Empire Plan Prescription Drug Program

SCHEDULE OF PRESCRIPTION DRUG REPORTS

	Report Name	Frequency	Due Date	Type
	MIS REPORTS (ACCESS Format):			
1	Monthly Paid Claims by Month of Incurral	Monthly	30th day after end of month	electronic file
2	Monthly Paid Claims by by Pharmacy and Rx Type	Monthly	30th day after end of month	electronic file
3	Participating Agency (PA) Claims (Medicare/Non Medicare)	Quarterly	30th day after end of quarter	electronic file
4	Claims & Credits Paid by Agency	Annual	Jan. 30th	electronic file

Empire Plan Prescription Drug Program

REQUIRED DATA FIELDS FOR PRESCRIPTION DRUG PROGRAM MIS REPORTS

Report		Description	Field Name
(a)	Monthly Paid Claims by Month of Incurral	1 Month Paid	MONTH PAID
		2 Year Paid	YEAR PAID
		3 Month Incurred	MONTH INC
		4 Year Incurred	YEAR INC
		5 Benefit Program Code	PROGRAM/BP
		6 Pharmacy Type	PHARMACY TYPE
		7 Medicare Part B Eligible (Yes or No)	MEDICARE
		8 # of Claims: Enrollees	EE CLAIMS
		9 $ Amount Paid: Enrollees	EE PAID
		10 # of Claims: Dependents	DEP CLAIMS
		11 $ Amount Paid: Dependents	DEP PAID
		12 # of Claims: Total	TOTAL CLAIMS
		13 $ Amount Paid: Total	TOTAL PAID
(b)	Monthly Paid Claims by Pharmacy and Rx Type	1 Year Paid	YEAR PAID
		2 Month Paid	MONTH PAID
		3 Transaction Type (P = Payment, R = Reversal)	TRANS TYPE
		4 Pharmacy Type	PHARMACY TYPE
		5 Drug Type	RXTYPE
		6 # of Claims: Total	TOTAL CLAIMS
		7 # of the days supply	QUANTITY DAYS
		8 Average whole price (AWP) of RX Dispensed	AWP
		9 Allowed ingredient cost (after discount)	INGCOST
		10 Dispensing Fee	DISPFEES
		11 Sales Tax	TAXES
		12 $ Ancillary Charge Amount	ANC CHRG
		13 $ Employee Co-Pay	COPAY
		14 $ Amount Paid (by the Plan)	AMT PAID
(c)	Participating Agency (PA) Claims (Medicare/Non Medicare)	1 Quarter Paid	QUARTER PAID
		2 Year Paid	YEAR PAID
		3 Year Incurred	YRINC
		4 Agency Code	AGNCYCD
		5 Coverage (Individual or Family)	COV
		6 Medicare Part B Eligible (Yes or No)	MEDICARE
		7 Pharmacy Type	PHARMACY TYPE
		8 # of Claims: Enrollees	EE CLAIMS
		9 $ Amount Paid: Enrollees	EE PAID
		10 # of Claims: Dependents	DEP CLAIMS
		11 $ Amount Paid: Dependents	DEP PAID
		12 # of Claims: Total	TOTAL CLAIMS
		13 $ Amount Paid: Total	TOTAL PAID

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REQUIRED DATA FIELDS FOR PRESCRIPTION DRUG PROGRAM MIS REPORTS

Report		Description	Field Name
(d)	Annual Claims & Credits Paid by Agency	1 Year Paid	YEARPD
		2 Agency Code	AGNCYCD
		3 Year Incurred	YEARINC
		4 Enrollee or Dependent Claim	EEDEP
		5 Agency Type (P = Participating Agency, N = New York Agency/ All Non-PA Agencies)	AGENCY TYPE
		6 Number of Claims	CLAIMS
		7 Amount Paid	AMTPD
		8 Constant: D-Drugs	CARRIER