOME
	Client 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.
	CLIENT MEDICARE PART D DENIAL
	DVS Requests for Pharmacy and DME Prior Approvals will be rejected for Clients who have Part D Medicare coverage (prescription drugs).
	CLIENT ELIGIBLE FOR EMERGENCY SERVICES ONLY
	Clients who have coverage for Emergency Services Only are eligible to receive treatment for emergency medical conditions requiring emergency medical care. DVS PA requests for DME, Dental and Hearing Aid procedure/Item codes which are not considered emergency will be rejected.
	CLIENT IS MEDICARE ELIGIBLE
For dual eligible Medicare/Medicaid Clients in cases where Medicare covers the service, DVS PA requests for DME, Hearing Aid and Dental Procedure/Item codes will be rejected. If you are billing for Medicare Deductible, Coinsurance, Co-pay for a Medicare covered service, a DVS PA is not necessary.	

11.1 MEVS Terminal Messages (Rev. 10/03)

CHECK LINE	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.
CONNECT XXXX	This message is displayed until transmission to the host computer begins.
DOWNLOAD DONE	This message is displayed when the download function process is complete. Pres ENTER to continue.
NO ENQ FROM HOST	No enquiry received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact Provider Services at 1-800-343-9000 for assistance.
NO RESPONSE FROM HOST	No response received from host. A problem exists with the network. Repeat the transaction. If problem persists, contact Provider Services at 1-800-343-9000 for assistance.
PLEASE TRY AGAIN	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.
PROCESSING	This message is displayed until the host message is ready to be displayed.
RECEIVING	This message is displayed until the host message is received by the VeriFone.
RETRY TRANSACTION	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.
TRANSMITTING	This message is displayed until the host computer acknowledges the transmission.
UNREADABLE CARD	Will be displayed after three unsuccessful attempts to swipe the card.

12.0 REVIEW FUNCTION (Rev. 11/02)

The Review function allows you to review the last response received, edit the transaction data and resubmit the transaction. To begin follow the Action/Display table.

DISPLAY	ACTION
Initial Screen	Press the P4 SCROLL FORWARD/REVIEW key
The response from the last transaction is displayed	Press the ENTER key to edit the data
Each screen displays the data that was entered	Reenter new data Or Press the ENTER key to accept current data

13.0 CODES SECTION (Rev. 10/03)**13.1 Co-payment Type Codes** (REV. 10/03)

For ARU only, codes used to designate the type of co-payment service you are rendering. Select the code which corresponds to the type of service being rendered. These codes are the only valid codes to be entered in the co-payment prompt.

CODES	DESCRIPTION
21	Inpatient Hospital
22	Emergency Room - non-emergency, non-urgent
23	Clinic
31	Prescription Drugs - brand name
32	Prescription Drugs - generic
33	Non-prescription Drugs (OTC)
41	Sickroom Supplies
42	Laboratory
43	X-Ray
92	No Co-pay

13.2 Taxonomy and Service Type Codes (Rev. 07/04)

To ensure correct Utilization Threshold processing use the appropriate Taxonomy Code/Service Type Code Combinations. Clinic providers must enter a Taxonomy Code or a Service Type Code or both on a Service Authorization transaction. Out of State Providers [see section 13.3](#)

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
AIDS Clinic - Freestanding	249, 355		85 - AIDS
Clinic - Freestanding	300, 301, 302, 303, 304, 305, 308, 309, 320, 900, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 960, 961, 962, 967, 968, 970, 975, 976, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1-Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital - Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 - Maternity 76 - Dialysis 78 - Chemotherapy A9 - Rehabilitation AJ - Alcoholism AK - Drug Addiction
Clinic -Hospital Based	300, 301, 302, 303, 304, 305, 308, 309, 320, 904, 908, 913, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 960, 961, 962, 967, 968, 970, 972, 973, 975, 976, 979, 983, 984, 985, 986, 987, 988, 989, 990, 991, 993, 994, 995, 996, 997, 998		1 - Medical Care 6 - Radiation Therapy 15 - Alternate Method Dialysis 53 - Hospital - Ambulatory Surgical 65 - Newborn Care 68 - Well Baby Care 69 - Maternity 76 - Dialysis 78 - Chemotherapy A9 - Rehabilitation AJ - Alcoholism AK - Drug Addiction
Clinic -Hospital Based	740		56 - Medically Related Transportation

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Clinic – Hospital Based or Freestanding	902, 903, 905, 909, 914, 915, 916, 917, 925, 926, 927, 928, 929, 930, 931, 932, 933, 950, 951, 952, 953, 954, 955, 956, 957, 965, 966, 999		2 – Surgical 3 – Consultation 17 - Pre-Admission Testing 20 - Second Surgical Opinion 21 - Third Surgical Opinion 50 - Hospital – Outpatient 64 – Acupuncture 67 - Smoking Cessation 71 – Audiology Exam (Non-DVS) 72 - Inhalation Therapy 73 - Diagnostic Medical 79 - Allergy Testing 80 - Immunizations 98 - Professional (Physician) Visit – Office 99 - Professional (Physician) Visit – Inpatient A0 – Professional (Physician) Visit – Outpatient A1 - Professional (Physician) Visit - Nursing Home A2 - Professional (Physician) Visit - Skilled Nursing Facility A3 - Professional (Physician) Visit – Home BD - Cognitive Therapy BE - Massage Therapy BF - Pulmonary Rehabilitation BG - Cardiac Rehabilitation BS - Invasive Procedures
Clinic – Hospital Based or Freestanding	918		93 – Podiatry 94 - Podiatry - Office Visits 95 - Podiatry - Nursing Home Visits
Clinic - Freestanding	919, 920, 921, 923, 924, 958	261Q0000X ----- or No Taxonomy	50 - Hospital – Outpatient ----- or AC - Rehabilitation – Outpatient AD - Occupational Therapy AE - Physical Medicine AF - Speech Therapy AL - Vision (Optometry)

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Clinic -Hospital Based	919, 920, 921, 923, 924, 958	282N00000X ----- or No Taxonomy	50 - Hospital – Outpatient ----- or AC - Rehabilitation – Outpatient AD - Occupational Therapy AE - Physical Medicine AF - Speech Therapy AL - Vision (Optometry)
Clinic –Hospital Based or Freestanding	922		AI - Substance Abuse
Clinic – Hospital Based or Freestanding	935		77 - Otological Exam
Clinic – Hospital Based or Freestanding	969		75 - Prosthetic Device
Clinic – Hospital based or Freestanding - DVS	967		71 - Audiology Exam
Clinic Abortion – Hospital based or Freestanding	907		84 - Abortion
Clinic Family Planning - Hospital based or Freestanding	906		82 - Family Planning
Clinic Pharmacy - Hospital based or Freestanding	760		88 - Pharmacy
Clinic Radiology - Hospital based or Freestanding	998		4 - Diagnostic X-Ray 62 - MRI/CAT Scan
Clinic/Center - Multispecialty - Hospital based or Freestanding	321	261QM1300 X	
Clinic/Center - Student Health - Freestanding	306, 325	261QS1000X	
Dental Clinic - Hospital Based or Freestanding	350, 351	261QD0000X	35 - Dental Care
Dental Clinic - Hospital Based or Freestanding	910, 911		40 - Oral Surgery

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Dental Clinic - Hospital Based or Freestanding	911		23 - Diagnostic Dental 24 - Periodontics 25 - Restorative 26 - Endodontics 27 - Maxofacial Prosthetics 28 - Adjunctive Dental Services 35 - Dental Care 36 - Dental Crowns 37 - Dental Accident 39 - Prosthodontics
Dental Clinic - Hospital based or Freestanding	912		38 - Orthodontics
DME Dealer –DVS Only			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Emergency Room - Hospital Based or Freestanding	901		51 - Hospital - Emergency Accident 52 - Hospital - Emergency Medical 86 - Emergency Services
Home Health DME – DVS			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Hospital General Acute Care - Special Use	060, 110, 181, 730	282N00000X	
Hospital Inpatient - Non-DVS	899		48 - Hospital – Inpatient 63 - Donor Procedures 70 – Transplants A7 - Psychiatric – Inpatient AB - Rehabilitation - Inpatient
Hospital Inpatient DVS	COS 0285		48 - Hospital – Inpatient 63 - Donor Procedures 70 – Transplants A7 - Psychiatric – Inpatient AB - Rehabilitation - Inpatient

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Lab	411, 412, 413, 414, 415, 416, 419, 420, 421, 422, 423, 427, 430, 431, 432, 435, 436, 438, 439, 440, 441, 442, 450, 451, 460, 470, 481, 482, 483, 484, 485, 486, 491, 510, 511, 512, 513, 514, 515, 516, 518, 521, 523, 524, 531, 540, 550, 551, 552, 553, 560, 571, 572, 573, 580, 599		5 - Diagnostic Lab
Clinic Pharmacy – Hospital based or Freestanding	760	333600000X	
Pharmacy DME	307		12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental
Physician	010, 030, 040, 041, 050, 060, 062, 063, 064, 065, 066, 067, 068, 069, 070, 080, 089, 092, 093, 100, 110, 120, 131, 135, 136, 137, 138, 139, 141, 142, 143, 146, 148, 160, 162, 170, 182, 183, 184, 185, 194, 200, 201, 202, 210, 220, 230, 241, 242, 402, 403, 404, 777		A0 - Professional (Physician) Visit - Outpatient
Physician	020, 130, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 161, 163, 169, 186, 187, 191, 192, 193, 195, 196, 205, 247, 249, 252, 253, 254, 270, 306, 401, 751		98 - Professional (Physician) Visit - Office
Physician			86 - Emergency Services
Physician	750		AK - Drug Addiction
Physician Abortion			84 - Abortion
Physician Group	010, 060, 063, 089, 100, 150, 158, 159, 161, 750	193400000X	
Physician Radiology	081, 206, 207, 208		04 - Diagnostic X-Ray

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Psychiatric Clinic – Hospital Based	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 971, 974		A4 – Psychiatric A6 – Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic - Freestanding	310, 311, 315, 316, 322, 945, 946, 947, 948, 963, 964, 974		A4 – Psychiatric A6 – Psychotherapy BC - Day Care (Psychiatric)
Psychiatric Clinic – Hospital Based or Freestanding	312, 313, 314, 317, 318, 319, 323, 352, 353, 354, 959, 978, 980, 982, 992		A8 - Psychiatric – Outpatient BB - Partial Hospitalization (Psychiatric)
Transportation DME – DVS Only			12 - Durable Medical Equipment Purchase 18 - Durable Medical Equipment Rental

13.3 Out of State Providers (REV. 10/03)

If you are an Out of State provider of one of the types listed below use the Taxonomy Code provided.

If you are	And your Specialty Code for the service is	Use Taxonomy	Service Type Code
Out of State Clinical Psychologist		103GC0700X	
Out of State Licensed Practical Nurse		164W00000X	
Out of State Midwife, Certified Nurse		367A00000X	
Out of State Nurse Practitioner		363L00000X	
Out of State Occupational Therapist		225X00000X	
Out of State Physical Therapist		225100000X	
Out of State Physician - General Practice		208D00000X	
Out of State Registered Nurse - General Practice		163WG0000X	
Out of State Speech-Language Pathologist		235Z00000X	

13.4 County/District Codes (Rev. 10/03)

The County/District, two-digit codes are used to identify the client'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

13.5 Exception Codes (Rev. 06/09)

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

Code 23	This code identifies a client who is enrolled in the OMH Home and Community Based Services (HCBS) Waiver for Seriously Emotionally Disturbed (SED) children. As a result, this individual is exempt from Utilization Threshold and Co-pay requirements.
Code 24	This code identifies a client who is enrolled in a Chronic Illness Demonstration Project (CIDP) program. The client's participation in a CIDP does not affect eligibility for other Medicaid services. As a result, this individual is not Utilization Threshold or Co-pay exempt.
Code 30	This code identifies a Medicaid client who is enrolled in the Long Term Home Health Care Program Waiver also known as the Lombardi Program/nursing home without walls. The client is authorized to receive LTHHCP services from an enrolled LTHHCP provider. Clients with R/E 30 are <u>not</u> Utilization Threshold or Co-pay exempt.
Code 35	This client is enrolled in a Comprehensive Medicaid Case Management (CMCM) program and is exempt from Co-payment and Utilization Threshold processing. The client's participation in CMCM does not affect eligibility for other Medicaid services.
Code 38	The client 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 client in the Aid Continuing program. As such, the client is subject to Utilization Threshold and exempt from Co-payment requirements.
Code 44	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Non-Intensive At Home Residential Habilitation services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 45	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Intensive At Home

	Residential Habilitation services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 46	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive services. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 47	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Service (HCBS) Waiver and resides in a <i>supervised</i> Community Residence. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 48	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Service (HCBS) Waiver and resides in a <i>supportive</i> Community Residence (CR) or a <i>supportive</i> Individual Residential Alternative (IRA). As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 49	This code identifies a Medicaid client who is enrolled in OMRDD's Home and Community Based Services (HCBS) Waiver, resides in a <i>supervised</i> 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.
Code 50	This client 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 Perinatal Family , refer to Section 3.4 on page 3.4.1 for the Eligibility Responses .
Code 51	This client has Connect services, plus is eligible for the services described in the Eligibility Response associated with the client. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements. For the range of possibilities, refer to Section 3.4 on page 3.4.1 for the Eligibility Responses .
Code 54	This code designates a client whose outpatient Medicaid coverage is limited to Home Health and Personal Care Services benefits. As such, the client is subject to Utilization Threshold and Co-payment requirements.
Code 60	This code identifies a client who is receiving Home and Community Based Services (HCBS) as part of the Nursing

	Home Transition and Diversion Waiver program. As a result, this individual is exempt from Utilization Threshold and Co-payment requirements.
Code 62	This code identifies a client 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 client 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 client 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 client 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 client 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 client 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 client 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 client 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.
Code 70	This code identifies a client 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 client 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 72	This Restriction/Exception code identifies Medicaid recipients under the age of 21 who are participants in the Bridges to Health Waiver for the Seriously Emotionally Disturbed (B2H/SED). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible. Participants in the B2H/SED waiver are exempt from Co-payment and Utilization Threshold.
Code 73	This Restriction/Exception code identifies Medicaid recipients under the age of 21 who are participants in the Bridges to Health Waiver for Developmentally Disabled (B2H). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible. Participants in B2H/DD are exempt from Co-payment and Utilization Threshold.
Code 74	This Restriction/Exception code identifies Medicaid recipients under the age of 21 who are participants in the Bridges to Health Waiver for the Medically Fragile (B2H/MedF). This waiver is for children who are initially in foster care but who can remain in the waiver after discharge, if otherwise eligible. Participants in B2H/MedF are exempt from Co-payment and Utilization Threshold.
Code 75	This code identifies a participant of the Partnership program who has Dollar for Dollar Asset Protection. The client may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services. This client is subject to Utilization Threshold and Co-payment requirements.
Code 76	This code identifies a participant of the Partnership program who has Total Asset Protection. The client may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services. This client is subject to Utilization Threshold and Co-payment requirements.
Code 77	This code identifies a client that may have long term care

	insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. This client is subject to Utilization Threshold and Co-payment requirements.
Code 81	This code identifies a client 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 client 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 84	This code identifies a Medicaid client who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Community Rehabilitation and Support (CRS) With Clinic Treatment. These services are exempt from Co-pay and Utilization Threshold requirements. Other base and clinical PROS programs, OMH clinic, CDT, IPRT, PMHP, and ACT intensive claims will be denied payment.
Code 85	This code identifies a Medicaid client who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Community Rehabilitation and Support (CRS) Without Clinic Treatment. These services are exempt from Co-pay and Utilization Threshold requirements. Other base PROS programs, OMH CDT, IPRT, and ACT intensive claims will be denied payment.
Code 86	This code identifies a Medicaid client who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS). These services are exempt from Co-pay and Utilization Threshold requirements. Other PROS providers will be denied payment for these services. OMH IPRT claims will be denied payment.
Code 95	This code identifies Medicaid Managed Care exempt (mandatory) recipients with a mental retardation or developmental disability diagnosis who are eligible to be billed under an enhanced APG (Ambulatory Patient

	<p>Groups) base rate for clinical services. It will allow for payment of the following rates codes:</p> <p>1435 - MR/DD/TBI APG Base Rate 1436 - MR/DD/TBI Existing Payment for Blend 1437 - Capital and R&R Add-on</p> <p>This code will not exempt recipients from the Utilization Threshold or copayment processing.</p>
Code AL	<p>This code identifies a client who resides in an Assisted Living Program residence. The following services are included in the ALP's Medicaid per diem rate and cannot be billed to the Medicaid Program:</p> <ol style="list-style-type: none"> 1. Adult day health care provided in a program approved by the Department of Health; 2. Home health aide services; 3. Medical supplies and equipment NOT requiring prior approval (underlined procedure codes in the DME and Pharmacy provider manuals are prior approved); 4. Nursing services; 5. Personal care services; 6. Personal emergency response services; and 7. Physical therapy, speech therapy, and occupational therapy.
Code NH	<p>This code identifies a client in a Nursing Home facility. The majority of the client'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 client, 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.</p>
Code ZZ	<p>This code indicates that more Exception codes are applicable than can be displayed. Call 1-800-343-9000 to obtain additional Exception code information.</p>

13.6 Insurance Codes (Rev. 03/08)

Insurance codes are two character codes which, if returned in the MEVS response, identifies the client's insurance carrier. If you see an Insurance Code of **ZZ**, call 1-800-343-9000 to obtain additional Insurance and coverage information. Refer to the billing section of your MMIS Provider Manual for a list of codes and descriptions.

Insurance Coverage Codes

The POS device will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the client's managed care plan.

<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 freestanding 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. Note: Orthodontia is a carved out service, so all COVERED orthodontic care is paid on a fee-for-service basis, even for clients enrolled in a plan that otherwise covers dental services.

<u>COVERAGE CODES</u>	<u>DESCRIPTION</u>	<u>EXPLANATION</u>
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you may not request it from the client. 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.
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.

<u>COVERAGE CODES</u>	<u>DESCRIPTION</u>	<u>EXPLANATION</u>
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 client's insurance carrier.

13.7 New York City Office Codes (Rev. 10/03)

The office codes and descriptions listed below are only returned for **County Code 66** clients. They are not returned for Telephone Verifications. Any data returned in this field for clients 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

Medical Assistance

500-593 34th Street Manhattan

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.

14.0 APPENDIX (Rev. 05/09)**14.1 Attestation of Resources Non-Covered Services** (Rev. 04/09)**Community Coverage No LTC**

If you are receiving “Limitations” and COMMUNITY COVERAGE NO LTC on your EPACES, OMNI, or 271 Eligibility Response or COMMUNITY COVERAGE WITHOUT LONG TERM CARE on your ARU Eligibility Response, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

INPATIENT HOSPITAL claims will be covered with the following exceptions:

If your Category of Service is 0285 (Hospital Inpatient) and you are billing for any of the following Rate Codes: 2950, 2951, 2954, 2955, 2962 thru 2971, your claim will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0260 (Home Health Agency) or 0284 (Home Care Program), and you are billing any of the following Rate Codes: 2609, 2611, 2616, 2621, 2631, 2636 thru 2639, 2641, 2651, 2652, 2661, 2663 thru 2665, 2671, 2681, 2682, 2685, 2689 thru 2699, 2809, thru 2818, 2821 thru 2837, 2864, 3823 thru 3827, 9981, 9990 thru 9995, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing any of the following Rate Codes: 2301 thru 2309, 2311 thru 2331, 9912 thru 9923, 9930 thru 9935, 9960 thru 9967, 9970 thru 9973, your claim will NOT BE COVERED.

If your Category of Service is one of the following: 0263 (TBI- Traumatic Brain Injury), 0264 (Personal Care Services), 0266 (Personal Emergency Response), 0269 (OMRDD Waiver Services), 0388 (Long Term Home Health Care), your claims will NOT BE COVERED.

If your Category of Service is 0268 (OMH Rehabilitative Services) and you are billing one of the following Rate Codes: 4650 thru 4667, your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124, your claim will NOT BE COVERED.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice), 0267 (Assisted Living Program ALP), 0383 (Day Care), your claims will NOT BE COVERED.

ICF DD claims will NOT be covered

Community Coverage w/ CBLTC

If you are receiving “Limitations” and COMMUNITY COVERAGE W / CBLTC on your EPACES, OMNI, or 271 Eligibility Response or COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE on your ARU Eligibility Response and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

INPATIENT HOSPITAL claims will be covered with the following exceptions:

If your Category of Service is 0285 (Hospital Inpatient) and you are billing for any of the following Rate Codes: 2950, 2951, 2954, 2955 or 2962 thru 2971, your claim will NOT BE COVERED.

ICF DD claims will NOT be covered

Outpatient Coverage w/ CBLTC

If you are receiving “Limitations” and OUTPATIENT COVERAGE W / CBLTC on your EPACES, OMNI, or 271 Eligibility Response or OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE on your ARU Eligibility Response, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type and Claim Type.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice) and you are billing Rate Code 3990, your claim will NOT BE COVERED.

ICF DD claims will NOT BE COVERED

INPATIENT HOSPITAL

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type.

MEDICAL- (DME, TRANSPORTATION, REFERRED AMBULATORY, PRACTITIONER, LAB, EYE CARE, DENTAL) claims will be covered with the following exceptions:

If you are billing any of these services and are submitting Place of Service 21-(Inpatient) on your claim, your service will NOT BE COVERED.

Fee for Service providers may refer to their Billing Manuals located on www.emedny.org under Provider Manuals. Access the Billing Guidelines to determine the Place of Service Code which can be found in the Appendix A- Code Sets.

Outpatient Coverage No LTC

If you are receiving “Limitations” and OUTPATIENT COVERAGE NO LTC on your EPACES, OMNI, 271 Eligibility Response or OUTPATIENT COVERAGE WITHOUT LONG TERM CARE on your ARU Eligibility Response, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type and Claim Type.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is one of the following: 0165 (Hospice), 0267 (Assisted Living Program ALP) or 0383 (Day Care), your claims will NOT BE COVERED.

HOME HEALTH claims will be covered with the following exceptions:

If your Category of Service is one of the following: 0263 (TBI Traumatic Brain Injury), 0264 (Personal Care Services), 0266 (Personal Emergency Response Services), 0269 (OMRDD Waiver Services), 0388 (Long Term Home Health Care), your claims will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) or 0284 (Home Care Program) and you are billing for one of the following Rate Codes: 2609, 2611, 2616, 2621, 2631, 2636 thru 2639, 2641, 2651, 2652, 2661, 2663 thru 2665, 2671, 2681, 2682, 2685, 2689 thru 2699, 2809 thru 2818, 2821 thru 2837, 2864, 3823 thru 3827, 3831, 3858 thru 3875, 9981, 9990 thru 9995, your claim will NOT BE COVERED.

If your Category of Service is 0260 (Home Health Agency) and you are billing one of the following Rate Codes: 2301 thru 2309, 2311 thru 2331, 9912 thru 9923, 9930 thru 9935, 9960 thru 9967, 9970 thru 9973, your claim will NOT BE COVERED.

If your Category of Service is 0268 (OMH Rehabilitative Services) and you are billing one of the following Rate Codes: 4650 thru 4664, your claim will NOT BE COVERED.

PRACTITIONER claims will be covered with the following exceptions:

If your Category of Service is 0521 (Private Duty Nursing LPN), 0522 (Private Duty Nursing RN), 0523 (Hospital Registry LPN), 0524 (Hospital Registry RN) and you are billing procedure codes S9123 or S9124, your claim will NOT BE COVERED.

ICF DD claims will NOT be covered

CONTINUED:

If you are receiving “Limitations” and **OUTPATIENT COVERAGE NO LTC** on your EPACES, OMNI, 271 Eligibility Response or **OUTPATIENT COVERAGE WITHOUT LONG TERM CARE** on your ARU Eligibility Response, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

INPATIENT

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type.

MEDICAL- (DME, TRANSPORTATION, REFERRED AMBULATORY, PRACTITIONER, LAB, EYE CARE, DENTAL) claims will be covered with the following exception:

If you are billing any of these services and are submitting Place of Service 21-(Inpatient) on your claim, your service will NOT BE COVERED.

Fee for Service providers may refer to their Billing Manuals located on www.emedny.org under Provider Manuals. Access the Billing Guidelines to determine the Place of Service Code which can be found in the Appendix A- Code Sets.

Outpatient Coverage No NFS

If you are receiving “Limitations” and OUTPATIENT COVERAGE NO NFS on your EPACES, OMNI, or 271 Eligibility Response or OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES on your ARU Eligibility Response, and if you are providing services (as detailed below) your claims may be denied. All other Medicaid-covered services/supplies NOT listed below ARE covered by Medicaid for eligible clients with this Community Coverage.

CLINIC, NURSING HOME, HOME HEALTH, CHILD CARE, ICF DD, HMO-(Managed Care) claims will be covered with the following exceptions:

If you are billing for services included within any of these claim types and you are submitting one of the following Bill Types on your claim: 11, 12, 15 thru 18, 61 or 62, your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type and Claim Type.

NURSING HOME, CHILD CARE, ICF DD

If you are billing for services included in any of these claim types and your Category of Service is NOT 0287 (Day Treatment) or 0383 (Day Care), your claims will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Claim Type.

RESIDENTIAL HEALTH claims will be covered with the following exceptions:

If your Category of Service is 0165 (Hospice) and you are billing Rate Code 3990, your claim will NOT BE COVERED.

INPATIENT

If your Category of Service is 0285 (Hospital Inpatient) and you are **NOT Billing** any of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996, your claim will NOT BE COVERED.

If your Category of Service is 0285 (Hospital Inpatient) and you **ARE Billing** one of the following Rate Codes: 2946, 2950, 2951, 2953, 2956, 2958, 2960 or 2996 and you are submitting one of the following Bill Types on your claim- (11, 12, 15 thru 18, 61 or 62), your claim will NOT BE COVERED.

Please refer to the Rate Code Crosswalk located on www.emedny.org under NYHIPAADESK which contains a table for use in filing claims. Select a Rate Code for which you are enrolled with, to determine your Bill Type.