For CSR describing the POS "WellPoint" process to a pharmacy:

The Point-of-Sale (POS) Facilitated Enrollment process is for providing immediate coverage of Part D drugs to dual eligible individuals who have not already been auto-enrolled into another Part D plan. Most dual eligible individuals have been auto-enrolled, so you should first check for enrollment in a Part D plan by asking for a plan ID card, other documentation from a Part D plan, or submitting an E1 query.

Questions concerning the E1 process should be directed to the TrOOP Facilitation Help Desk at NDCHealth at 1-800-388-2316 instead.

If your customer says they are enrolled in a plan but don't have their card yet (or an acknowledgement letter) and E1 does not show the enrollment yet, you should contact Medicare's dedicated pharmacy enrollment line (1-866-835-7595) available Mon.-Fri. 8 AM-8PM EST; or 1-800-MEDICARE (available 24/7) to find out how to contact the plan.

(When calling the dedicated pharmacy line or 1-800 MEDICARE, you must provide the beneficiary's name, Medicare ID number, date of birth, and address. While the HIC number alone may be used for eligibility (E1) queries to the TrOOP Facilitator, all 4 pieces of information are needed for phone inquiries.)

To Use the POS process: If you cannot find evidence of a Part D plan enrollment AND you can confirm reasonable evidence of both Medicare and Medicaid eligibility, you may bill the POS Contractor for the claim.

To verify Medicaid eligibility: In addition to existing state resources, such as IVR systems, you can use the following as verification of Medicaid eligibility:
- Medicaid ID card
- Recent history of Medicaid billing in the pharmacy patient profile
- Copy of current Medicaid award letter

To verify Medicare eligibility: You can check for either Part D enrollment **or** eligibility for Medicare Parts A & B by submitting an E1 query to the TrOOP facilitator.

Other (offline) ways to check for A/B Medicare eligibility are:
- Request to see a Medicare card; or
- Request to see a Medicare Summary Notice (MSN); or
- Call the dedicated Medicare pharmacy eligibility line (1-866-835-7595); or
- Call 1-800-MEDICARE

To Bill the POS Contractor: Make sure you have first submitted an E1 query and ruled out evidence of enrollment in a Part D plan, then:

There are mandatory data elements that must be included on the claim, including both the Medicare and Medicaid ID numbers. All claims generated by the POS process must be billed in accordance with the WellPoint (Anthem) payer sheet that is available at:

http://www.anthem.com/jsp/antiphona/apm/nav/ilink_pop_native.do?content_id=PW_A0 81085

If you need more information after reviewing the payer sheet, you can contact the Anthem pharmacy help desk at 800-662-0210, as indicated on the payer sheet.

ID Numbers: You will have to submit the beneficiary's Medicare ID number (known as the HICN), as well as the Medicaid ID number. Both numbers are critical to rapid verification of dual eligibility and should be available from all the valid sources of Medicaid or Medicare eligibility verification.

If your pharmacy's systems do not currently support the entry of more than one ID number into the B1 record, there are two workarounds:

1. Enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND bill a separate payer account: BIN: 610575; PCN: CMSDUAL**02**;

   or

2. Enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND include the Patient ID Qualifier field [331-CX] AND program the pharmacy system to map the Group ID field to the Patient ID field in the creation of the B1 transaction

Edits: There are no edits for Non-Formulary Drugs, or for Prior Authorization or Step Therapy. However, drugs excluded from Medicare coverage will not be paid for.

Copays: The claim will always process at a $1/$3 copay level.

Quantity Limits: The POS process will allow up to a 14 day fill, but you may elect to fill less than a 14 days supply at your discretion. We expect dual eligible individuals who are not already enrolled in another plan to be enrolled into a WellPoint (UNICARE) plan by the end of 14 days.