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This is important information regarding your enrollment in the Medical Indemnity Fund. Please have it translated.

HAITIAN CREOLE
Sa se yon enfòmasyon enpòtan konsènan re-awòlman ou nan Fon Endamnite Medikal, Medical Indemnity Fund. Fè tradwi li souple.

KOREAN
이것은 의료 보장 기금 등록에 관한 중요한 정보입니다. 번역해 주십시오.

RUSSIAN
Здесь содержится важная информация, касающаяся вашей регистрации в фонде "Medical Indemnity Fund." Пожалуйста, переведите документ.

CHINESE
本信息为注册纽约州医疗赔偿基金会的重要信息。请翻译。

SPANISH
Esta es información importante con respecto a su inscripción en el Fondo de Indemnización Médica, Medical Indemnity Fund. Por favor téngalo traducido.
1.0 About The Medical Indemnity Fund

The Medical Indemnity Fund (MIF) was established in 2011 to provide a funding source for future health care costs associated with birth-related neurological injuries. Enrollees of the Fund are plaintiffs in medical malpractice actions who have received either court-approved settlements or judgments deeming the plaintiffs' neurological impairments to be birth-related. Enrollment in the Fund is for the enrollee’s lifetime. MIF covers all qualifying healthcare, which includes but is not limited to all future medical, hospital, surgical, nursing, dental, rehabilitation services pursuant to New York Public Health Law Article 29-D.

Public Consulting Group, Inc. (PCG), has been designated as Fund Administrator by the New York State Department of Health to administer the MIF in accordance with New York Codes, Rules and Regulations, Title 10 (10 NYCRR) subpart 69-10. As MIF’s Administrator, PCG oversees the MIF enrollment process, provides technical and case management support to enrollees and families, and adjudicates requests for services requiring prior authorization. PCG is also the MIF Claims Administrator responsible for healthcare and pharmacy benefit claims processing.

2.0 Welcome to The MIF

PCG would like to take the opportunity to welcome you to the New York State Medical Indemnity Fund. The Case Management and Claims Administration teams are looking forward to working with you to meet your health care needs.

This handbook will provide you with the following information:

- What healthcare costs are covered by the Fund?
- What case management services are provided?
- Which services require prior approval before they can be provided?
- How are claims submitted?
- What are the pharmacy benefits?

At the end of the handbook you will find all useful forms:

<table>
<thead>
<tr>
<th>Form</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENT FORM</td>
<td>Please print and send back to us</td>
</tr>
<tr>
<td>INFORMATION FOR PROVIDERS</td>
<td>Please take to each provider as it explains how providers can file claims for services rendered</td>
</tr>
<tr>
<td>PRIOR APPROVAL REQUEST FORM</td>
<td>Submit if you need services that require your Case Manager’s approval</td>
</tr>
<tr>
<td>AUTHORIZATION FORM</td>
<td>Submit if you want to authorize additional persons to provide and obtain information</td>
</tr>
<tr>
<td>GENERAL REIMBURSEMENT FORM</td>
<td>Submit to have your health-related expenses reimbursed</td>
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</table>
Please read each of the sections carefully because they will help you to better understand the MIF regulations and definitions regarding qualifying health related costs.

3.0 Case Management

Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs. The case manager communicates available resources to ensure quality and cost-effectiveness.

Individualized case management assists with access to care and maintaining medically necessary services. Case management activities may include negotiation and advocacy for services, consultation with providers, navigation through the healthcare system, psycho-social support, and general education regarding the MIF and healthcare system.

Goal of Case Management

Case managers share the goal to promote and support your access to health care services. Given the individualized nature of each enrollee, your consent and active decision-making with PCG is essential. PCG supports your right to privacy, confidentiality, self-determination, dignity and respect as well as nondiscrimination, and compassionate care. PCG ensures that you will be working with a culturally competent Case Manager and quality providers.

What you can expect from your Case Manager:

- Assisting with prior authorizations by helping you complete prior authorization forms and contacting providers for necessary documentation
- Performing monthly telephone and/or email contact to ensure all services are meeting your needs
- Assisting with care access by identifying service providers and determining any gaps in care
- Completing assessment and reassessments of enrollee’s medical condition during a home visit or telephone appointment, at a minimum of annually
- Developing a comprehensive care plan for all qualifying health care services you may need
- Assisting in obtaining service referrals through agency and qualified individuals
- Coordinating care with all agencies involved in care and wellbeing, including but not limited to Waiver programs, community resources and school-based services
- Assisting with questions about coverage or operations in the MIF
- Maintaining continuity of care without interruption of services
- Guiding you through the MIF process of care coordination and service payment
4.0 Qualifying Healthcare Costs
The Fund will pay qualifying health care costs as determined by a physician, physician assistant or nurse practitioner, and as defined by the Commissioner of Health in regulation. Examples of qualifying health care costs consist of:

- Medical treatment
- Hospital-based care
- Surgical care
- Nursing care
- Dental care
- Rehabilitative care
- Custodial care
- Durable medical equipment
- Certain environmental modifications
- Assistive technology
- Certain vehicle modifications
- Prescription and non-prescription medications
- Other health care costs for services rendered to, and supplies utilized by, enrollees

5.0 Services Requiring Prior Approval
Some services will require your Case Manager’s approval before they can be provided and covered by the MIF. See below those services requiring prior approval and how to obtain prior approval.

Services Always Requiring Prior Approval
The following services will always require prior approval in accordance with MIF regulations:

- Environmental modifications
- Vehicle modifications
- Assistive technology
- Private duty nursing
- Certain types of transportation for medical care and services (including travel involving overnight accommodations)
- Treatment with a specialty drug
- Experimental treatment
- Myo-electric limbs
- Custom-made durable medical equipment
- Hearing Aids
- Over the counter medications and supplements

Services Requiring Prior Approval When Certain Limits Are Exceeded
The following services will require prior approval when defined limits are exceeded:
More than 1,080 hours of respite care in a calendar year
More than 16 hours a day for home health aide services

**Non-Typical Services Requiring Prior Approval**

Certain services that are non-typical medical services also require prior approval. Non-typical services may be supplies or therapy that may be determined medically necessary. Some common examples include but are not limited to:

- Hippotherapy
- Aqua therapy
- Equestrian therapy
- Formula
- Gloves
- Food items
- Miscellaneous codes
- Incontinence products

**Items Not Covered by the MIF**

Please note, the MIF has received requests for every day personal hygiene items, such as toothpaste, toothbrushes, deodorant, and other day necessities. These items are not reimbursable under the MIF program.

**How to Obtain Prior Approval**

You may start the Prior Approval process by submitting a **PRIOR APPROVAL REQUEST FORM**. In this form you will need to provide the following information:

- MIF Enrollee ID: NYS______
- Name of Person(s) Submitting Request
- Signature of Person(s) Submitting Request
- Relationship to Enrollee
- Date Request Submitted
- Item and/or Services Requested: (services you are requesting)
- Provider(s) Supplying the item and/or Services Requested
- Reason for the Request

**PRIOR APPROVAL REQUEST FORM** can be found in the **FORMS** section at the end of this Handbook as well as on the MIF website at: www.health.ny.gov/mif. Once completed and signed, you can submit it by:

- Mail: MIF c/o PCG, PO Box 7315 Albany, NY 12224
- Fax: 518-344-1293
- Scan it and email to your Case Manager

**Minimum Required Documentation for Prior Approval or Authorization Processing**
For services requiring prior approval or authorization, at a minimum, you will be required to submit the following information with your Prior Approval Request Form:

- A valid diagnosis (ICD-10 code); and
- A Letter of Medical Necessity: a physician signed letter specifically identifying the service or product needed and the medical reasons for the item(s)

**Processing of Prior Approvals**

We review all authorization requests. After making a determination, we will send you a letter informing you of our decision, within 30 days from receiving all required documents.

If a service requiring prior approval is approved, your Case Manager will provide you with an approval letter that includes an authorization number, as well as any limitations or expiration date, if applicable. You will need to obtain a new prior approval for services beyond the approval dates.

If a service requiring prior approval is denied, you may request a review by completing a Request for Review of Denial Prior Approval Form within 30 days of the notice of denial. You can find the form on the MIF website at www.health.ny.gov/mif.

Certain services, such as vehicle and environmental modifications have additional requirements. Please see below the Prior Approval process for specific categories:

**5.1 Environmental Modifications, Vehicle Modifications and Assistive Technology**

As per MIF regulation, **environmental modification** means interior or exterior physical adaptation to the residence in which an enrollee lives that is necessary to ensure the health, welfare, and safety of the enrollee, enables him or her to function with greater independence in the community and/or helps avoid institutionalization, and has been ordered by a physician. Environmental modifications include but are not limited to: ramps, widened doorways and handrails, roll-in showers, vertical lifts, elevators only when there is no other safe and cost-effective alternative, and cabinet and shelving adaptations. Environmental modifications do not include any routine home maintenance. Environmental modifications also do not include adaptations or modifications that are of general utility and that do not provide direct medical or remedial benefit to the enrollee. With respect to new construction, environmental modifications do not include modifications needed as a result of avoidable barriers created by the new construction floor plan. Rent and/or utility expenses incurred while the adaptation is taking place are not covered by the MIF.

As per MIF regulation, **vehicle modification** means:

1. Adaptive equipment designed to enable an enrollee to operate a vehicle or be transported in a vehicle such as hand controls, deep dish steering wheels, spinner knobs, wheelchair lock down devices, parking brake extensions, foot controls, wheelchair lifts, left foot gas pedals; or
2. Changes to the structure, internal design, or existing equipment of a vehicle, such as replacement of the roof with an elevated fiberglass top, floor cut-outs, extension of the steering column, raised door, repositioning of seats, wheelchair floor, and dashboard adaptations.

Please note that you need to own the vehicle before any modifications can be approved. As per MIF regulation, assistive technology means those devices, controls, appliances, items, pieces of equipment, or supplies of either a communication or an adaptive type, determined necessary by a physician for purposes of the enrollee’s habilitation, ability to function or safety in his or her current or desired residence which are not listed in the Medicaid Durable Medical Equipment (DME) Provider Manual at https://www.emedny.org/ProviderManuals/DME/index.aspx

The Prior Approval process for environmental modification, vehicle modification or assistive technology starts when you submit:

- PRIOR APPROVAL REQUEST FORM
- Letter of Medical Necessity from your physician, and:

<table>
<thead>
<tr>
<th>For environmental modification:</th>
<th>For vehicle modification:</th>
<th>For assistive technology:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of ownership of the residence, such as deed and/or taxes and home owner insurance</td>
<td>Proof of ownership of the vehicle, such as registration and vehicle insurance</td>
<td>Copies of all assessments made to determine the necessary assistive technology, including an assessment of the enrollee’s unique functional needs and the intended purpose and expected use of the requested assessment technology</td>
</tr>
<tr>
<td>Evaluation by rehabilitative evaluation agency, rehabilitative specialist, or an independent building contractor</td>
<td>Vehicle Modifications and Equipment Evaluation obtained from a Driver Rehabilitation Specialist</td>
<td></td>
</tr>
</tbody>
</table>

Your Case Manager will determine if the documentation is complete and will notify you if anything is missing. The MIF will evaluate the request for appropriateness, and if approved, you will need to obtain three bids for the requested work.

Each bid must include:

- A description of work and specifications of the work, and:

<table>
<thead>
<tr>
<th>For environmental modification:</th>
<th>For vehicle modification:</th>
<th>For assistive technology:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of insurance for the contractor for the duration of the project</td>
<td>Proof of ownership of the vehicle</td>
<td>If assistive technology equipment is less than $2,500, documentation showing the prices from three different suppliers may be submitted. In other cases, formal bids from suppliers must be submitted</td>
</tr>
<tr>
<td>Statement signed by the contractor that the work will be done in a workmanlike manner, using materials suitable for the project construction while maintaining the safety of the enrollee and household members. The contractor agrees to comply with all applicable building and zoning laws</td>
<td>Statement signed by the contractor that the work will be done in a workmanlike manner, using materials suitable for purposes of the project</td>
<td></td>
</tr>
</tbody>
</table>
If you are unable to obtain three bids, you will need to provide a written explanation of why three bids were not obtained. You will also need to explain why the one or two bids submitted can be considered as reasonably priced.

Next, your Case Manager will review the bids. If the price difference between them is higher than 10%, the Case Manager will choose the bid that represents the best value. Factors determining the best bid are based on price and quality including durability, warranties provided, product safety and workmanship offered. If the price difference is less than 10%, you can choose a bid based on your preference.

Your Case Manager will discuss the bids with you and the reasons for selecting a particular bid. If you do not provide a written consent because you disagree with your Case Manager’s determination, you can request a review of the decision.

Your Case Manager will notify the successful bidder and authorize one-third payment of the total job amount. After the work is completed, an evaluator performs a post-modification assessment. This evaluation ensures that the modification meets your needs, is consistent with the initial evaluation, and follows all safety standards. After the post-modification evaluation is completed and approved, final payment is authorized.

Steps are shown in Figure 1 on the following page:
Your Prior Approval Request is reviewed, and:

- You need to obtain a minimum of 3 bids

You will receive a letter explaining why your request was denied. You have a right to appeal this decision.

Case Manager will notify successful bidder and authorize payment of 1/3

You will receive a letter explaining how to complete your request.

You will need to explain why 3 bids were not obtained and why the one or two bids you submitted can be considered as reasonably priced.

You will need to resubmit the bids and make sure each bid includes: description of work, proof of insurance, statement signed by the contractor.

Any changes to scope must be approved by PCG

Evaluation is conducted to ensure the modification:
- Meets enrollee’s functional needs
- Is in compliance with the initial evaluation
- Follows safety and all applicable building code standards

Figure 1. Prior Approval Process for Environmental Modification, Vehicle Modification and Assistive Technology
5.2 Private Duty Nursing

The Prior Approval process for **private duty nursing** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter of Medical Necessity
- If the service will be provided at **home**, submit physician’s written order and treatment plan
  - The physician’s order must state either that there is no approved home health agency available to provide the intermittent or part-time nursing services needed by the enrollee or that the enrollee is in need of individual and continuous care beyond that available from an approved home health agency
- If the service will be provided in **hospital**, physician’s order must state that the enrollee is in need of individual and continuous care beyond that available by the hospital staff

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness and you will be notified of the decision by mail.

![Diagram](image)

*Figure 2. Prior Approval Process for Private Duty Nursing, Transportation, Experimental Treatment, Specialty Drug, and Home Supplies*

If your private duty nursing request is denied, you can request a review by submitting a Request for Review Form within 30 days of the notice of denial. The form is located on the MIF website.

5.3 Transportation

Prior authorization is required for all transportation related to health care appointments (the one exception is for enrollee self-transportation.) Travel related expenses, including hotel and airfare, also require prior authorization. For medical appointments over 50 miles meal reimbursement is available

Self-transportation – which includes taxis, car services (such as Uber/Lyft), and public transportation – does not require prior authorization but requires proof of visit.

The Prior Approval process for **transportation** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
• A request for prior approval for non-emergency ambulance transportation or transportation by ambulette must be accompanied by the order of the enrollee’s attending physician, nurse practitioner, or physician assistant.

Transportation requests may be made for a one-time appointment or for multiple appointments during a specific period of time.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness and you will be notified of the decision by mail.

We will use the following criteria to determine whether to approve a transportation request:

- What is the nature and/or severity of enrollee’s condition?
- Is there a need of multiple treatments or visits over a short period of time?
- What is the distance between the enrollee and the provider?
- What is the cost of travel?
- Is there a medical necessity for a specific provider that requires additional travel?
- Are there any other unique circumstances?

If your transportation request is denied, you can request a review by submitting a Request for Review Form within 30 days of the notice of denial. The form is located on the MIF website.

5.4 Experimental Treatment

As per MIF regulation, **experimental treatment** means a drug, device, or treatment for which:

1. there is insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
2. approval required from the FDA for marketing to the public has not been granted; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
4. it is a type of drug, device or treatment that is the subject of an investigational new drug treatment pursuant to 21 C.F.R. § 312.21, or is the subject of an investigational device treatment pursuant to 21 C.F.R § 812.36; or
5. the written protocol or protocols used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental or investigational.

The Prior Approval process for **experimental treatment** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter from the treating physician explaining why the enrollee needs the experimental treatment
• Documentation indicating that standard treatment has not been effective for the enrollee or there is no standard treatment available to treat the enrollee’s condition, injury or impairment

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness and you will be notified of the decision by mail.

If your experimental treatment request is denied, you can request a review by submitting a Request for Review Form within 30 days of the notice of denial. The form is located on the MIF website.

5.5 Specialty Drug
As per MIF regulation, specialty drug means a drug that is typically high in cost and has one or more of the following characteristics:

1. is a component of complex therapy for treatment of a complex disease;
2. requires specialized patient training and coordination of care prior to therapy initiation and/or during therapy;
3. requires unique patient adherence to treatment regimen and safety monitoring of the patient during treatment with the drug;
4. requires unique handling, shipping, and storage; and
5. presents a potential for significant waste because of the manner in which the drug is packaged/dispensed or the failure to follow accepted clinical protocols prior to administration to the patient or both.

The Prior Approval process for specialty drug starts when you submit:

• PRIOR APPROVAL REQUEST FORM
• Written statement from your physician stating why treatment with the specialty drug is necessary, what other alternatives have been tried or explored, and what testing the enrollee has undergone for purposes of determining whether treatment with the specialty drug is appropriate and safe for the enrollee

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate the complete request for appropriateness and you will be notified of the decision within three business days of receipt of all necessary information. If your specialty drug request is denied, you can request a review by submitting a Request for Review Form within 30 days of the notice of denial. The form is located on the MIF website.

5.6 Health-related Home Care Supplies
Covered home care supplies may include but are not limited to the following: nutritional supplements and feeding supplies, chux/under-pads, ointments and disposable gloves. The cost
of diapers is covered by the MIF for enrollees whose development delays as a result of a neurological injury have resulted in the enrollee requiring the continued use of diapers beyond the expected age of accomplishment of toilet training.

The Prior Approval process for **home care supplies** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter of Medical Necessity from your physician

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness and you will be notified of the decision by mail. If your request is approved, your Case Manager will assist you in obtaining items from homecare supply vendors who accept the MIF for payment and who can deliver these supplies to your home address. We will assist you so that routine ordering and delivery of supplies can be set up in a manner that best meet your needs.

Please keep your Case Manager informed of any changes in your routine home care supply needs once this process is in place with a vendor. This will allow the Case Manager to update the authorization and get all the necessary documentation for the services.

This process is in place so you can avoid out of pocket payments for this type of expense. Work with your Case Manager to locate a vendor so you can benefit as soon as possible.

If you need to purchase homecare supplies and must pay out of pocket while we are working with you to set up routine supply delivery or, if we have determined that there is no vendor available to service your geographical area, please submit your itemized receipt(s) and fill in a **GENERAL REIMBURSEMENT FORM**.

If your home care supplies request is denied, you can request a review by submitting a Request for Review Form within 30 days of the notice of denial. The form is located on the MIF website.

### 6.0 Claim Submission Guidance

We encourage providers to submit claims for reimbursement directly to the MIF. Providers should use industry standard CMS-1500 and UB-04 claim forms. Please encourage your providers to call us if they have any questions about submitting claims or the MIF. Make sure you show your provider your MIF ID card so that they can bill the Fund directly.

In case you are submitting the claim, the MIF support team will help you to submit complete and accurate claims with supporting documentation. Please do not hesitate to contact us with any questions regarding the claim submission process.

To submit a claim, please complete the **GENERAL REIMBURSEMENT FORM** or **TRAVEL REIMBURSEMENT FORM**. In addition to the standard form, additional information is needed from you for certain claims to avoid unnecessary delays in reimbursement.

You can submit your claims by:

- Mail: MIF c/o PCG, PO Box 22008, Portsmouth, NH 03802

Please note:
• We do not accept or process photographs or faxes of claims.
• The MIF must receive completed claims within 90 days from the date services are rendered or purchased.

Below you will find additional information that we need to process particular types of claims:

• **Respite Care**
  Respite workers are encouraged to bill the MIF directly and can find the directions for claims submission under the provider section on the MIF website. The following requirements apply to all respite claims submitted by you:
  o **GENERAL REIMBURSEMENT FORM**
  o Requires prior authorization if more than 1,080 hours of respite care are provided in a calendar year
  o Specific list of services provided during respite
  o Dates of respite care
  o Number of respite hours provided per day
  o Name of respite worker
  o Hourly rate charged and total billed amount

• **Supplies**
  o **GENERAL REIMBURSEMENT FORM**
  o List of specific supplies requested
  o Copies of receipts for the items requested to include descriptions, amount paid for each item and the date paid

• **Non-Emergency Transportation and Travel Related Expenses (hotel, meals, airfare)**
  o **TRAVEL REIMBURSEMENT FORM**
  o All transportation (except for enrollee self-transportation) and travel related expenses (including hotel and airfare) require prior authorization
  o Meal Reimbursement is provided for medical appointments over 50 miles from the home
  o List of specific expenses requested for reimbursement
  o Evidence of medical appointment associated with travel
  o Copies of receipts for the items requested

• **Self-transportation** including taxis, car services such as Uber/Lyft, and public transportation
  o **TRAVEL REIMBURSEMENT FORM**
  o Meal Reimbursement is provided for medical appointments over 50 miles from the home
  o List of specific expenses requested for reimbursement
  o Evidence of medical appointment associated with travel
  o Copies of receipts for the items requested: receipts for mileage, parking, tolls, public transit receipts, Uber/Lyft receipts

• **Mileage, Tolls, Parking**
- **TRAVEL REIMBURSEMENT FORM**
  - Copies of receipts for expenses
  - Evidence of medical appointment associated with mileage, tolls and parking
  - Starting point address, destination address, ending address (mileage will be determined using MapQuest)

- **Office Visit Copays, Coinsurance and Deductibles**
  - **GENERAL REIMBURSEMENT FORM**
    - Copay receipts need to be on office or pharmacy letterhead and must include date of service, provider name, patient name, amount paid, indication that amount is a copayment
    - Coinsurance and Deductibles from primary insurance carrier:
      - Enrollees should either give their MIF information to providers at the time of their visit and request they bill the MIF directly or obtain an itemized bill from the provider and submit to the MIF with a copy of primary insurance Explanation of Benefits (EOB) if applicable
  - **Balance Due or Credit Card Statements:**
    - Balance due or credit card statements cannot be processed for reimbursement due to lack of information required to determine accurate reimbursement. Enrollees have two options: 1) they may supply their MIF information to providers and request they bill the MIF directly or, 2) they may obtain an itemized bill from the provider and submit to the MIF with a copy of primary insurance EOB if applicable.

**Coordination of Benefits**

Some enrollees may have commercial health insurance coverage from their parent’s employer. If this is your situation, please inform us so that we can update your information and coordinate with the insurer. Coordination of additional coverage with the MIF may lower your medical and out of pocket expenses.

If you have commercial health insurance, it will always be primary (or first payer) before the MIF. All claims must be submitted to the commercial health insurance before submitting the claim to MIF. If the primary insurance does not pay for the entire claim, the provider should submit the itemized bill to MIF with a copy of the Explanation of Benefits they received from the primary insurance. The MIF requires an EOB before any payment can be made. If the MIF receives a claim without the primary EOB, the claim will be denied until the EOB is received and the claim can be adjusted.

If the primary health insurance does not cover certain services that are covered under the MIF, please submit a document from the primary payer that lists what is not covered. This can be in the form of a letter from the commercial health insurance or a copy of the “What is Not Covered” or “Exclusions” section of your commercial health insurance plan booklet. We can use this document for processing these claims. We know that having more than one coverage can be confusing. Please call us if you have any questions.
If your primary health insurance is Medicaid, you must inform your local county social services so that the MIF shows as a third-party payer on your eligibility file. Please do this within thirty days of enrollment into the MIF. You should also let your Case Manager know if you are enrolled in Medicaid and if you are receiving any services or waiver services through Medicaid, so we can coordinate your health care services.

**Payments**
Under the New York State Regulations, the MIF reimbursements are based on 80% of the usual and customary rates (UCR). This means that 80% of the providers in the geographic area of where services were rendered are charging what the Fund is paying. The data to determine these rates is gathered from all payers and is calculated by FAIR Health.

If there is no usual and customary amount for the services being provided, the MIF reimburses 130% of New York Medicaid or Medicare rate, whichever is higher.

All rates are subject to periodic adjustments due to updated data, inflation and budgetary considerations.

**Because the MIF is not an insurance company, there is no provider network**
The MIF has not contracted with any providers to render services at guaranteed rates because it is not an insurance company. While you are free to see any provider you wish, we strongly encourage you ask your provider if they accept MIF payments. Providers are encouraged to accept payments directly from the Fund. Providers cannot bill the enrollee or persons authorized to act on behalf of the enrollee for any additional amount beyond the amount covered by the Fund.

If a provider wants to know what the MIF will pay for a service prior to rendering the service, they should send a request to the MIF with the following information:

- Provider Name and National Provider Identifier (NPI)
- Procedure Code(s) and Billed Amounts for each code
- Approximate date services are expected to be rendered

The MIF will respond within 2 business days from receipt with the payment the provider can expect to receive.

**When you receive medical statements**
Most providers have billing cycle procedures. For example, they may send a statement every 30 days until payment is received. Some providers may send you the statements as part of their billing practice. Often, these statements are sent to you for your information only, but occasionally they are requesting that you pay a balance after they received payment from your commercial health insurance or the MIF. Please be advised, the MIF has 45 days to process a claim. The process time may be longer if additional documents are required including insurance EOBs. While the bill may seem “late”, it may just be in process. Before making any payments, please call us. We will do our best to help you understand if any action on your part is necessary.
7.0 Pharmacy Benefits and Prescription Program

MIF covers the cost of all approved medications that the enrollee’s healthcare provider has determined medically necessary. Citizens Rx is the MIF’s pharmacy benefit partner. Covered medications can be filled at no out-of-pocket cost to you at one of the many participating pharmacies, including CVS, Rite Aid, Walgreens, and Wal-Mart. You can also visit citizensrx.com or call Citizens Rx customer service at 1-855-NYMIF33 (1-855-696-4333) to find a pharmacy near you.

Citizens Rx can also provide long-term medications by mail, through the mail order service, PraxisRx. The pharmacy mail program makes it easy and convenient for you to get long-term medications delivered directly to you. Enclosed in this Handbook are instructions along with a mail order claim form to complete.

Although the majority of medications are covered under the MIF pharmacy benefit, there may be some medications that require prior authorization by the MIF before they will be covered. To avoid any delays in filling any new medications, please call your Case Manager whenever a healthcare provider has determined that the enrollee needs a new medication (a medication not taken before by the enrollee.) The Case Manager will be able to tell you if prior authorization is required.

Five ways to start using your Citizens Rx prescription program:

- Bring your prescription to a Citizens Rx participating pharmacy
- Fill out and mail the service form – use the one included in this Handbook or print one at citizensrx.com
- If you currently have a prescription for a controlled substance or compound medication, you will need an updated prescription in order to fill via the mail service
- Visit citizensrx.com
- Call Citizens Rx at 1-855-NYMIF33 (1-855-696-4333)

8.0 Contact Information

The New York State Medical Indemnity Fund and Public Consulting Group, Inc. are dedicated to excellence in service as we partner with you in meeting each enrollee’s health related needs. If you have MIF-related questions, please do not hesitate to contact your Case Manager directly or the Fund Customer Service Department via a toll free line at 1-855-NYMIF33 (1-855-696-4333) from Monday through Friday during normal business hours, 8:30 am to 5:00 pm Eastern Standard Time or via email at MIF@health.ny.gov

You can also visit the Fund website for updates, forms, and frequently asked questions at: www.health.ny.gov/mif

Once again, welcome to the MIF and we look forward to working with you.
9.0 Forms

All forms included in this section are also available on the Fund website in Forms and Instruction section.

9.1 Acknowledgement Form

You must sign and return this form as soon as possible in the self-addressed stamped envelope provided with this Handbook.

9.2 Information for Providers

Please take this form to each health-related provider (have them make and keep a copy on file) as it contains important information about the MIF and explains how providers can file claims for services rendered.

9.3 Prior Approval Request Form

Use this form to request services that require Case Manager’s prior approval.

9.4 Authorization Form

Use this form to authorize additional persons to obtain and submit information on behalf of the enrollee.

9.5 General Reimbursement Form

Use this form for health-related expenses. Please make sure you have already obtained any necessary authorization before submitting your claim.

9.6 Travel Reimbursement Form

Use this form for health-related travel. Please make sure you have already obtained any necessary authorization before submitting your claim.
9.7 Pharmacy Delivery Registration Form

Use this form to register for pharmacy home delivery service.

PCG complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Health Information Technology for Economic and Clinical Health Act (HITECH) Breach Notification Rule, and all federal requirements related to 42 CFR 495, Standards for the Electronic Health Record Technology Incentive Program, Subpart D, such as, but not limited to 42 CFR 495.324, 495.346, 495.354 and 495.360 as well as Social Security Administration (SSA) Required Provisions for Data Security.

PCG uses data encryption to move data between entities over external networks that are outside of the PCG firewall. PCG strictly adheres to HIPAA guidelines and encrypts Protected Personal Information (PPI) and Protected Health Information (PHI). This is done for data at rest and in databases. PCG uses secure File Transfer Protocol (FTP) software to both send and receive data. Only authorized personnel are allowed to access client data. Client data is not co-mingled with other client data at any time.
Acknowledgment

I, ________________________, am the (Please underline the appropriate designation) Parent/Legal Guardian/Authorized Representative of/for ________________________, who is an Enrollee in the New York State Medical Indemnity Fund ("MIF").

By signing this form, I am acknowledging that I have received the following information about the MIF:

1. Information regarding how to access the website for the MIF (www.health.ny.gov/mif) on which the regulations that govern the MIF and other information about the MIF can be found and reviewed.
2. A hard copy of the MIF regulations, which contain the MIF definition of "qualifying health care costs", state what services, items, equipment, etc. require prior approval from the MIF as a condition for payment, and my right upon any denial of a claim or a request for prior approval by the MIF, to:
   a. An informal conference with a representative of the Fund administrator and/or
   b. A formal review by an administrative law judge.
3. Information about the case management process and the requirement that I participate in periodic telephone case conferences with the MIF case manager assigned to (Name of Enrollee) ________________________, as required by the Enrollee’s health care related needs. I have also been advised of the availability of translation services as needed and how to request such services.
4. Instructions to contact Public Consulting Group at 1-855-NYMIF33 (1-855-696-4333) within 24 hours for any inpatient admission of the enrollee.
5. The toll-free phone number for the MIF which I may call during normal business hours with any questions or concerns that I may have about the Enrollee’s coverage under the MIF. That number is 1-855-NYMIF33 (1-855-696-4333).

Date: ________________________________

Signature of Parent/Legal Guardian/Authorized Representative | Address

Printed Name of Parent/Legal Guardian/Authorized Representative | Phone number

Witness Signature | Address

Printed Name of Witness | Phone number
Information for Providers
about the New York State Medical Indemnity Fund

What is the Medical Indemnity Fund and Why Was It Created?
The Medical Indemnity Fund ("Fund" or "MIF") was established in 2011 to provide a funding source for future health care costs associated with birth-related neurological injuries. Enrollees of the Fund are plaintiffs in medical malpractice actions who have received either court-approved settlements or judgments deeming the plaintiffs' neurological impairments to be birth-related.

The Fund’s purposes are to (1) pay or reimburse the costs necessary to meet the health care needs of qualified plaintiffs throughout the plaintiff’s lifetime and (2) lower the expenses associated with medical malpractice litigation throughout the healthcare system. To achieve its purposes, it is designed to pay the cost of all future health care needs of plaintiffs who have received either a court-approved settlement or a judgment as a result of a medical malpractice action alleging that the plaintiff’s neurological injuries were the result of medical malpractice during the delivery admission.

The Fund was created as an amendment to Article 29-D of the New York Public Health Law in 2011. Regulations governing the proper administration of the Fund are the responsibility of the Commissioner of Health in consultation with New York State Department of Financial Services. The regulations are set forth in 10 NYCRR Subpart 69-10.

Information about the Fund can be found on the DOH website at: www.health.ny.gov/mif

Who Is Eligible for Enrollment in the Fund?
Any person who has been deemed in a court-approved settlement or found in a judgment to have sustained a “birth-related neurological injury” as a result of medical malpractice or alleged medical malpractice is a “qualified plaintiff” for enrollment purposes.

What Costs Will the Fund Cover or Reimburse?
The Fund will pay or reimburse the cost of those health care services, supplies, equipment, and medications that the qualified plaintiff’s physician, physician assistant or nurse practitioner has determined are necessary to meet the qualified plaintiff’s health care needs. Such costs include those incurred for:

- Medical treatment
- Nursing care
- Prescription & non-prescription medication
- Assistive technology
- Other health care costs related to services, supplies, equipment and medication utilized by Fund enrollees.
- Hospital-based care, including surgical care
- Dental care
- Durable medical equipment
- Certain environmental & vehicle modifications

Services, supplies or equipment provided to or available to enrollees under an individual Education Program, Preschool Supportive Health Services, and the Early Intervention Program or through any commercial insurance under which the enrollee is covered are not covered by the Fund.
At What Reimbursement Rates Are Qualified Health Care Costs Paid by the Fund?
Qualifying health care services are reimbursed at the 80th percentile of the “usual and customary rate” for that type of practice in the geographic area in which the practice is located, as reported by Fair Health, Inc. Where no such rate exists, qualifying health care services are paid at the greater of 130% of Medicaid or the Medicare rate. Providers cannot bill the qualified plaintiff or persons authorized to act on behalf of the plaintiff for any additional amount beyond the amount covered by the Fund.

Who Administers the Fund?
The Fund is administered by DOH. DOH has contracted with Public Consulting Group Inc. (PCG) to administer healthcare and pharmacy benefit claims processing and day-to-day operations of the Fund.

MIF Identification Cards
Approved enrollees are issued NYS MIF Identification Cards (sample below).

Payment Request Submission Instruction
The New York Medical Indemnity Fund accepts both electronic and paper claims with industry standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act (HIPAA) Transaction Set Standards. Providers seeking payment or reimbursement of qualifying health care costs may send completed CMS 1500 or UB 04 Forms to:

New York State Medical Indemnity Fund
c/o PCG
PO Box 22008
Portsmouth, NH 03801

The Fund offers two options for submitting Electronic Data Interchange (EDI) claims. With the appropriate option in place for your electronic workflow, electronic billing results in fewer errors, lower costs and increased efficiency for businesses on both ends of the transaction. These options are detailed below:
- **Clearinghouse Submitters**
  Standard 837 file submission through a clearinghouse using the Fund’s receiver ID, NYDFS. This PIN is the identifier at the Clearinghouse to route claims directly to the Claims Operation Department.

- **Direct Submitters**
  This option is for providers who choose to create their own 837 file and submit that file directly to the MIF portal. If you wish to request online access, you can send a request via email with your Tax ID and group NPI to MIF@health.ny.gov. Claims must be submitted within 90 days of the date of service unless the provider obtains permission from the Fund to file a claim later than that date upon a showing of good cause for the delay. Providers must submit a W9 with their initial claim to avoid payment delay.

Feel Free to Call (Toll Free): 1-855-696-4333 (NYMIF33)
with any questions you may have
Prior Approval Request Form

Request being made on behalf of (Name of Enrollee): ________________________________
MIF Enrollee ID: NYS__ __ __ __ __ __ __ __ __
Name of Person(s) Submitting Request: ________________________________
Signature of Person(s) Submitting Request: ________________________________
Relationship to Enrollee: ________________________________
Date Request Submitted: ______________

ITEM AND/OR SERVICES REQUESTED: (services you are requesting)
I am requesting approval of the following item(s) and/or services from the New York State
Medical Indemnity Fund:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

PROVIDER(S) SUPPLYING ITEM AND/OR SERVICES REQUESTED:

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<th>Address</th>
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REASON FOR REQUEST:
The reason(s) for this request is/are:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please provide a Letter of Medical Necessity for each service and/or item requested from the
appropriate healthcare provider for the enrollee. The letter of necessity should include any
specifications that he/she recommends.

If a Letter of Medical Necessity is not included with this request, one will be sought by the
enrollee’s Case Manager from the appropriate healthcare provider for the enrollee.
I, ______________________, am the (please underline the appropriate designation) Parent/Legal Guardian/ Authorized Representative of/for ________________________, who is an enrollee in the New York State Medical Indemnity Fund (“MIF”).

By signing this form, I authorize persons listed below to obtain and submit information to Public Consulting Group, Inc. (PCG) on behalf of the enrollee. I authorize PCG to disclose medical or health information regarding the enrollee to persons listed below. The individuals below must be able, and required, to provide information, such as the Enrollee’s date of birth, Social Security Number, etc. as conditions of the information’s release.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to enrollee</th>
<th>Phone number</th>
<th>Email address</th>
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I also specifically authorize PCG to initiate, participate in, and conduct communications with the above individuals on behalf of the Fund, whether or not I am present or have received notice thereof. I understand that the information about the Enrollee that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof.

1. **What information is covered by this authorization?** This Authorization applies to all medical or health information regarding the enrollee’s diagnoses, care, and treatment. The enrollee’s
information to be disclosed may include medical or health information received from other health care providers, community agencies and education entities.

2. **How long is this authorization valid?** This Authorization is valid during the duration of the Enrollee’s enrollment in the Fund but no later than the date upon which the Enrollee becomes 18 years of age if he or she has the capacity to make health care decisions at that time.

3. **Revocation of this authorization.** Unless otherwise provided by federal or state law, I understand that I may revoke this Authorization at any time by notifying PCG, in writing, of my revocation and that my revocation shall be effective upon the PCG’s receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by the PCG before it receives my revocation.

I understand that I have the right to request and receive a copy of this signed Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

Date: ____________________________________________

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<tr>
<th>Signature of Parent/Legal Guardian/Authorized Representative</th>
<th>Address</th>
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<tbody>
<tr>
<td>Printed Name of Parent/Legal Guardian/Authorized Representative</td>
<td>Phone number</td>
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<tr>
<td>Provider Last Name</td>
<td>Provider First Name</td>
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I certify the information given is accurate and that none of these items have been reimbursed by any other source for any amount, nor are they pending reimbursement from other sources.

Signature: ___________________ Relationship to enrollee: ___________________

Print Name: __________________ Date: ___________________
## TRAVEL REIMBURSEMENT FORM - USE FOR:
- Non-Emergency Transportation and Travel Related Expenses (hotel, meals, airfare)
- Self-transportation (taxi, car services such as Uber, Lyft, public transportation)
- Mileage, Tolls, Parking

### Instructions

- Add as many rows as you would like (no other alterations can be made).
- All transportation (except for enrollee self-transportation) and travel related expenses require prior authorization.
- Add additional payment receipts for the items requested and attach evidence of medical appointment associated with travel.
- For Mileage reimbursement requests, mileage will be determined using the USQ program.
- Medical Reimbursement is provided for medical appointments over 10 miles from the home.
- Completed forms may be sent to MF@health.ny.gov or mailed to:

MF c/o PCG, PO Box 22008, Portsmouth, NH 03602

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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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<th>H</th>
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<tbody>
<tr>
<td>Medical appointment associated with travel</td>
<td>Names of persons who travelled with enrollee</td>
<td>Type of Transportation (i.e., Ambulance, Ambulite, Car, Van, Train, Airplane, Taxi, Uber, Lyft, Public Transportation)</td>
<td>Dates of Travel</td>
<td>Starting point</td>
<td>Destination address</td>
<td>Ending address</td>
<td>Total Billed Per line</td>
</tr>
</tbody>
</table>

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I certify the information given is accurate and that none of these items have been reimbursed by any other source for any amount, nor are they pending reimbursement from other sources.

Signature: ____________________ Relationship to enrollee: ____________________

Print name: ____________________ Date: ____________________
We look forward to serving your

HOME DELIVERY PHARMACY NEEDS

Mail Prescriptions to:

PraxisRx
5455 W. Waters
Suite 214
Tampa, FL. 33634

1 (844) 553-7500
www.praxisrx.com
**HOW TO USE PRAXISRX PHARMACY HOME DELIVERY**

**OBTAINING YOUR PRESCRIPTION**
- PraxisRx Pharmacy can contact your physician for you.
- You can obtain a prescription from your physician and send it to PraxisRx Pharmacy by mail.
- Your physician can send a prescription to PraxisRx Pharmacy by fax or through electronic prescribing to PraxisRx Pharmacy.
- Be sure to ask your physician to write the prescription for a 30-day supply with three refills and authorize a one-year supply (when appropriate).
- Auto refills may be available to members. Please contact customer service for more information.

**PAYMENT IS DUE AT TIME OF ORDER**
- Credit Card (you can elect to securely save your credit card information for future online or automated voice refills)
- Check (by mail)
- Money Order

**REMEMBER**
- Allow up to 10 days from the time you mail your prescription until you receive the medication in your mailbox.
- Faster shipping is available, for an additional cost, by contacting customer service.
- Contact customer service for additional forms, or visit our website at www.praxisrx.com to print as many as you need.

**ABOUT GENERICS**
Generic medications will be used when available and appropriate. The Food and Drug Administration requires a generic medication to be as safe and effective as its brand counterpart. Generic medications are considerably less expensive than brand name drugs.

**IF YOU NEED MEDICATION RIGHT AWAY**
Request two prescriptions from your physician, one for an initial 30-day supply that your local pharmacy can fill immediately, and one for a 90-day supply with three refills to fill through PraxisRx.

**ADDITIONAL INFORMATION**
- Provide your phone number in case we need to contact you.
- Provide your e-mail address to receive shipment notifications and refill reminders.
- If you need a new prescription, we will contact your physician.
- We will contact you by phone if your order is delayed.

**REGISTRATION OPTIONS**
- Call us with your registration information
- Fill out the enclosed registration form
- Register online at www.praxisrx.com

**Visit our website www.praxisrx.com to register or manage your prescriptions online.**
**MEMBER INFORMATION**

(844) 553-7500 | [WWW.PRAXISRX.COM](http://www.praxisrx.com)

**CARDHOLDER ID#** *(REFER TO ID CARD)*

**GROUP #** *(REFER TO ID CARD IF APPLICABLE)*

**LAST NAME OF CARDHOLDER**

**FIRST NAME OF CARDHOLDER**

**DELIVERY ADDRESS (STREET AND APARTMENT NUMBER)**

**CITY**

**STATE**

**ZIP CODE**

**EMAIL ADDRESS**

**DAYTIME PHONE NUMBER**

**DATE OF BIRTH (MM/DD/YYYY)**

**GENDER**

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**Drug Allergies:**

- [ ] No Known Allergy
- [ ] Codeine
- [ ] Iodine
- [ ] Penicillin
- [ ] Sulfa
- [ ] Aspirin
- [ ] Erythromycin
- [ ] Other

**Health Conditions:**

- [ ] Arthritis
- [ ] Diabetes
- [ ] Heart Condition
- [ ] High Cholesterol
- [ ] Ulcer
- [ ] Asthma
- [ ] Epilepsy
- [ ] High Blood Pressure
- [ ] Thyroid
- [ ] Depression
- [ ] Glaucoma
- [ ] Other

List any OTC, herbal, or other medications you take regularly:

---

**PAYMENT OPTIONS**

Payment is due with each order. **Do not send cash.** If you use a credit card for payment, PraxisRx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

**Credit Card Type** *(Our preferred payment method for faster service)*

- [ ] MasterCard
- [ ] Visa
- [ ] American Express
- [ ] Discover
- [ ] Use credit card on file
- [ ] Please place credit card on file for future orders

**ACCOUNT NUMBER**

**EXPIRATION DATE**

**SECURITY CODE**

**Notes to Pharmacy:**

**PLEASE READ AND SIGN TO COMPLETE ORDER**

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to PraxisRx Pharmacy.

**Signature:**

**Date:**

To refuse generics check here (☐), AND sign and date. PraxisRx Pharmacy substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products. “I understand that I have the right to refuse generic medications. I understand this may result in a high cost to me, that I am responsible for payment, and that the drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept the conditions.”

**Signature:**

**Date:**