Participating Pharmacy Administrative Manual

for

Pharmacies Participating in the
Coventry National Network
(Bin 610029)

First Health®
Pharmacies Participating in the
First Health® Rx National Network
(Bin 002286)

AdvantraRx
Pharmacies Participating in the
Coventry National Medicare Part D Network
(BIN 610029)

First Health Premier
Pharmacies Participating in the
First Health National Medicare Part D Network
(BIN 610029)
COVENTRY HEALTH CARE, INC.

PARTICIPATING PHARMACY ADMINISTRATIVE MANUAL

FOREWORD

This manual is intended to serve as an administrative guide to assist your pharmacy staff by providing detailed information regarding the policies of Coventry Health Care, Inc. for the Coventry National Network, the First Health® Rx Network, and the Advantra-RX and First Health® Premier National Medicare Part D Network(s). The information in this manual is current at press time. Therefore, page changes and supplements to this manual will be forwarded from time to time and should be kept with the manual for easy reference. On-line adjudication of claims will reflect the most current benefit; and takes precedence over printed information. For specific details regarding the basic elements of the Agreement between Coventry Health Care, Inc. and its participating pharmacies, refer to the Coventry Health Care, Inc. National Pharmacy Participation Agreement.

For ease of use, the defined terms in this Participating Pharmacy Administrative Manual have the same meaning as the Agreement. As always, in the event that this manual and your Agreement differ, the Agreement supersedes the manual. While we hope that most of your day-to-day questions concerning the Coventry Health Care, Inc. pharmacy program are adequately addressed in this manual, please call if you have any questions.
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If you need additional clarification, please contact the telephone numbers listed below:

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<th>Network Name</th>
<th>Web Site</th>
<th>Pharmacy Program Administrator</th>
<th>BIN Number</th>
<th>Inquiries</th>
<th>Claims Submission</th>
<th>Member Benefit &amp; Eligibility</th>
<th>Pharmacy Contracting</th>
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<tr>
<td>Coventry National Network</td>
<td><a href="http://www.cvty.com">www.cvty.com</a></td>
<td>Caremark, Inc.</td>
<td>610029</td>
<td>1-800-378-7040</td>
<td>Located on ID Card</td>
<td>1-800-378-7040</td>
<td>Pharmacy Network Services Department</td>
</tr>
<tr>
<td>First Health® Rx</td>
<td><a href="http://www.firsthealth.com">www.firsthealth.com</a></td>
<td>First Health® Rx</td>
<td>002286 (610678 for Medicare Part D COB)</td>
<td>1-800-364-6331</td>
<td>1-800-364-6331</td>
<td>Located on ID Card</td>
<td>Pharmacy Network Services Department</td>
</tr>
<tr>
<td>Advantra® Rx</td>
<td><a href="http://www.advantrarx.com">www.advantrarx.com</a></td>
<td>Caremark, Inc.</td>
<td>610029</td>
<td>1-800-364-6331</td>
<td>Located on ID Card</td>
<td>1-800-364-6331</td>
<td>Pharmacy Network Services Department</td>
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<td>First Health® Premier</td>
<td><a href="http://www.firsthealthpremier.com">www.firsthealthpremier.com</a></td>
<td>Caremark, Inc.</td>
<td>610029</td>
<td>1-800-364-6331</td>
<td>Located on ID Card</td>
<td>1-800-364-6331</td>
<td>Pharmacy Network Services Department</td>
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<td>Subsidiary Name</td>
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<tr>
<td>Altius Health Plans, Inc.</td>
<td>10421 South Jordan Gateway Suite 400 South Jordan, UT 80495</td>
<td>1-877-215-4100</td>
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<tr>
<td>Carelink Health Plans, Inc.</td>
<td>500 Virginia St., East Suite 400 Charleston, WV 25301</td>
<td>1-877-215-4100</td>
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<tr>
<td>Group Health Plan, Inc.</td>
<td>111 Corporate Office Dr., Suite 400 Earth City, MO 63045</td>
<td>1-877-215-4100</td>
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<tr>
<td>HealthAmerica Pennsylvania, Inc./HealthAssurance Pennsylvania, Inc.</td>
<td>2575 Interstate Drive Harrisburg, PA 17110</td>
<td>1-877-215-4100</td>
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<tr>
<td>HealthAmerica Pennsylvania, Inc./HealthAssurance Pennsylvania, Inc.</td>
<td>11 Stanwix Street, Suite 2300 Pittsburgh, PA 15222</td>
<td>1-877-215-4100</td>
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<tr>
<td>HealthCare USA of Missouri, LLC</td>
<td>100 South Fourth Street, Suite 1100 St. Louis, MO 63102</td>
<td>1-877-215-4100</td>
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<tr>
<td>Coventry Health Care of Delaware, Inc.</td>
<td>Little Falls Center II 2751 Centerville Road, Suite 400 Wilmington, DE 19808</td>
<td>1-877-215-4100</td>
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<tr>
<td>Coventry Health Care of Iowa, Inc.</td>
<td>4320 N.W. 114th Street Urbandale, IA 50322</td>
<td>1-877-215-4100</td>
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<td>Coventry Health Care of Kansas, Inc.</td>
<td>1001 East 101st Terrace, Suite 300 Kansas City, MO 64131</td>
<td>1-877-215-4100</td>
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<tr>
<td>Coventry Health Care of Kansas, Inc. – Wichita</td>
<td>8301 East 21st North, Suite 300 Wichita, KS 67206</td>
<td>1-877-215-4100</td>
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<tr>
<td>Coventry Health Care of Iowa, Inc.</td>
<td>3715 Northside Parkway, Suite 4-300 Atlanta, GA 30327</td>
<td>1-877-215-4100</td>
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<tr>
<td>PersonalCare Insurance of Illinois, Inc.</td>
<td>2110 Fox Drive Champaign, IL 61820</td>
<td>1-877-215-4100</td>
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<tr>
<td>WellPath Select, Inc.</td>
<td>6330 Quadrangle Drive, Suite 500 Chapel Hill, NC 27514-9872</td>
<td>1-877-215-4100</td>
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<tr>
<td>OmniCare Health Plans, Inc.</td>
<td>1333 Gratiot Avenue Suite 400 Detroit, MI 48207</td>
<td>1-877-215-4100</td>
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<td>HealthCare USA of Missouri, LLC</td>
<td>2575 Interstate Drive Harrisburg, PA 17110</td>
<td>1-877-215-4100</td>
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<tr>
<td>Southern Health Services, Inc.</td>
<td>9881 Maryland Drive Richmond, VA 23233</td>
<td>1-877-215-4100</td>
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II. COVENTRY HEALTH CARE PLAN SUBSIDIARIES (continued)
Pharmacy Program Administrator: First Health Group Corp. (Bin 002286, 610678)

First Health Life & Health Insurance Company
3200 Highland Avenue
Downers Grove, Illinois 60515
(630) 737-7900

First Health Benefits Administrator Corporation
3200 Highland Avenue
Downers Grove, Illinois 60515
(630) 737-7900

First Health Group Corporation
3200 Highland Avenue
Downers Grove, Illinois 60515
(630) 737-7900

Cambridge Life Insurance Company
3200 Highland Avenue
Downers Grove, Illinois 60515
(630) 737-7900

NOTE: BIN 610678 is used only for submitting secondary claims to facilitate Medicare Part D COB. See revised First Health® RX payor specifications issued October 2005.
III. MEMBER ELIGIBILITY

**Member Eligibility**

The Coventry and First Health identification cards are integrated Member ID cards used for both medical and pharmacy benefits. Not all members with Coventry or First Health ID cards use the respective pharmacy networks for their benefits. The Advantra® RX and First Health Premier Medicare Part D ID cards are used only for Medicare Part D pharmacy benefits. The identification card is not an assurance of Member eligibility. Pharmacies should verify eligibility through the Pharmacy Program Administrator’s on-line system. For Member eligibility questions, please contact the phone number on the back of the Member’s ID card.

**Confirmed Eligibility**

Under no circumstances should a Member, whose eligibility can be verified by using the on-line system be denied a Covered Service or asked to pay more than is due under the terms of the National Pharmacy Participation Agreement.

**Unconfirmed Eligibility**

When Member eligibility cannot be verified, the Pharmacy may charge the member the Pharmacy's Usual & Customary Charge. Members may then seek reimbursement from their applicable Coventry Health Care Plan.

**Signature Log**

Pharmacy shall maintain a signature log on which each Member receiving a Covered Service is required to provide in writing the Payor’s name, the prescription number, the date the Covered Service is received by the Member and the Member’s signature or his or her designee’s signature.
IV. MEMBER IDENTIFICATION CARDS

The Identification Card

Each Member enrolled individually or with dependents, is provided an identification card which contains all of the pertinent Member information. If instructions describing how to enter the Member’s information appear on the card, please follow them to avoid any problems or delays in processing the claim.

Do NOT transmit the asterisk in the Member’s ID number when submitting the claim (when applicable).

The Member ID number must be used to determine the eligibility status of the subscriber, spouse or dependent. The Member shall present the identification card each time services are requested at a Participating Pharmacy. Be sure to review the Member’s ID card for the Pharmacy Program Administrator logo, BIN number and processor control number.

Please note that benefit plans utilizing the First Health® Rx national network may use the Member’s Social Security Number as the ID number. Due to confidentiality, some Member ID cards substitute “XXXXXXXXXX” for the ID number. New benefit plans effective January 1, 2005, may have non-SSN ID numbers. Please confirm with the Member the correct ID number.

Below is a sample of Member identification cards (not all inconclusive).

Carelink Health Plans:

Group Health Plan:
IV. MEMBER IDENTIFICATION CARDS (continued)

HealthAmerica:

HealthCare USA:

WellPath Select:

Southern Health Services:
IV. MEMBER IDENTIFICATION CARDS (continued)

Coventry Health Care Delaware, Georgia, Iowa, Kansas, Louisiana and Nebraska and Coventry Health and Life Insurance Company:

All medical services must be coordinated through your Primary Care Physician.  

Coventry's Medicare Services must be authorized by your PCP or must be referred to Coventry Health Care within 48 hours of their occurrence.  

Preauthorization prior to hospitalization is required to guarantee maximum benefits.  

For Mental Health or Substance Abuse services, prior approval is required and can be obtained 24 hours a day by calling 1-800-250-3908.  

Proceed with care outside the service area, call 1-800-775-7477 to locate an IPA provider.  

Please visit us at www.CHCInsurors.com

For urgent care outside the service area, call 1-888-814-5588.

All medical services to be coordinated through your Primary Care Physician.

Coventry's Medicaid Services must be authorized by your PCP or must be referred to Coventry Health Care within 48 hours of their occurrence.

Preauthorization prior to hospitalization is required to guarantee maximum benefits.

For Mental Health or Substance Abuse services, prior approval is required and can be obtained 24 hours a day by calling 1-800-250-3908.

Proceed with care outside the service area, call 1-888-814-5588.

All medical services must be coordinated through your Primary Care Physician.

Coventry's Medicare Services must be authorized by your PCP or must be referred to Coventry Health Care within 48 hours of their occurrence.

Preauthorization prior to hospitalization is required to guarantee maximum benefits.

For Mental Health or Substance Abuse services, prior approval is required and can be obtained 24 hours a day by calling 1-800-250-3908.

Proceed with care outside the service area, call 1-888-814-5588.
HealthAssurance of Pennsylvania (some Coventry Health and Life Insurance products may also use the HealthAssurance logo):
V. BILLING PROCEDURE

NCPDP Standards

Claims for Covered Services provided to Members by Participating Pharmacies must be submitted for adjudication to the appropriate Pharmacy Program Administrator using Coventry Health Care, Inc. approved on-line billing procedures. Caremark Inc. and First Health® Rx adhere to NCPDP standards for electronic claims submission. A list of NCPDP reject codes is included at the end of this section. Free form messages have also been developed for some conditions and are relayed with rejected or accepted claims to provide additional claim information.

Submit All Prescriptions

All claims transactions should be submitted on-line at the point of sale (POS) in order to properly process Member benefits. Pharmacies may transmit POS claims within thirty (30) days of the date of service. This includes prescriptions for which the Usual and Customary Charge or the contracted rate is less than the Copayment and no reimbursement is due to Pharmacy. This also includes prescriptions for (1) Members of any Coventry Health Care Plan product with high deductibles or (2) 100% Member responsibility because the Member's outpatient prescription drug benefit has been exhausted. In the event a claim cannot be submitted via POS, some benefit plans allow paper claims. Claims submitted to the Pharmacy Program Administrator on paper are processed in accordance with the requirements of the benefit plan and carry no guarantee of payment.

On-Line Access

All POS claims must be submitted using NCPDP v.5.1 transaction standards as specified in the applicable Pharmacy Program Administrator payor specifications. Other versions should not be submitted and may result in claim rejection. Access to the Pharmacy Program Administrator's electronic claims submission system (on-line) can be obtained by contacting your software vendor. The software vendor will likely have a service agreement with National Data Corporation (NDC), WebMD/Envoy, or Medi-America. The Caremark Inc. BIN Number is 610029. You may download a copy of the Caremark payor specifications at www.caremark.com/wps/portal/_s.155/3398. The First Health® Rx Bin number is 002286. You may request a copy of the First Health® Rx payor specifications at FirstHealthRx@firsthealth.com.

On-Line System Availability

The Pharmacy Program Administrator claims processing system is available for on-line processing 24 hours a day.

The Pharmacy Program Administrator claims processing system has minimal non-scheduled downtime. It is possible, however, that hardware or software problems at the Pharmacy, switch company, or remote locations could prohibit electronic claims submissions for a period of time. In this event, the Pharmacy will need to submit manual claims if its electronic billing method lacks the capability to report the proper date of service.
V. BILLING PROCEDURE (continued)

If the system is down and the Member, physician, and drug eligibility cannot be determined, the Pharmacy may collect the Usual and Customary Charge for the prescription. The member may then seek reimbursement from their Coventry Health Care Plan.

**Timeliness of Claims Submission**

Unless otherwise required by law, claims submitted on-line must be received by the Pharmacy Program Administrator, for all Coventry Health Care Plans within thirty (30) days of the date of service; manual pharmacy claims within ninety (90) days. Pharmacy claims greater than ninety (90) days old may be denied.

**Accuracy of Claim Submission**

It is imperative that Participating Pharmacies submit accurate claim information. Precise reporting of member number, Physician number, quantity, NDC and days supply will assure that members receive the Benefits outlined in their Benefit plan and that Pharmacies are accurately reimbursed. It is crucial to submit the correct metric decimal quantity and the 11-digit National Drug Code (NDC) for the actual package size of the Covered Service being dispensed as written on the prescription.

**Group Code**

The Group Code of CVTY must be used to submit claims on-line to Caremark, Inc. for any Coventry Health Care Plan. For claims submitted on-line to First Health® Rx, the Group Code is listed on the Member’s ID Card and may vary by benefit plan.

**Refill Frequency**

The frequency with which a Prescription can be refilled is monitored by the claims processing system. Members may have their prescriptions refilled when there is a ten (10) day supply of medication remaining from a previous fill. Claims submitted for refills before this “ten day grace period” will be rejected with NCPDP reject code 79 “Refill Too Soon”. The member is then responsible for the cost of the Prescription.

*If, however, a claim is rejected because the Prescription instructions have changed or the days supply on the original Prescription was entered incorrectly:*

*For claims processed on-line by Caremark (BIN 610029), the Pharmacy must call 1-800-378-7040 for assistance in processing a claim.*

*For claims processed on-line by First Health Rx (Bin 002286/610678), the Pharmacy must call the number on the back of the Member’s ID card for assistance in processing a claim.*
V. BILLING PROCEDURE (continued)

Prescriber Number

Report the Prescribing Providers or health care professional's correct DEA number (if available) as the provider number. This number is used to identify the Prescribing Provider that generated the prescription.

Pharmacy ID Number

Use your 7-digit NCPDP (formerly NABP) number assigned to the dispensing location as your provider number for billing purposes and the Provider ID Qualifier of “7” (NCPDP number).

National Drug Code (NDC)

The NDC is an 11-digit number consisting of 5 digits for the manufacturer, 4 digits for the product number, and 2 digits for the package size. Please “zero fill” the NDC when submitting claims for payment. For example, if the NDC appearing on the container is 781-26-01, the NDC should be reported as 00781-0026-01. As such, 17314-4315-1 should be reported as 17314-4315-01. If the NDC is 18393-272-42, report 18393-0272-42.

Dispense as Written

Enter the appropriate “Dispense as Written” indicator into the DAW field of the on-line claim billing record.

PHYSICIAN (DAW=1)

This code is used only when a Physician indicates “DAW” for a brand product subject to MAC reimbursement level and should not be used for any other purpose. The claim will process based on the pharmacy’s contracted reimbursement rate, and the copay value that is passed back will be the brand copay amount and ancillary charge when applicable.

MEMBER (DAW = 2)

This code is used when the member has requested a brand-name product subject to a MAC reimbursement level. The claim will process based on the MAC reimbursement level. The copay value passed back will include the additional cost incurred by the member for receiving the brand product. The message “Copay includes ancillary charge” may also be passed back as a free-form message.

DAW = 3, 4, 5, or 6

When these codes are submitted, the pharmacy will be responsible for the difference between brand cost and generic cost.

DAW = 7 or 8

When these codes are submitted, the appropriate Coventry Health Care Plan will be responsible for the difference between the brand cost and generic cost.
V. BILLING PROCEDURE (continued)

**Quantity**

It is crucial to submit the correct metric decimal quantity and the 11-digit National Drug Code (NDC) for the actual package size of the Covered Service being dispensed as written on the prescription. The metric quantity of the Pharmaceutical Product should be reported as the number of gm or ml for liquids or topicals. If the metric quantity is a fraction, round up to the nearest whole number (i.e. for 42.4g round up to 43).

**On-Line Adjustment of Claims**

All claims are adjudicated based on information submitted to the Pharmacy Program Administrator. If a claim is adjudicated based on incorrect information, it is the responsibility of the Pharmacy to adjust the claim. A claim submitted in error may be adjusted by submitting a standard reversal transaction of the claim. This procedure may be used for a claim before or after payment has been made.

By means of on-line claims reversal, Participating Pharmacy will credit to the appropriate Coventry Health Care Plan the charges for Covered Services which, after seven (7) days have not been provided to the member.

**Compound Prescriptions**

A claim for a compound prescription should be submitted using the NDC (National Drug Code) of the most expensive legend ingredient. (At least one of the ingredients must be a legend drug). Your software should flag the prescription as a “Compound Prescription” and the compound ingredient cost must be manually entered by the pharmacy. The Pharmacy Program Administrator will not accept invalid NDCs for any compounds. The claim may be submitted manually if the pharmacy system is unable to process compound prescriptions on-line.

**Prior Authorization**

The Pharmacy Program Administrator automatically, in accordance with NCPDP standards, relays a message code when Prior Authorization is required. Prior Authorization is provided by the appropriate Coventry Health Care Plan or the Pharmacy Program Administrator to a Participating Pharmacy allowing processing of a claim requiring prior authorization. See Section VII for more information on Prior Authorization procedures.

**Claims Age Edit**

If the dispensing date is greater than 30 days prior to the date of processing the claim, the on-line system may reject the claim as “Claim Too Old” for point of service.
V. BILLING PROCEDURE (continued)

**Days Supply**

The number of days the supply of the medication must be accurately reported. For prescriptions in which the dosage is variable, the days supply reported should reflect the MAXIMUM DOSAGE, reporting the MINIMUM NUMBER OF DAYS. If the number of days supply cannot be determined, as for topicals or inhalers, use professional judgement and estimate the appropriate days supply.

The number of days-supply submitted should reflect the frequency of the dosing interval for Covered Services not dosed daily or more often. Examples include:

- Fosamax® 70 mg (4 tablets per 28 days supply)
- Prozac® Weekly™ 90 mg (4 caplets per 28 days supply)
- Seasonale® – 91 quantity (91 days)

A 30-day supply is standard for most benefits. However, some benefits permit up to a 90-day supply in one fill.

**Manual Claim Process**

A Universal Claim Form (UCF) may be used for billing a Covered Service, as in the following situations: a Member’s eligibility cannot be verified; an NDC number is not on file; the on-line claims processing system is down and the pharmacy billing system cannot back date to fill date.

The following information must be supplied. Claims submitted with incomplete or inaccurate information will be rejected.

1. The member’s ID number.
2. Your pharmacy's provider number (7 digit NCPDP number)
3. Date prescription was dispensed
4. Pharmacy Rx number
5. New Prescription Order (N) or Refill (R)
6. Metric Quantity dispensed
7. Number of days the supply of medication should last
9. Prescriber's DEA number (if applicable), or Prescriber name
10. DAW (Report the appropriate code if a DAW is indicated)
11. Ingredient cost (per Coventry Health Care, Inc. National Pharmacy Participation Agreement)
V. BILLING PROCEDURE (continued)

Include all required billing information and mail the claim to:

<table>
<thead>
<tr>
<th>Network</th>
<th>Address:</th>
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<tbody>
<tr>
<td>Coventry National</td>
<td>COVENTRY HEALTH CARE, INC.</td>
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<tr>
<td></td>
<td>c/o Caremark Inc – Claims Department.</td>
</tr>
<tr>
<td></td>
<td>7034 Alamo Downs Parkway</td>
</tr>
<tr>
<td></td>
<td>San Antonio, Texas 78238</td>
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<tr>
<td>First Health® Rx</td>
<td>Mail Handlers Benefit Plan (Only):</td>
</tr>
<tr>
<td></td>
<td>MHBP PO Box 23824 Tucson, AZ 85734</td>
</tr>
<tr>
<td></td>
<td>All other First Health® Rx:</td>
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<tr>
<td></td>
<td>First Health PO Box 8400 London, KY 40742</td>
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<td>Advantra® Rx</td>
<td>Caremark, Inc. – Medicare Part D Claim</td>
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<tr>
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<td>P.O. Box 686007 San Antonio, TX 78268</td>
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<tr>
<td>First Health® Premier</td>
<td>Caremark, Inc. – Medicare Part D Claim</td>
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<td>P.O. Box 686007 San Antonio, TX 78268</td>
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### NCPDP Reject Codes

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<td>Missing/Invalid NDC Number</td>
</tr>
<tr>
<td>22</td>
<td>Missing/Invalid Disp. As Written Code</td>
</tr>
<tr>
<td>23</td>
<td>Missing/Invalid Ingredient Cost</td>
</tr>
<tr>
<td>24</td>
<td>Missing/Invalid Sales Tax</td>
</tr>
<tr>
<td>25</td>
<td>Missing/Invalid Prescriber ID</td>
</tr>
<tr>
<td>26</td>
<td>Missing/Invalid Fee/Mark-Up Written</td>
</tr>
<tr>
<td>27</td>
<td>Missing/Invalid Amount Due Written</td>
</tr>
<tr>
<td>28</td>
<td>Missing/Invalid Date RX Written</td>
</tr>
<tr>
<td>29</td>
<td>Missing/Invalid # Refills Authorized</td>
</tr>
<tr>
<td>30</td>
<td>Missing/Invalid P.A./M.C. Code</td>
</tr>
<tr>
<td>31</td>
<td>Missing/Invalid P.A./M.C. Number</td>
</tr>
<tr>
<td>32</td>
<td>Missing/Invalid Level Of Service</td>
</tr>
<tr>
<td>33</td>
<td>Missing/Invalid Rx Origin Code</td>
</tr>
<tr>
<td>34</td>
<td>Missing/Invalid Rx Denial Override</td>
</tr>
<tr>
<td>35</td>
<td>Missing/Invalid Primary Prescription</td>
</tr>
<tr>
<td>36</td>
<td>Missing/Invalid Clinic ID</td>
</tr>
<tr>
<td>37</td>
<td>Missing/Invalid Authorization #</td>
</tr>
<tr>
<td>38</td>
<td>Missing/Invalid Basis of Cost</td>
</tr>
<tr>
<td>39</td>
<td>Missing/Invalid Diagnosis Code</td>
</tr>
<tr>
<td>40</td>
<td>Missing/Invalid Fee/Mark-Up Written</td>
</tr>
<tr>
<td>41</td>
<td>Missing/Invalid Amount Due Written</td>
</tr>
<tr>
<td>42</td>
<td>Missing/Invalid Date RX Written</td>
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<tr>
<td>43</td>
<td>Missing/Invalid # Refills Authorized</td>
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<tr>
<td>44</td>
<td>Missing/Invalid P.A./M.C. Code</td>
</tr>
<tr>
<td>45</td>
<td>Missing/Invalid P.A./M.C. Number</td>
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<tr>
<td>46</td>
<td>Missing/Invalid Level Of Service</td>
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<td>Missing/Invalid Rx Origin Code</td>
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<td>Missing/Invalid Authorization #</td>
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<td>Missing/Invalid Basis of Cost</td>
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<td>Missing/Invalid Diagnosis Code</td>
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<td>Non-Matched Pharmacy #</td>
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<td>55</td>
<td>Non-Matched Group #</td>
</tr>
<tr>
<td>56</td>
<td>Non-Matched Cardholder ID</td>
</tr>
<tr>
<td>57</td>
<td>Non-Matched Person Code</td>
</tr>
<tr>
<td>58</td>
<td>Non-Matched Primary Prescriber</td>
</tr>
<tr>
<td>59</td>
<td>Non-Matched Clinic ID</td>
</tr>
<tr>
<td>60</td>
<td>Patient is Not Covered</td>
</tr>
<tr>
<td>61</td>
<td>Patient Age Exceeds Maximum Age</td>
</tr>
<tr>
<td>62</td>
<td>Filled Before Coverage Effective</td>
</tr>
<tr>
<td>63</td>
<td>Filled After Coverage Terminated</td>
</tr>
<tr>
<td>64</td>
<td>NDC Not Covered</td>
</tr>
<tr>
<td>65</td>
<td>Prescriber Is Not Covered</td>
</tr>
<tr>
<td>66</td>
<td>Primary Prescriber Is Not Covered</td>
</tr>
<tr>
<td>67</td>
<td>Refills Are Not Covered</td>
</tr>
<tr>
<td>68</td>
<td>Deductible Exceeds Payable</td>
</tr>
<tr>
<td>69</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>70</td>
<td>Plan Limitations Exceeded</td>
</tr>
<tr>
<td>71</td>
<td>Discontinued NDC Number</td>
</tr>
<tr>
<td>72</td>
<td>Cost Exceeds Maximum</td>
</tr>
<tr>
<td>73</td>
<td>Refill Too Soon</td>
</tr>
<tr>
<td>74</td>
<td>Drug Diagnosis Mismatch</td>
</tr>
<tr>
<td>75</td>
<td>Claim Too Old</td>
</tr>
<tr>
<td>76</td>
<td>Claims Is Post-Dated</td>
</tr>
<tr>
<td>77</td>
<td>Claim Has Been Paid</td>
</tr>
<tr>
<td>78</td>
<td>Claim Has Not Been Paid/Captured</td>
</tr>
<tr>
<td>79</td>
<td>Submit Manual reversal</td>
</tr>
<tr>
<td>80</td>
<td>Reversal Not Processed</td>
</tr>
<tr>
<td>99</td>
<td>Host Processing Error</td>
</tr>
</tbody>
</table>
VI. Payment

Payment Cycle

Coventry Health Care, Inc. and/or Plan(s) reimburses pharmacies based on the Pharmacy Program Administrator and BIN numbers. Each BIN number may have its own separate check, payment cycle, remittance advice, and payor specifications.

Payments for claims processed through BIN 610029 will be included with your Caremark payment and Caremark remittance advice. Please contact Caremark with any questions regarding payment or remittance for these claims.

Payments for claims processed through BIN 002286 and 610678 will be included with your First Health® Rx payment and First Health® Rx remittance advice. Please contact First Health® Rx with any questions regarding payment or remittance for these claims. Payments for claims processed by First Health through other BIN numbers will be paid separately.
VII. PRIOR AUTHORIZATION PROCEDURE

Prior Authorization is a method of utilization management to verify the medical necessity for use of certain Pharmaceutical Products. Prior authorization must be obtained for these Pharmaceutical Products prior to dispensing. Without a valid prior authorization in the Pharmacy Benefit Administrator’s claims adjudication system, the claim will not process for payment. Dispensing of a Pharmaceutical Product requiring prior authorized without a valid approval in place will not be grounds for a backdated prior authorization by a Plan or Affiliate Payor. If a Pharmacy dispenses a Pharmaceutical Product without first verifying the authorization status of the Pharmaceutical Product requiring prior authorization, through claims adjudication or otherwise, the Pharmacy risks not receiving payment for such Pharmaceutical Product.

Prior Authorized Drugs - To process a claim for Pharmaceutical Products classified as requiring Prior Authorization for coverage: If authorization has not taken place before the Pharmacy receives the prescription the Pharmacy should contact the Prescribing Provider, or agent of the Prescribing Provider. The Prescribing Provider, or agent of the Prescribing Provider will need to contact the appropriate call center, by phone or by fax, to provide the necessary clinically relevant patient specific information needed to verify the medical necessity of the Prior Authorized Pharmaceutical Product.

Not Covered Drug – Pharmaceutical Products adjudicated with the not covered status of NCPDP rejection code 70 are excluded from the benefit design and are not covered.

Quantity Level Limit – Certain Covered Services have quantity limits associated with their proper use. Claims exceeding these limits will reject when submitted for payment. If there are special circumstances where a Member needs to exceed these predetermined quantity limits, the Prescribing Provider or agent of the Prescribing Provider will need to call to clinically justify this need. Prior authorization must be granted for an exception to any quantity limit from the appropriate call center prior to dispensing the Covered Service.

Ample Supply - To process a prescription claim when the prescription directions or dosage have changed since the previous fill: A Prior Authorization overrides the Ample Supply edit (NCPDP rejection code 79). An authorization for this condition is valid one time only and should be obtained from the Pharmacy Benefit Manager.

Travel Supply - To process a Covered Service requiring a larger quantity of Pharmaceutical Products to cover the medication needs of a member during a vacation period: An authorization for this condition is valid one time only and should be obtained from the Pharmacy Benefit Administrator.

Cost Exceeds Maximum - To process a claim for a Covered Service which exceeds the maximum cost as determined by the Plan or Affiliate Payor (NCPDP rejection code 78), first verify the claim information. If an error has occurred, correct the information and resubmit the claim. If the information is correct, please contact the appropriate call center for further instructions.

Except as noted above, Coventry Health Care, Inc., the Plan and/or Affiliate Payor has defined an authorized duration of use for Prior Authorized Covered Services of six months to one year. The length of prior authorization will be communicated to the Prescribing Provider or agent of the Prescribing Provider at the time the authorization is granted. The length of authorization will vary by Covered Service.

In summary, to request a Prior Authorization or to check the status of an existing authorization, please contact the appropriate Coventry Health Care Plan and/or Affiliate Payor (please refer to the phone numbers listed in Section II or the toll-free telephone number on the back of the Member’s ID card) or the Pharmacy Benefit Administrator depending upon the type of authorization.
VIII. DRUG FORMULARY POLICY

Please refer to the respective Coventry Health Care Plan Formularies or the First Health® Rx Drug Formulary which fully defines the Drug Formulary Policy.

If a member presents a Prescription Order for a Pharmaceutical Product listed in the Coventry Health Care Drug Formularies or First Health® Rx Drug Formulary as not covered, the Participating Pharmacy shall contact the Prescribing Provider and request a change to an approved Drug Formulary Product. If the Prescribing Provider denies the request or the Participating Pharmacy is unable to reach the Prescribing Provider after a reasonable effort or period of time, the non-formulary product may be dispensed, and will be reimbursed based upon the submitted NDC of the product dispensed.

The following is a list of websites for the Coventry Health Care Plan Formularies:

- Carelink Health Plans, Inc. and Coventry Health and Life Insurance products in WV:
  www.carelinkhealthplans.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Delaware, Inc. and Coventry Health and Life Insurance products in MD and DE
  www.chcde.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Georgia, Inc. and Coventry Health and Life Insurance products in GA:
  www.chcga.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Iowa, Inc. and Coventry Health and Life Insurance products in IA:
  www.chciowa.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance products in KS:
  www.chckansas.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Louisiana, Inc. and Coventry Health and Life Insurance products in LA:
  www.chclouisiana.com/framesetdef.asp?Community=Provider

- Coventry Health Care of Nebraska, Inc. and Coventry Health and Life Insurance products in NE:
  www.chcnebraska.com/framesetdef.asp?Community=Provider

- Coventry Health and Life Insurance Company insurance products in OK:
  www.chcoklahoma.com/framesetdef.asp?Community=Provider

- Group Health Plan, Inc. and Coventry Health and Life Insurance products in MO and IL:
- HealthAmerica Pennsylvania, Inc., HealthAssurance Pennsylvania, Inc., and Coventry Health and Life Insurance products in OH:

- HealthCare USA of Missouri, LLC:

- OmniCare Health Plans, Inc.

- PersonalCare Insurance of Illinois, Inc.

- Southern Health Services, Inc.

- WellPath Select, Inc.

- First Health® Rx

- Advantra®RX

- First Health® Premier
IX. AUDITING OF CLAIMS

Participating Pharmacies in any Coventry Health Care, Inc. network may be subject to on-site and/or desk audits in which Coventry Health Care, Inc., a subsidiary or affiliated Plan, designee, or an applicable Affiliate Payor or government agency may inspect all records of the Pharmacy relating to the Agreement, applicable Participating Pharmacy Administrative Manual, and Participation Form, if applicable.

If the Pharmacy is selected for an on-site audit, Coventry Health Care, Inc. will use reasonable efforts to notify the pharmacy by letter approximately two weeks prior to the audit, however, not less than specified in the Agreement.

In general, original prescription hard copies of each prescription must be maintained for three years, or longer as required by law, and made available upon request. Original prescription hard copies and any updated copies, including telephone and electronic prescriptions, must contain all data elements required by applicable laws (e.g., prescriber name, name and strength of the Pharmaceutical Product to be dispensed, original date of service, patient name and quantity) and all prescriber’s instructions (e.g., DAW, refill, use and dosage) that support the Pharmacy's claim submission to the Pharmacy Program Administrator. The Pharmacy must note subsequent changes or refill authorizations approved by the prescriber on the hard copy prescription, or in an electronic format acceptable by the applicable State Board of Pharmacy.

The following list includes, but is not limited to, claim submission parameters subject to review:

1. **Incorrect DAW Code Submitted**
   Pharmacy submitted a DAW Code = 1, physician did not indicate “dispensed as written” on the prescription.

2. **Overbilled Quantity**
   The quantity claimed exceeded the quantity indicated on the prescription.

3. **Incorrect Days Supply**
   The days supply submitted does not correspond to the days supply indicated on the prescription.

4. **Incorrect Patient Information**
   Pharmacy submitted an identification number for a member different from the patient appearing on the prescription.

5. **Prescription Not on File**
   The actual hard copy prescription was not on file at time of audit.

6. **Incorrect Prescriber**
   The pharmacy submitted the name or DEA number of a prescriber different from the one that actually prescribed the medication.
The following chart lists claims exceptions and actions to be enforced for inaccurate claim submission:

<table>
<thead>
<tr>
<th>Discrepancy</th>
<th>Exceptions</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect DAW Code</td>
<td>None</td>
<td>Pharmacy charged back approved Brand Ingred. Cost minus (-) MAC Cost</td>
</tr>
<tr>
<td>Overbilled Quantity</td>
<td>None</td>
<td>Pharmacy charged back cost of quantity claimed minus (-) cost of actual quantity prescribed</td>
</tr>
<tr>
<td>Incorrect Days Supply</td>
<td>None</td>
<td>Pharmacy charged back cost of days supply claimed minus (-) cost of actual days supply prescribed</td>
</tr>
<tr>
<td>Incorrect Patient Information</td>
<td>None</td>
<td>Pharmacy charged back dispensing fee. PHC reverses claim; Pharmacy must resubmit claim with correct patient information.</td>
</tr>
<tr>
<td>Prescription Not on File</td>
<td>None</td>
<td>Pharmacy charged back entire cost of claim.</td>
</tr>
<tr>
<td>Incorrect Prescriber</td>
<td>If prescription originates from hospital or clinic setting without a prescriber name printed on blank.</td>
<td>Pharmacy charged back dispensing fee.</td>
</tr>
</tbody>
</table>
X. Medicare Part D

The following information applies to the Advantra®Rx and First Health® Premier Medicare Part D products. This information may be different than the information provided in other areas of this manual. Unless specifically changed in this section, all other applicable sections of this manual will apply to Advantra®Rx and First Health® Premier.

**Processor Information:**
Pharmacy Program Administrator: Caremark

RxBIN: 610029

RxPCN: CRK

Payor Specifications available at: [www.caremark.com/wps/portal/_s.155/3398](http://www.caremark.com/wps/portal/_s.155/3398)

**NCPDP V.5.1 Transactions**

B1 = Original Claim
B2 = Reversal
B3 = Re-Bill
E1 = Eligibility
N1 = Information (TrOOP Information)

Transaction Limit/Claim = 1 claim per transactions (verses 4)

**Home Infusion/Long-Term Care/Indian Health Service/Tribal/Urban Indian**

In addition to NCPDP v5.1 transaction via the Pharmacy Program Administrators electronic claims transaction system, the following types of Pharmacies may submit ANSI X12 837 transactions to the Pharmacy Benefit Administrator: Home IV Infusion, Long-Term Care, Indian Health Service, Tribal, and Urban Indian. For additional information on submitting the ANSI X12 837, including payor specifications, 835 mapping, and address to send the transactions, please visit [www.caremark.com/wps/portal/_s.155/3398](http://www.caremark.com/wps/portal/_s.155/3398). Please note that Caremark is not accepting NCPDP Batch format claims.

All Pharmacies sending ANSI X12 837 must do so for all claims submitted to Caremark. Caremark will produce one 835 RemittanceAdvice per ANSI X12 837 file submitted.

For more information on submitting ANSI X12 837 claims, please contact 800-364-6331.
X. MEDICARE PART D (continued)

Home Infusion Therapy Pharmacies
For Home Infusion claims, Caremark will accept compound billing based on the most expensive legend drug per NCPDP specifications. CMS rules and regulations specify that the Pharmaceutical Product may be submitted as a Covered Service, but not the services or supplies associated with the administration of that drug (under Part D). Caremark is requesting that the Home Infusion pharmacies send an indicator on the claim of ‘01’ to which translates to ‘home’.

Patient Location Codes
Caremark is in the process of updating system requirements to include patient location codes in the adjudication process for Medicare Part D claims. We anticipate this update will be implemented at the end of February 2006.

Pharmacies need to submit patient location codes effective January 1, 2006, in order for the February system update to implement effectively. Patient Location codes must be entered in field 307-C7 (Patient Location) for every claim submission in order for appropriate adjudication and payment. As recommended by The National Council for Prescription Drug Programs (NCPDP), Caremark will accept the following values: 01 = Home, 03 = Nursing Home (LTC Facility), 05 = Rest Home. To ensure that Pharmacies with multiple contracts receive the correct pricing, Pharmacies need to submit the correct Patient Location codes in order to obtain the correct pricing. Pharmacies processing claims with a Patient Location = <blank> or 00 will default to retail pricing, when applicable.

Definition of Long-Term Care (LTC) Facility
The CMS definition of a LTC Facility encompasses not only skilled nursing facilities (SNFs), as defined in section 1819(a) of the Social Security Act, but also any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. CMS has previously advised that this definition generally includes ICFs/MR and inpatient psychiatric hospitals, along with skilled nursing and nursing facilities. Only submit a Patient Location = 03 Nursing Home for claims dispensed to Members residing in a LTC Facility that meets this definition.

Partial Fills
NCPDP v5.1 for “partial” fill of Covered Services will be enabled. Filing limit for completion of the “partial” fill is 60 days from the initial partial fill. For Members with “flat” copayments, the member will pay the full copayment at the time the initial partial fill is dispensed. For Members with a percentage coinsurance, the percentage charge will be based on the actual quantity dispensed for each partial fill.

Prior Authorization Required
Pharmacists may receive an NCPDP error 75 – Prior Authorization Required. For authorization, pharmacies should direct Members to have their Prescribing Providers call 1-800-551-2694. Physicians may also fax to 800-639-9158.

Unit Dose
Unit Dose package sizes are covered only for Members residing in a Long-Term Care Facility. For Members not residing in a Long-Term Care Facility, Unit Dose package sizes will deny with the NCPDP error 70 – NDC NOT COVERED with the supplemental message "Unit Dose Drugs Not Covered for Non-LTC Beneficiaries".
X. MEDICARE PART D (continued)

Emergency Supplies

A 72-hour emergency supply is permitted at the dispensing pharmacist's discretion. The 72-hour emergency supply allows the Member to receive a non-formulary Pharmaceutical Product that requires Prior Authorization prior to review. To submit an emergency supply, enter 99118822773 in the Prior Authorization Number Submitted field (462-EV). One emergency supply override is allowed per Member per drug class per year. If the drug comes in a package that is unable to be broken down (e.g., inhaler, antibiotic suspension), the entire package quantity may be dispensed.

Refill Frequency

The frequency with which a Covered Service can be refilled is monitored by the claims processing system. Members may have their Covered Services refilled when less than 25% of the total supply of Pharmaceutical Product remains from a previous fill. Claims submitted for refills before 75% of the total supply of the Covered Service is used up will be rejected with NCPDP reject code 79 “Refill Too Soon”. The Member is then responsible for the cost of the Pharmaceutical Product.

Medicare Part B Drugs

Claims for Pharmaceutical Products covered by Medicare Part B will deny.

Additional Information

For additional information about AdvantraRx, including formulary, benefits, Prior Authorization guidelines and products, visit www.advantrarx.com. For additional information on First Health® Premier, including formulary, Prior Authorization guidelines, benefits, and markets, visit www.firsthealthpremier.com.

Pharmacies may also contact the Pharmacy Help Desk at (800) 364-6331.

Member Grievance and Appeals

Pharmacies must utilize standardized notices developed by CMS to notify Medicare Part D enrollees of the right to receive, upon request, a detailed written notice from their Medicare Part D Plan Sponsor regarding the enrollee's prescription drug coverage, including information about the exceptions process. The standardized notices may be posted in or disseminated by the pharmacy.

For additional information about the Advantra® MA-PD Plans available in select areas, visit the following websites:

PA – (Health America Health Assurance) http://www.pa.chcadvantra.com/
WV – (Carelink) http://www.wv.chcadvantra.com/
OH – (Carelink) http://www.oh.chcadvantra.com/
Iowa http://www.ia.chcadvantra.com/
Kansas City http://www.kc.chcadvantra.com/
MO – (Group Health Plan): http://www.ghpmedicare.com/

Pharmacies may also call the Advantra MA-PD Pharmacy Help Desk at (877) 215-4100.
XI. COORDINATION OF BENEFITS WITH MEDICARE PART D PLANS

When Medicare Part D is Secondary
The Medicare Modernization Act extended Medicare Secondary Payor ("MSP") laws applicable to MA organizations to Part D sponsors. Accordingly, Part D sponsors will have the same responsibilities under MSP laws as do MA plans, including collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities; and the interaction of MSP rules with State laws.

In order to provide a consistent set of rules for the order of payment on Part D claims and establish a basis for the accurate calculation of the TrOOP balance, CMS establishes that Part D plans and all secondary payers on Part D claims should adhere to the following order of payment standards. All payers are legally required to adhere to MSP laws and any other federal and state laws establishing payers of last resort (e.g., TRICARE). In all other situations, the Rules for Coordination of Benefits adopted in the most current National Association of Insurance Commissioners Coordination of Benefits Model Regulation should be followed.

Participating Pharmacies are expected to comply with MSP laws and regulations in coordinating benefits between other group health or worker’s compensation coverage and Part D Plans.

When Commercial Group Health is Secondary
Some commercial benefit plans may coordinate as a secondary payor with Medicare Part D PDP and MA-PD Plans. Pharmacies will receive unique RxBIN / RxPCN information for secondary and tertiary payment from the Medicare Part D plan via an on-line transaction. This RxBIN / RxPCN will be different and distinct from the Member’s primary RxBIN / RxPCN displayed on the Member’s ID card. Members may not have secondary or tertiary RxBIN / RxPCN information available on their ID card. Use the RxBIN / RxPCN information transmitted to you from the applicable Medicare Part D processor to submit secondary COB claims. If you have any questions, please contact the phone number on the back of the Member’s ID card.

If a Member has Medicare Part D as their primary coverage, always submit a claim to Medicare Part D FIRST, even if the drug is not covered or listed on the drug formulary. The v.5.1 COB segment includes optional fields to indicate other responsible parties to the non-primary payor as well as the date upon which payment or denial was made. Payment or reject information must be sent in the fields for OTHER PAYOR AMOUNT PAID COUNT (Field 341-HB), OTHER PAYOR AMOUNT PAID QUALIFIER (Field 342-HC), and OTHER PAYOR AMOUNT PAID (Field 431-DV) or OTHER PAYOR REJECT COUNT (Field 471-5E), and OTHER PAYOR REJECT CODE (Field 472-6E), respectively. Value 08, SUM OF ALL REIMBURSEMENT, in OTHER PAYOR AMOUNT PAID QUALIFIER should be used only to indicate the total reimbursement from the other payor and NOT when submitting line item details of reimbursement components.

When zeroes are sent in the OTHER PAYOR AMOUNT PAID (Field 431-DV), the pharmacy system is notifying the processor of no payment dollars received. Pharmacy systems should be cautioned that this segment should not be sent unless needed and the OTHER PAYOR AMOUNT PAID field should not be defaulted (zero filled), as it would lead the processor to an incorrect conclusion of other payment paid.
XII. CONTRACTING CONTACT INFORMATION

Participating Pharmacies with questions regarding the participation agreement or need to communicate changes to the pharmacy or group information—for example, adding new stores to a group, updating pharmacy addresses or remittance addresses—contact pharmacy network contracting:

Send a detailed e-mail to: FirstHealthRx@firsthealth.com

Mail documentation to: Call the Pharmacy Network Department:
First Health
Attention: Pharmacy Network
750 River Point Drive
West Sacramento, CA 95691
(916) 374-3756

***Always be sure to include the pharmacy NCPDP number with all communications.***

Some First Health claims may be processed through a different BIN number and pay on a different claims reimbursement cycle determined by the Affiliate Payor and specified in the applicable Participation Form attached to the National Participating Pharmacy Agreement. Below is a list of these programs:

First Health Medicare Discount Card Network
For claim, eligibility, and other plan inquiries regarding the First Health Medicare discount card network, please call toll-free 800-261-5989. Participating Pharmacies located in the states listed below may join the network by calling pharmacy network contracting at 916-374-3756.

First Health Medicare-Approved Discount Card Network—NY BIN 011495
First Health Medicare-Approved Discount Card Network—PA BIN 011487
First Health Medicare-Approved Discount Card Network—MI BIN 011503

Additional information may be obtained at: medicarediscount.fhsc.com.

MI EPIC Program / MIrX discount card
For claim, eligibility, and other plan inquiries regarding the Michigan EPIC program and Michigan Rx discount card program, please call toll-free 866-589-7982. To join the network, please call pharmacy network contracting at 916-374-3756.

MI EPIC BIN 009506
MI Rx discount card BIN 011503

MO Senior Rx
For claim, eligibility and other plan inquiries regarding the Missouri senior Rx program, please call toll-free 800-437-8482. Participating Pharmacies located in MO may join the network by calling pharmacy network contracting at 916-374-3756.

MO senior Rx BIN 011511