TO: Local District Commissioners, Medicaid Directors, Third Party Supervisors

FROM: Betty Rice, Director, Division of Consumer and Local District Relations, Office of Medicaid Management

SUBJECT: Revised Third Party Data Entry Forms

EFFECTIVE DATE: Immediately

CONTACT PERSON: Bureau of Local District Support: Upstate – 518-474-8216
NYC - 212-417-4500

The purpose of this GIS message is to introduce you to two revised LDSS data entry forms; LDSS 4198-"Third Party Data Sheet" and LDSS 4384-"Third Party Health Insurance Data, Medicare Coverage Update" (copies attached).

The revisions to these forms were made to reflect information required for the new eMedNY third party system.

In all instances the date format in eMedNY is MM/DD/YYYY (for example, March 17, 2005 would be entered as 03/17/2005). For open-ended end date, use 12/31/9999. Note: The "/" separator does not need to be entered. The system will automatically read the separator.

LDSS 4198-Third Party Data Sheet changes include:

Policy Sequence Number has been added to the top of the form. This is a system generated number which will be available on eMedNY after third party insurance has been added.

Section I:

1. CIN number appears first in column with asterisk indicating it is a required field.
2. Relationship box has asterisk indicating required field; Relationship to Policy Holder options now include: 5) Custodial Child; 6) Stepchild.

Section II:

1. Good Cause has been added, with fields for Begin and End Date.
2. Claiming Address of Insurance Company has been moved to this area.
3. Insurance Code has been expanded to 6 spaces. Current 2-digit codes may continue to be used. This also has an asterisk to indicate the field is required.
4. Policy Number is double asterisked (**) indicating this field or SSN field is required.
5. Medicare HMO Indicator field has been added with a space to check yes or no. This is a required field and is therefore asterisked.
6. Policy Source options have been modified as follows; A. Cobra Premiums *Only;* E. LDSS Reimburses *Client;* M. Accident *(Not Workers Comp Related)*; O. Military Service; P. Workers Compensation; Q. Retirement Benefit; Not Applicable.

7. Coverage codes are alphabetized and have been changed as follows (at least one must be checked):

   - Major Med has been eliminated;
   - 01 is now "Comp to Medicare A";
   - 02 is now "Comp to Medicare B";
   - Drugs No Card has been eliminated;
   - Drugs Recovery has been added;
   - Hospice has been added;
   - X-Ray has been added.

10. The SSN field has a double asterisk indicating either this field is required or the Policy Number listed earlier on the form is required.
11. *Policy Holder's* Address has been added to the form.

LDSS 4384-Third Party Health Insurance Data, Medicare Coverage Update changes include:

1. HIC Number: Begin and End Date has been added.
2. OMH-*OMR* CD indicates OMH/OMR facility code, changed from OMH–DDSO CD.
3. Eligibility Status has been changed to *Medicare Savings Program Indicator.*
4. Two Medicare Savings Program indicators have been added; U=QI-1, X=QDWI.
5. A line has been added to indicate Eligibility Worker Name and Date.

A full explanation for every field listed on these documents can be found on the eMedNY third party data screens by using the "Help" button at the top of each screen.

Until forms are printed and available for ordering, we suggest that you photocopy the attached forms as necessary.

LDSS-4198 (3/05)

Policy Sequence #

☐ APPLICATION ☐ ENROLLMENT ☐ RECERTIFICATION ☐ TERMINATION

THIRD PARTY DATA SHEET

SECTION I: CLIENT IDENTIFICATION INFORMATION

CASE NAME (Last)	First	MI	CASE NUMBER

*CIN	RECIPIENT'S LAST NAME	F I	*REL

RELATIONSHIP TO POLICYHOLDER

REL CODE	DESCRIPTION
1	SELF
2	SPOUSE
3	CHILD
4	OTHER
5	CUSTODIAL CHILD
6	STEPCHILD
7	IV-D CHILD
8	IV-D SPOUSE

SECTION II: ESSENTIAL INSURANCE INFORMATION

INSURANCE COMPANY NAME

GOOD CAUSE

BEGIN	END
M M/ / D D/ Y Y Y Y	M M/ D D/ Y Y Y Y

CLAIMING ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP CODE

*INS. CD

**POLICY NUMBER

COVERAGE

*BEGIN	END
M M / D D / Y Y Y	M M / D D / Y Y Y

GROUP NO.

*Medicare HMO IND: Y N

EMPLOYER ID

BENEFIT PKG

*Coverage (at least one must be checked)		
☐ 06 – CLINIC	☐ 05– EMRG ROOM	☐ 19 – PSCH INPAT
☐ 01 – COMP MED A	☐ 04 – HOME HLTH	☐ 20 – PSCH OUT
☐ 02 – COMP MED B	☐ 22 – HOSPICE	☐ 17 – SUB AB INP
☐ 15 – DENTAL	☐ 03 – INPATIENT	☐ 18 – SUB AB OUT
☐ 12 – DRUG COPAY	☐ 09 – NURSING HM	☐ 14 – TRANSP
☐ 11 – DRG MJ MED	☐ 16 – OPTICAL	☐ 21 – X-RAY
☐ 10 – DRUG RECOVERY	☐ 07 – PHYS HOSP	
☐ 13 – DME	☐ 08 – PHYS OFFIC	

POLICY SOURCE

- ☐ A. COBRA Premiums Only
- ☐ B. AIDS Program
- ☐ C. LDSS Pays Carrier
- ☐ D. LDSS Pays Employer
- ☐ E. LDSS Reimburses Client
- ☐ F. IV-D Court Ordered
- ☐ G. Absent Parent Voluntary
- ☐ H. Employment
- ☐ I. Union
- ☐ J. Fraternal Organization
- ☐ K. Tuition Fee
- ☐ L. Private Pay
- ☐ M. Accident (Not Workers Comp Related)
- ☐ N. Other
- ☐ O. Military Service
- ☐ P. Workers Compensation
- ☐ Q. Retirement Benefit
- ☐ Not Applicable

*POLICY HOLDER'S NAME First	Last	*SEX	**SSN

POLICYHOLDER'S ADDRESS	CITY	STATE	ZIP CODE

COMMENTS: ______

SECTION III: PREPARER INFORMATION

ELIGIBILITY WORKER	DATE	TPR WORKER	DATE

*Required Fields **Either policy number or SSN is required

CASE NO.

CASE NAME

LDSS-4384 (3/05)

THIRD PARTY HEALTH INSURANCE DATA
MEDICARE COVERAGE UPDATE

CASE NO. ☐☐☐☐☐☐☐☐☐☐ **CIN NO.** ☐☐☐☐☐☐☐☐

NAME ____________________

HIC NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐

BEGIN DATE ☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y

END DATE ☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y

PART A

MEDICARE A		BUY-IN A			
BEGIN DATE	END DATE	BEGIN DATE	END DATE	TRANS CD	OMH-OMR CD
☐☐☐☐☐☐☐☐ M M/D D / Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D / Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y	☐☐	☐☐☐

PART B

MEDICARE B		BUY-IN B			
BEGIN DATE	END DATE	BEGIN DATE	END DATE	TRANS CD.	OMH-OMR CD
☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D /Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y	☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y	☐☐	☐☐☐

MEDICARE SAVINGS PROGRAM INDICATOR

Check appropriate indicator

P = QMB /_/ **L = SLIMB /_/** **U = QI-1 /_/** **X = QDWI /_/**

BEGIN DATE ☐☐☐☐☐☐☐☐ M M/D D/Y Y Y Y END DATE ☐☐☐☐☐☐☐☐ M M/D D/ Y Y Y Y

COMMENTS ____________________

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DATE ____________ **ELIGIBILITY WORKER** ____________

DATE ____________ **TPR WORKER** ____________