**Claim Submission**

* Claim processing may be delayed if the information submitted in this worksheet is illegible.
* If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
* A claim should not be submitted until the product has been administered to the patient.
* The manufacturer invoice showing the acquisition cost of the product administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the product, or it will be rejected for not enough documentation.

# Enrollee Information

**Enrollee Last Name: Enrollee First Name:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Date of Birth (MM/DD/YYYY): Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Address:**

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**City, Town or Post Office: State: ZIP Code:**

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# Prescriber Information

**Prescriber Last Name: Prescriber First Name:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**National Provider Identifier (NPI) Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Preferred Contact (Telephone Number)**

|  |  |  |  |  |  |  |  |  |  |  |  |
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# Coverage Conditions

* Reimbursement will not be provided for a diagnosis of osteoarthritis of the knee. Please see the article titled “[Viscosupplementation of the Knee: Non-coverage Decision](https://health.ny.gov/health_care/medicaid/program/update/2022/no04_2022-04.htm%22%20%5Cl%20%22vis)” in the March 2014 issue of the *Medicaid Update* for additional information. Coverage will continue to be provided for compendia-supported uses.
* For billing guidance and a list of covered products, providers may refer to the billing guidelines and fee schedules located on the [eMedNY Physician Manual web page](https://www.emedny.org/ProviderManuals/Physician/index.aspx).

**Enrollee Last Name: Enrollee First Name:**

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# Clinical Criteria – Product Information

**Product Administration:**

Provide the date of product administration (MM/DD/YYYY):

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

Provide the expiration date of the product if the invoice date is greater than 6 months from the date of product administration (MM/DD/YYYY):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

**Product Name and Healthcare Common Procedure Coding System (HCPCS) Code:**

[ ]  EUFLEXXA® – J7323

[ ]  Gel-One® – J7326

[ ]  HYALGAN® – J7321

[ ]  SUPARTZ® – J7321

[ ]  VISCO-3™ – J7321

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strength:**  **Directions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quantity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Treatment:** [ ]  Yes [ ]  No

If **No**, date therapy initiated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Clinical Criteria – Diagnosis

[ ]  Arthropathy – disorder of shoulder

[ ]  Subacromial impingement, syndrome of the shoulder

# Attestation

*I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.*

|  |  |  |
| --- | --- | --- |
| Prescriber Signature (Required) |  | Date (MM/DD/YYYY) |