Pharmacy Provider Manual
2016

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Introduction

Citizens Rx, LLC is a pharmacy benefit management company located in Oak Park, IL. We provide pharmacy benefit design, administration, and management services as well as a sophisticated, state-of-the-art pharmacy claim-processing program to health plan sponsors. Programs such as (a) drug utilization reviews, (b) clinically based formularies, (c) generic substitution programs, and (d) disease-oriented managed care allow third-party payers to effectively manage the cost of providing prescription benefits for their health care members.

Important Information Regarding the Use of this Manual

This provider manual is designed to explain the administrative and compliance procedures as they relate to providers, and is updated as necessary by Citizens Rx. For terms not otherwise defined in the provider manual, refer to the terms defined in your pharmacy participation agreement.

In the event of a conflict or inconsistency between your agreement with us and this manual, the provisions of your agreement with us will control.

In the event of a conflict or inconsistency between regulatory requirements (included in or attached to your provider agreement) and this manual, the provisions of the regulatory requirements will control with regard to benefit plans within the scope of the regulatory requirement.

Contact Information

For questions regarding any of the administrative and compliance policies or procedures or other information communicated in the Citizens Rx provider manual, please call the Citizens Rx Help Desk at **(888) 316-6510**, or by sending an e-mail to providerrelations@citizensrx.com.

Citizens Rx Pharmacy Help Desk

The Citizens Rx Pharmacy Help Desk can be reached at (888) 316-6510. Our customer service representatives, certified pharmacy technicians, and licensed clinical pharmacists will be available to answer questions and assist providers any time – 24/7/365.

Citizens Rx Pharmacy Claim Submission

Citizens Rx
Provider Relations
1144 Lake Street, 4th Floor
Oak Park, IL 60301

Frequently Asked Questions by Providers

What eligibility information does the provider need to validate for this plan member (e.g., member identification number, group identification number, date of birth, gender)?

Identification of the plan member and validation of the patient record is essential for accurate claims processing. Providers should validate the plan member's name, date of birth, allergy, demographic information (e.g. address, telephone number), and insurance information, including validation of the plan member's identification card, prior to billing the claim. When a provider submits a claim using a plan member's eligibility information which does not match the eligibility information for this plan member in the Citizens Rx claims adjudication system, the claim will be rejected. When this occurs, the provider will receive a denial message due to non-matched eligibility data. Upon receipt of a denial message, the provider will verify eligibility information with the plan member to ensure that the provider has the correct information. If correct, the provider is encouraged to contact a customer services representative at Citizens Rx to clarify any discrepancies in eligibility information. Until the discrepancies are corrected, the plan member's claims will continue to reject. Moreover, the provider should advise the plan member to contact and inform their health plan sponsor of the incorrect eligibility information and request that the information be corrected.

What is the plan member's co-payment for Brand medications and Generic medications?

The provider needs to submit the claim through the claims processing system to receive the adjudicated response, which will include the co-payment amount to collect, as well as any relevant information about eligibility, plan coverage, pricing, and applicable clinical programs and services. A Citizens Rx customer service representative can help the provider by releasing information about the amount the plan member must pay per their health plan design.

What is the prior authorization approval procedure for a plan member?

Citizens Rx administers prior authorization (PA) services for most of its health plan sponsors. A Medicaid provider needs to note the PA response, which generally includes the on-line retransmission instruction or appropriate contact information and telephone numbers. A commercial provider needs to contact the Citizens Rx call center for prior authorization procedures. The representative at the call center will assist by providing information about the plan member's group, directing the provider the health plan administrator, or assisting at the point of service with the prior authorization number code.

What is the procedure for authorizing claims identified as "refill too soon," "cost exceeds maximum," "plan limitations exceeded," or "submit to primary carrier, Citizens Rx to be billed as a secondary payer"?

Many health plan sponsors allow plan members to secure an early refill for a vacation supply. If the plan member states that they are for an early refill (e.g., vacation overrides, spilled or lost medications), the provider can submit the claim as usual. If the claim rejects as an early refill or exceeds plan limitations, the provider should contact Citizens Rx's call center for coverage verification. If the health plan sponsor allows for an early refill, the representative from the call center will issue the appropriate prior authorization so that the claim can be processed.

A claim for which Citizens Rx is the secondary payer may trigger a "submit to primary carrier, Citizens Rx to be billed as a secondary payer" message. This message indicates that the member has dual coverage and that payment must be coordinated with the primary payer through coordination of benefits (COB). Many times the secondary claims are not accepted online and must be submitted on a paper claim. This will have to be verified on a case by case basis.

What are the annual benefits for the plan member?

When the provider submits the claim, the adjudicated response will provide messaging to include plan coverage limits. Our call center representatives are also available to provide plan limitation information, (e.g., co-pays, maximum benefit, plan guidelines).

What is your bank identification number (BIN) and processor control number (PCN)?

With the many different types of plans that we have, there can be more than one PCN for the same pharmacy chain depending on which type of plan the specific plan member is enrolled in. The BIN is often provided on the plan member's identification card. If the number is not provided, please call the provider services call center for the Citizens Rx BIN or PCN.

Pharmacy Network Application and Credentialing Guidelines

Provider Enrollment and Participation

To apply as a provider and participate in the Citizens Rx Pharmacy Network, the applicant must dial **(888) 316-6510** and then press the menu option for Provider Relations. Applicants should be prepared to present the provider name, corresponding NCPDP number, contact name, business address, telephone number, facsimile number, email address, and the purpose for the call. Following this initial contact, Citizens Rx will initiate the process for the applicant to enroll and participate in the Citizens Rx Pharmacy Network.

Application for Enrollment in the Citizens Rx Pharmacy Network

When applying for enrollment in the Citizens Rx Pharmacy Network, the Citizens Rx provider relations coordinator will send the pharmacy a Pharmacy Participation Agreement and its related exhibits.

Pharmacy Participation Agreement

The applicant is required to complete, sign, and return the Citizens Rx Pharmacy Participation Agreement. Said agreement requires complete documentation including, but not limited to:

- provider's name and address;
- telephone phone number;
- facsimile number;
- current state license number;
- current federal tax identification number;
- current NABP number;
- Corporate status.

Pharmacy Participation Agreement Checklist

A set of minimum level criteria is used to determine the applicant's eligibility for participation in the Citizens Rx Pharmacy Network. If the applicant is a representative of a pharmacy chain, such applicant is requested to submit a spreadsheet listing all chain pharmacies in addition to the following requested information.

Licensure

The applicant must meet all standards of operation as described in federal, state, and local law. The applicant must furnish copies of federal, state, and local licenses and/or business permits as required by applicable law when applying for enrollment as a provider in the Citizens Rx Pharmacy Network. The applicant must at all times maintain such licenses and/or permits in good standing.

Once credentialed to participate in the Citizens Rx Pharmacy Network, the provider must notify Citizens Rx immediately in writing if any of its licenses and/or permits are canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Citizens Rx in writing of any such action may result in immediate termination from the pharmacy network. Moreover, failure to maintain the appropriate licenses and/or permits will result in immediate termination from the Citizens Rx Pharmacy Network as a provider.

Insurance

When applying for enrollment as a provider in the Citizens Rx Pharmacy Network, the applicant must furnish copies of policies for general and professional liability insurance, including malpractice, at a minimum, in the amount of $1,000,000.00 per occurrence and $3,000,000.00 in aggregate or as otherwise required by law. The applicant must at all times maintain said policies in amounts necessary to ensure that the provider

and any of its personnel are insured against any claims for damages arising from the provision of pharmacy services.

Once credentialed to participate in the Citizens Rx Pharmacy Network, the provider must notify Citizens Rx immediately in writing if its insurance is canceled, suspended or otherwise terminated. Failure to immediately notify Citizens Rx in writing of any such termination of insurance coverage may result in immediate termination from the pharmacy network. Additionally, failure to maintain the minimum coverage will result in immediate termination as a provider.

Drug Enforcement Agency Controlled Substance Registration Certificate

The applicant must furnish a copy of its Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate as required by applicable law when applying for enrollment as a provider in the Citizens Rx Pharmacy Network. The applicant must at all times maintain such DEA registration certificate in good standing.

Once credentialed to participate in the Citizens Rx Pharmacy Network, the provider must notify Citizens Rx immediately in writing if its DEA registration certificate is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Citizens Rx in writing of any such action may result in immediate termination from the pharmacy network. Furthermore, failure to maintain the DEA registration certificate may result in immediate termination from the Citizens Rx Pharmacy Network as a provider.

Medicaid Provider Number

When applying for enrollment as a provider in the Citizens Rx Pharmacy Network, the applicant must furnish its Medicaid Provider Number as required by applicable law. The provider must at all times maintain its Medicaid Number as current.

Once credentialed to participate in the Citizens Rx Pharmacy Network, the provider must notify Citizens Rx immediately in writing if its Medicaid Number is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Citizens Rx in writing of any such action may result in immediate termination from the pharmacy network. Also, failure to maintain the Medicaid Provider Number may result in immediate termination from the Citizens Rx Pharmacy Network as a provider.

Credentialing Standards

Credentialing and re-credentialing initiatives exist to ensure that participating providers abide by the criteria established by Citizens Rx as well as governmental regulations and standards. The applicant must comply with the credentialing and re-credentialing initiatives required by Citizens Rx, and agree to provide Citizens Rx with documentation and other relevant information that may be required in connection with such initiatives.

Citizens Rx has developed a standardized process for the receipt, review, documentation and verification of applicants' credentials for participation in the Citizens Rx Pharmacy Network, which all applicants are subject to. Citizens Rx has the right to determine whether an applicant meets and maintains the appropriate credentialing standards to participate as a provider in the Citizens Rx Pharmacy Network.

Pharmacy Credentialing Application

The applicant is required to complete, sign and return the Pharmacy Credential Application to Citizens Rx. The application requires complete documentation of the following pharmacy-specific criteria:

- Pharmacy profile information (e.g., name, address, telephone number, after-hours emergency telephone number, facsimile number, email address, contact person for credentialing, NABP number, federal identification number, name and license number of pharmacist-in-charge)

- Pharmacy hours of operation
- Pharmacy services provided
- License and policy maintenance (e.g., license/registration number and expiration date; history of pending felony and/or misdemeanor charges or convictions; history of limited, suspended, revoked or reprimanded license; history of fraud or abuse; violations leading up to suspension or revocation of pharmacy license or DEA registration; history of being investigated or sanctioned by Medicare or Medicaid; compliance with American with Disabilities Act of 1990; privacy; and accessibility)

Said application requires documentation of the following pharmacist-in charge specific criteria:

- Any misdemeanors, felony convictions or charges pending against them;
- History of loss of pharmacy license anywhere (e.g., limited, suspended, revoked or reprimanded);
- History of disciplinary action including restriction/limitation on license or ability to otherwise practice;
- Malpractice claims history within the past 5 years; and
- Fraud or abuse convictions within the past 5 years.

There are certain other accessibility requirements that are integral to Citizens Rx application process which include, but are not limited to the following:

- Plan member must have access to a pharmacy-employed pharmacist 24 hours a day, 7 days a week via phone, pager, or answering service/machine;
- Pharmaceutical products are dispensed in an acceptable business facility subject to an onsite visit by Citizens Rx.

Pharmacy-employed pharmacists must be proficient in reading, writing and speaking the English language, demonstrating proficiency in communicating clinical advice, and providing clinical services to plan members in the English language.

Primary Source Verification of Applicant's Documentation

The Contract File Credential Information Checklist is used to track the receipt date of the applicant's required documentation submitted for enrollment and credentialing in the Citizens Rx Pharmacy Network. All relevant documents and records are assembled in the provider's credentialing file.

Once the applicant's credentialing file is complete, the credentialing specialist will execute primary source verification of the applicant's credentials. As part of this process, the provider's information will be searched through both federal and state level data, and data available for all published disciplinary and licensing boards for all published professions within those jurisdictions. This includes, but is not limited to querying various databases and other sources of information to verify evidence of a current and valid permit to operate a pharmacy in the applicant's respective state(s); current insurance policies; current and valid DEA registration; current and valid Medicaid Number; any malpractice activity; any state disciplinary actions including terminations, suspensions or reductions in privileges; any violations leading to suspension or revocation of pharmacy license or DEA registration; and any sanction activities related to Medicare, Medicaid or other governmental programs or agencies (OIG Exclusions List: http://oig.hhs.gov/exclusions/).

Citizens Rx reserves the right to schedule an onsite visit with the applicant to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. Citizens Rx wants to ensure that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards.

The applicant is considered to be "credentialed" and accepted into the Citizens Rx Pharmacy Network when all required documentation has been verified as being valid and current, all credentialing criteria have been met, and the applicant's credentialing status has been approved by the Quality Management Committee at Citizens Rx. Moreover, the Pharmacy Participation Agreement will not be signed by an authorized Citizens Rx designee and executed until this initial enrollment and credentialing process has been completed, and

the applicant has been formally accepted for participation in the Citizens Rx Pharmacy Network.

Citizens Rx Credentialing Committee

Each week, the credentialing specialist at Citizens Rx will prepare a network credentialing report which includes information regarding the eligibility status of providers applying for enrollment and credentialing privileges in the pharmacy network. This report is forwarded to the Credentialing Chair for their review and recommendations. The Credentialing Committee reviews those applicants whose credentials meet the criteria for participation in the Citizens Rx Pharmacy Network.

Applicant files that do not meet the Citizens Rx Pharmacy Network criteria, contain any deficiencies identified via the credentialing process, or have issues identified with the integrity of administrative policies and procedures will be documented and referred to the Credentialing Committee for review. The Credentialing Committee will determine the type and extent of the occurrence and refer the occurrence to the Quality Improvement/Utilization Committee for further review and recommendations. Final determination will be made by the Quality Oversight Committee and may include action up to and including termination from the Pharmacy Network. All such occurrences and corrective action will be placed in the provider's credential file.

The credentialing specialist will notify the applicant in writing of any recommendation to deny participation in the Citizens Rx Pharmacy Network. The applicant is informed in writing that he/she may appeal the decision in writing to the Credentialing Committee within 10 business days of the receipt of the decision. The Committee will notify the applicant of the appeal decision within 20 days of the receipt of the appeal. All completed credentialing records will be filed in a secure area.

Re-Credentialing Standards

Providers accepted into the pharmacy network are subject to re-credentialing as often as annually. The process for re-credentialing is identical to that of credentialing, except that as part of the review, Citizens Rx will consider any plan member complaints; quality improvement review studies; utilization management review studies; pharmacy audits and customer satisfaction surveys. The entire re-credentialing process is commenced approximately 90 days prior to the re-credentialing date, which is based on the network approval date. A date tickler file will automatically identify and set into motion the re-credentialing process to assure timely and complete review processes.

As with the initial credentialing verification process, the credentialing specialist performs primary source credential verifications by querying databases and other sources of information as necessary. Upon satisfactory completion of verifications and a preliminary assessment that applicant meets credentialing criteria, the credentialing review specialist may schedule an onsite visit with the pharmacy to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. Citizens Rx wants to make certain that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards. Citizens Rx retains the absolute right to conduct a facility review any time a deficiency, breaches of standards of care or delivery are suspected.

Changes in Documentation and Other Information

Provider must notify Citizens Rx in writing within 10 days of any changes in the documentation and other information provided to Citizens Rx in connection with any credentialing or re-credentialing initiatives. Pharmacy updates are processed through NCPDP on a monthly basis. Network Pharmacy Providers are strongly encouraged to notify and submit all changes to NCPDP immediately, in order to ensure timely processing.

National Plan and Provider Enrollment System (NPPES) Updates

Network Pharmacy Providers need to update their information, including all taxonomy codes on the National Plan and Provider Enrollment System (NPPES) at https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do, as this information may be used for network and contract validation by administrator, clients and CMS.

Ownership Changes

Provider is required to provide 30 calendar days' notice in the event of an ownership change. Provider must meet all of Citizens Rx's credentialing and enrollment standards and may be required to execute a new Pharmacy Participation Agreement.

Citizens Rx is not bound by its obligation under the Pharmacy Participation Agreement if provider has assigned the Agreement, or changed ownership or control of its operation without Citizens Rx's prior written consent.

Advertising and Promotions

Without the prior written consent of Citizens Rx, provider must not use words, symbols, trademarks or service marks which Citizens Rx uses, in advertising or promotional materials or otherwise, and provider must not advertise or publicly display that it is a member pharmacy without the prior written consent of Citizens Rx. Provider must immediately cease any and all usage of such immediately upon termination of this agreement

Citizens Rx may list provider by name, address, and telephone number for each of its locations in applicable directories, brochures or other publications for distribution and/or use by Citizens Rx, payers and plan members.

Termination from Pharmacy Network

Providers are instructed to contact the Citizens Rx Provider Relations Coordinator if they have been suspended and/or excluded from participating in Medicare, Medicaid, or any other federal program for any reason. Citizens Rx will take appropriate action when occurrences of poor quality, fraud, or abuse are identified, including suspending or terminating affiliation with the contracted pharmacy.

Office of Inspector General

Providers sanctioned by the Office of Inspector General (OIG) who are not to participate in Medicare, Medicaid, and other federal health care programs are not to participate in the Citizens Rx Pharmacy Network.

If sanctioned by the OIG and excluded from participation in federal health care programs, the provider will be immediately terminated from the Citizens Rx Pharmacy Network. However, if the provider is terminated based upon information on the OIG website, and the provider in good faith disputes the validity of that information in writing to Citizens Rx, the provider will be given a 45-day extension to provide proof of the provider's reinstatement or other ability to participate in federal health care programs.

Reporting of Investigations and Disciplinary Actions

As stated in the foregoing, the provider must notify Citizens Rx immediately in writing if its license(s) and/or permit(s) have been suspended or revoked, or are in jeopardy of being suspended or revoked for any reason. The provider must also notify Citizens Rx immediately in writing if it receives notice of any proceedings that may lead to disciplinary actions, or if any disciplinary actions are taken against the provider or any of its personnel, including actions by Boards of Pharmacy, the Office of Inspector General (OIG), or

other regulatory bodies. Failure to immediately notify Citizens Rx in writing of any such investigations or disciplinary actions may result in immediate termination as a provider.

Confidentiality and Proprietary Rights

All plan member information related to Covered Pharmacy Services and other records identifying plan members shall be treated by the provider as confidential and proprietary. All materials relating to pricing, contracts, programs, services, business practices and procedures of Citizens Rx are proprietary and confidential. The provider must maintain the confidential nature of such materials and return them to Citizens Rx upon termination of the agreement.

The provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Citizens Rx would cause Citizens Rx immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if a provider should fail to abide by these provisions, Citizens Rx is entitled to seek and obtain injunctive relief, monetary remedies or other such damages as available by law against the provider.

Court Orders, Subpoenas, or Governmental Requests

If Citizens Rx receives a court order, subpoena or governmental request relating to a participating provider, Citizens Rx may comply with such order, subpoena or request and the provider must indemnify and hold harmless Citizens Rx for, from, and against any and all costs (including reasonable attorney's fees and costs) losses, damages or other expenses Citizens Rx may incur in connection with responding to such order, subpoena or request.

Subcontracting

Citizens Rx prohibits pharmacy from using any individual or entity (including, but not limited to any employee, contractor, subcontractor, agent, or representative) to perform pharmacy services.

Discrimination against Members

Citizens Rx prohibits discrimination against members including, but not limited to discrimination based on a person's age, gender, race, disability, ethnic group, national origin, or making a distinction in favor of or against a person based on the group, class or category to which that person belongs rather than on individual merit.

Pharmacy Claim Submission, Adjudication and Payment Guidelines

Professional Judgment

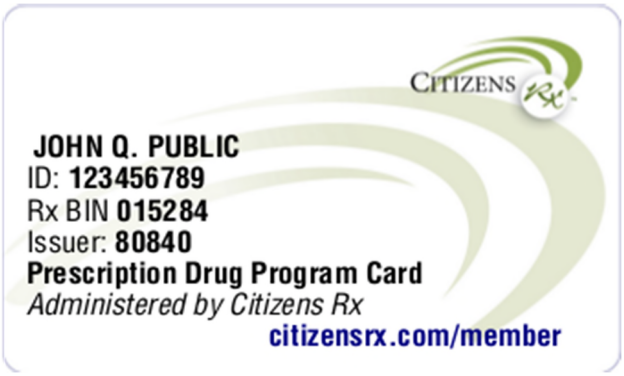
The provider is required to deliver pharmacy services under the direct supervision of a licensed pharmacist and according to prescriber instructions in accordance with applicable law. The provider must exercise professional judgment at all times in rendering pharmacy services to an eligible plan member. Moreover, the provider may refuse to deliver pharmacy services to an eligible plan member based on that professional judgment.

Nondiscrimination

The provider cannot discriminate against an eligible plan member on the basis of race, color, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, or marital/ family status. Unless professional judgment dictates otherwise, the provider is required to deliver to all eligible plan members in accordance with applicable Law.

Identification Cards

Citizens Rx and/or health plan sponsors will provide eligible plan members with identification cards. An identification card may show for the eligible plan member only, or it may show coverage for the eligible plan member and his/her dependent(s). Although identification cards vary by health plan, a sample of a typical identification card produced by Citizens Rx is illustrated below.



As illustrated, the identification card will be designed and produced using the National Council for Prescription Drug Programs (NCPDP) format, and will contain the plan member identification number, the bank identification number (RxBIN) and the group (RxGRP) and/or processor control number (RxPCN). On occasion, health plan sponsors may distribute identification cards that do not include all of the information highlighted above.

The provider is required to request the identification card from the plan member and utilize the information on the identification card to submit claims through the Citizens Rx claims adjudication system. The provider will not be paid for rendering pharmacy services to a plan member whose eligibility was not correctly submitted.

Plan Member Fees

The provider is required to submit claims only for the plan member for whom a prescription for a covered item was written by the prescriber and dispensed to the plan member.

The provider is required to collect any administrative, transaction, access or other types of fees at the point-of-service from the plan member, when applicable. The total amount collected from the plan member for providing pharmacy services related to a covered item will be transmitted through the Citizens Rx claims adjudication system, and may be debited from provider's claims payment account.

Collection of Plan Member Pay Amounts

Health plan sponsors determine the co-payment amounts which provider is required to collect from a plan member for Covered Pharmacy Services. The plan member co-payment amounts will vary by health plan sponsor and/or health plan. Unless otherwise directed by Citizens Rx, the provider is required to collect from the plan member the co-payment amount as indicated by the Citizens Rx claims adjudication system. The provider cannot waive, discount, reduce or increase the plan member co-payment amount determined by the claims adjudication system. Moreover, if Citizens Rx determines that the provider has charged or collected from a plan member an amount in excess of the plan member co-payment amount determined by the claims adjudication system, the provider must promptly reimburse the plan member for the excess amount upon request from Citizens Rx. Otherwise, Citizens Rx retains the right to recover said excess amounts or unauthorized fees from the provider (including by offset against other amounts owed to the provider) and return the recovered amounts to the appropriate plan member.

Refills

The provider shall not process an automatic refill for a prescription for a plan member unless and until such refill has been authorized by the plan member.

Compounds

Prescriptions which are compounded for plan members must be submitted to Citizens Rx using the NDC of the most expensive legend drug. The compound must contain at least one ingredient that is a legend drug, the compound indicator field must indicate that the claim is for a compound prescription, and the appropriate fields in the compound segment must be completed. Covered compound products shall be reimbursed in accordance with a provider's submitted claim information and subject to any contractual, plan or network benefit design. If an excluded or non-PDL agent is included in the compound, the claim will reject for "invalid compound" and would require the pharmacy to obtain a prior authorization.

Limitation on Collection

The provider cannot bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a plan member for the provision of Covered Pharmacy Services in any event, including nonpayment by or bankruptcy of a health plan sponsor or Citizens Rx. However, this does not prohibit the provider from collecting the authorized co-payment amount or charging the plan member for non-covered items disclosed and agreed to in advance by plan member.

Submitting a Claim

The provider is required to submit pharmacy claims electronically through the Citizens Rx claims adjudication system for all Covered Pharmacy Services. The provider must also submit all necessary information requested in the Pharmacy Participation Agreement and required by the claims adjudication system for each claim. Each claim submitted by the provider will constitute a representation by the provider to Citizens Rx that the pharmacy services were provided to the plan member, and that the information

transmitted is accurate and complete.

The only exception to this rule is for a claim for which Citizens Rx is the secondary payer and the claim submission may trigger a "submit to primary carrier, Citizens Rx to be billed as a secondary payer" message. This message indicates that the member has dual coverage and that payment must be coordinated with the primary payer through coordination of benefits (COB). Many times secondary claims are not accepted online and must be submitted on a paper claim to the address identified below. This will have to be verified on a case by case basis.

Paper Claims Billing Address

Citizens Rx
Provider Relations
1144 Lake Street, 4th Floor
Oak Park, IL 60301

Claim Definition

A claim is an electronic request for reimbursement for any covered prescription transaction submitted in accordance with standard formats as established by the National Council for Prescription Drug Programs (NCPDP). Citizens Rx's on-line processing system will use its messaging system to notify the pharmacy of the status of the processed claim based on determination of whether the claim is for processing and/or payment. For each claim processed, a claims detail report is mailed to the pharmacy that submitted the original claim. For further information, the provider can access the adjudication software system transaction inquiry on the Citizens Rx website for explanation of the denial. Citizens Rx shall adjudicate clean pharmacy claims in a timely manner according to industry standards.

Clean Claim Definition

A clean claim shall mean a claim, prepared in accordance with the standard formats promulgated by the National Council for Prescription Drug Programs, electronic, batch, and on paper, which contains all of the information necessary for processing (including, without limitation, the plan member identification number, the plan member's name and date of birth, Prescription Drug Product NDC number, drug quantity, days' supply, health care provider DEA/NPI number, NCPDP/NPI number, date of service, Submitted Cost Amount and the Usual and Customary Charge), that requires no further information, adjustment, or alteration by the provider in order to be processed and paid by Citizens Rx. The following exceptions apply to this definition (a) claim for which fraud or abuse is suspected and (b) a claim for which a third party is responsible.

Non-Clean Claim Definition

"Non-clean claims" are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims will result in a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; review of additional records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines of a health plan.

Filing/Reversing a Claim

All claims must be submitted electronically through the Citizens Rx claims adjudication system. Failure to submit a claim within 30 days from the date of the fill, unless otherwise specified by Citizens Rx or by law, may result in nonpayment of the claim.

The provider must reverse all prescriptions not received by a plan member through the electronic claims system. The provider may only reverse and submit a claim within the same payment cycle in which the

claim was originally submitted.

Rejected Claims

Rejected claims may be resubmitted in the same manner as the original claim with corrected information. Some of the most common reasons for rejected claims include the following:

Reject Code/Rejection Message

07 – Missing/Invalid Cardholder ID

09 – Missing/Invalid Date of Birth

19 – Missing/Invalid Days Supply

68 – Filled After Coverage Expired

70 – Product/Service Not Covered

75 – Prior Authorization Required

79 – Refill Too Soon

Days' Supply

The provider should submit the number of consecutive days' supply the prescription product will last based on the prescriber's exact written directions.

Quantity

The quantity dispensed must be exactly as written. Quantities should be submitted as metric quantity without rounding using the current version NCPDP compatible software.

Claims Adjustments

Citizens Rx may make an adjustment to any statement or remittance when determined that the provider received an incorrect amount based on the Covered Pharmacy Services provided. Provider is required to reverse any claim that is not received by or delivered to the plan member.

Partial Fill Transactions

Partial fill claims occur when a provider attempts to fill a prescription and determines that there is not enough of the medication in stock to provide the entire prescribed quantity/days' supply. Citizens Rx does not accept partial fill transactions from providers.

Taxes

If any taxes, assessments and/or similar fees ("taxes") are imposed on the provider by a governmental authority based on the provider's provision of prescription drugs to plan members, the provider may request reimbursement from the payer or plan member for such taxes that are allowed and imposed by applicable state or local law. In order to be reimbursed for the payment of tax, the provider must transmit the applicable tax amount allowed by law through the claims adjudication system in the correct amount and in the appropriate field on the claim submission. In no event does this give the provider any additional or different rights than those allowed by law. In no event shall Citizens Rx be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments or similar fees.

Data Fields and Submission Requirements

Citizens Rx requires all providers to file claims electronically with the following criteria:

- All documentation must be legible;
- Providers must submit claims data for every plan member's prescription drug transaction;
- Providers must ensure that all data and documents submitted to Citizens Rx, to the best of their knowledge, information and belief, are accurate, complete and truthful; and
- All claims data must be submitted by electronic media in an approved format.

Provider Payment

Clean claims will be adjudicated within 30 days of the receipt of the claim for most health plans, unless otherwise specified by law.

No later than the 15th business day after the receipt of a provider claim that does not meet clean claim requirements, Citizens Rx will pend the claim and request additional information through the Citizens Rx website for all outstanding information such that the claim can be deemed clean.

NOTE: Prompt Pay: Some states mandate "prompt payment laws." Citizens Rx will comply with state requirements regarding time frames for provider "clean" claims.

Payment Rules under Medicare and Medicaid Programs

In accordance with requirements as set forth in 42 CFR Section 423. 520(a)-. Section 423.520(h) provider claims will be paid as follows (other than mail-order and long-term care pharmacies).

- For Medicare Part D, Clean Claims will be paid within 14 days of the date of receipt for electronic claims and within 30 days of receipt for paper claims.
- For managed Medicaid, Clean Claims will be paid within thirty (30) days of the date of receipt for electronic claims and within thirty (30) days of receipt for paper claims, except where a state requires a shorter timeframe, in which case, state requirements prevail.

Claims Payment/Remittance Advice

Citizens Rx will pay the provider according to the published payment schedules and the agreed upon rates subject to the terms and conditions of the Pharmacy Participation Agreement, and will supply the provider with a report showing the record of all claims submitted, processed and paid in each processing cycle. Said reports may be distributed by mail, posted on the Citizens Rx website or presented by other electronic means.

If the provider is receiving pharmacy remittance electronically, the provider must adhere to HIPAA regulations which mandate ASCX-12N 835 and updates as required. Citizens Rx will not provide any other electronic formats. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Citizens Rx at **(888) 316-6510**, or by sending an e-mail to providerrelations@citizensrx.com.

Claim Payment Inquiries

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact Citizens Rx's Accounts Payable department at **(937) 310-5198**.

- Providers may discuss questions with Citizens Rx representatives regarding the amount reimbursed or denial of a particular claim. Providers may also submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration of additional

reimbursement.

- Any response to approved adjustments will be provided by way of check with accompanying EOP.

All disputed claims will be processed in compliance with the claims payment resolution procedure described herein.

Pricing Changes

Citizens Rx may change the applicable AWP discount and dispensing fee and/or transaction/service fee by giving the provider written notice of such amendment thirty (30) days prior. The provider may reject such amendment by providing written notice to Citizens Rx. Such notice must be received by Citizens Rx prior to the effective date of the amendment. Citizens Rx has the right to immediately terminate the Agreement or provider participation from a particular network in the event any such amendment is rejected by provider.

Signature Log

Unless otherwise agreed to in writing by Citizens Rx, the provider must utilize a third party signature log that contains all information required by Citizens Rx and health plan sponsors in accordance with industry standards. Said information must include, but is not limited to the following: date, prescription number, name of the third party program, and authorization for the release of the information to Citizens Rx and/or health plan sponsor.

Documentation

The provider is required to maintain all documents and records related to Covered Pharmacy Services provided to the plan member in accordance with industry standards. Documents and records must be in a readily obtainable location for a minimum of three years or as required by both federal and state law. Said documents and records may include, but are not limited to the following: original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; prescriber information and patient profiles. Refer to the Audit Policy section for more detail on documentation requirements.

Clinical Programs and Services

The provider must support all clinical programs and services, and utilize software that will display all messages related to clinical programs and services. Said provider software must provide patient drug and medical information records, as allowed by applicable law.

Subject to applicable law, the provider must provide Citizens Rx any and all reasonably available information that Citizens Rx needs to perform such clinical programs and services, and conduct drug utilization review accordingly.

The provider must act upon all messages related to clinical programs, subject to professional judgment.

Provider Information Updates

Providers must notify Citizens Rx in writing of any changes in name, address, telephone number, services, and/or ownership. Said information is required to be sent by either:

1. Facsimile to (888) 556-7482; or
2. Mail to: Citizens Rx
   Provider Relations
   1144 Lake Street, 4th Floor
   Oak Park, Illinois 60301

Directories

The provider must allow Citizens Rx and health plan sponsors to list the provider in applicable directories and databases for distribution and use by plan members, health plan sponsors and others as determined by Citizens Rx and/or plan sponsors. Moreover, Citizens Rx may list the providers that participate in performance initiatives foremost in paper and web-based directories and in health plan sponsor reporting.

Performance Initiatives

The provider must support Citizens Rx performance initiatives such as, but not limited to, performance drug program, drug utilization review, formulary adherence, prior authorization, managed drug limitations, dose optimization, and prerequisite step therapy.

Member Safety Program

Provider must support Citizens Rx's Member Safety Program to ensure that the most common safety issues affecting the member can be addressed in a timely fashion, thus reducing the safety risks to which a member is exposed.

As such, providers will have implemented approved policies and procedures to notify patients and/or caregivers and prescribers of significant medication errors and provide patient follow-up as needed, and adhere to the following reporting requirements:

- Provider must track and report annually any adverse reactions/medication errors experienced by a member, including the classification of the medications errors according to severity and type of error via the Citizens Rx online Annual Medication Errors Safety Log. Any medication errors resulting in hospitalization, death or permanent damage to a body part should be reported to Citizens Rx as soon as possible, but not to exceed 10 days after becoming aware of the situation via the Citizens Rx online Medication Error Incident Report.

Citizens Rx will investigate significant medication error incidents within 10 business days of Citizens Rx becoming aware of the error. Citizens Rx will contact the patient/caregiver during this time period to ascertain member's condition and his/her awareness of the medication error.

Citizens Rx will evaluate provider's policies and procedures at least annually during desktop reviews and on-site audit conducted by Citizens Rx at the pharmacy site.

Important News, Updates and Educational Materials

Our preferred method of communication with you is electronically regarding any news or updates regarding policy, product, or reimbursement changes prior to implementation. However, when required by law or contractual arrangement, updates will be provided in writing. Citizens Rx may also use alternate channels to communicate with or educate providers about products, programs, policies, procedures, and services as well as distribute health plan sponsor announcements (such as mail, phone, fax, and e-mail) or posted on the Citizens Rx website and/or affiliate health plan sponsor website.

Plan Member Complaints

The provider is required to cooperate with Citizens Rx and/or health plan sponsors to resolve complaints by plan members. The provider must make a reasonable effort to rectify the situation that leads to the complaint from a plan member. The provider must maintain written records of events and actions surrounding each complaint.

Generic Drug Standards

Whenever permitted, the provider is required to dispense a generic drug in accordance with applicable laws. Additionally, the provider is required to use reasonable efforts to fulfill Citizens Rx and health plan sponsor mandatory generic programs. The provider is required to stock a sufficient amount of drugs under their generic name coinciding with the practice of local prescribers, the Citizens Rx and/or local health plan sponsor formulary(s) or their preferred drug lists.

The provider is required to contact the prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multisource brand medication. When a multisource brand medication is dispensed, provider must submit the correct "dispense as written" code as set forth in the section of this Manual entitled Product Selection (Dispensed as Written) Codes and Descriptions.

Product Selection (Dispensed as Written) Codes and Descriptions

0 – No Product Selection Indicated: This is the field default value appropriately used for prescriptions where selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

1 – Substitution Not Allowed by Prescriber: This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be "Dispensed as Written".

2 – Substitution Allowed – Patient Requested Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

3 – Substitution Allowed – Pharmacist Selected Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

4 – Substitution Allowed – Generic Drug Not in Stock: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the market place.

5 – Substitution Allowed – Brand Drug Dispensed as Generic: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, and the pharmacist is utilizing the brand product as the generic entity.

6 – Override: This value is used by various claims processors in very specific instances, as defined by the claims processors and/or its client(s).

7 – Substitution Not Allowed – Brand Drug Mandated By Law: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

8 – Substitution Allowed – Generic Drug Not Available in Marketplace: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable.

9 – Other: This value is reversed and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value.

Drug Utilization Review

Inappropriate drug therapy can cause plan member injury and lead to additional health care costs. In an effort to reduce the number of situations where ~~an~~ a plan member may receive inappropriate drug therapy, Citizens Rx provides a concurrent drug utilization review (DUR) program that detects a potential therapeutic problem or drug interaction at the point of service.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Citizens Rx
- Screen prescriptions for several types of therapeutic or drug interaction problems
- Serve as a clinical information service

Citizens Rx's claims adjudication system will electronically alert the dispensing pharmacy of therapeutic or drug interaction problems via the following standard NCPDP point of service (POS) alerts:

- "DA" drug allergy
- "DC" inferred drug-disease precaution

- "DD" drug-drug interaction
- "DF" drug-food interaction
- "ER" overuse precaution
- "HD" high dose alert
- "ID" ingredient duplication
- "LD" low dose alert
- "LR" underuse precaution
- "MC" actual drug-disease precaution
- "MN" insufficient duration alert
- "MX" excessive duration alert
- "OH" drug-alcohol interaction
- "PA" pediatric
- "PG" pregnancy
- "PR" prior adverse reaction
- "TD" duplicate therapy
- Clinical Significance
- Other Pharmacy Indicator
- Previous Fill Date
- Previous Fill Quantity
- Database Indicator
- Other Prescriber Indicator

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the provider or prescriber. The provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims adjudication system and for performing provider services in each jurisdiction consistent with the scope of their respective licenses. Drug use inconsistent with the Citizens Rx criteria may be appropriate in certain clinical settings.

Formularies

Citizens Rx develops and assists health plan sponsors in developing formularies that achieve desirable clinical outcomes and help control overall health care costs. Formularies are provided as a reference for drug therapy selections. The final choice of specific drug selection for a plan member rests solely with the prescriber.

The provider must support all formulary initiatives and inform a plan member when a non-formulary drug has been prescribed, and as stated in the foregoing, use best efforts to contact the prescriber to encourage formulary compliance. When a claim is submitted for a non-formulary drug and the health plan has a drug formulary, it will reject with CODE 75: PRIOR AUTHORIZATION REQUIRED. In many cases, the member co-payment is higher for a non-formulary medication.

Some plan members may have a choice between brand and generic drugs. In some programs, the plan member pays the difference between the cost of the brand and the available generic drug.

The total amount collected from the plan member for providing Covered Pharmacy Services will be transmitted through the Citizens Rx claims adjudication system, and may be debited from provider's claims payment account.

Prior Authorization

For some health plans, certain medications, excessive quantities, excessive days' supply, or unusually high cost medications may require a prior authorization (PA). In these situations, the prescriber is required to supply additional documentation to Citizens Rx and/or the health plan sponsor to determine whether certain criteria are met for the drug to be covered under the health plan.

If a medication is designated for prior authorization, the claim can reject with the following messages:

- "NOT ON PDL"
- "PRIOR AUTHORIZATION REQUIRED"

In most cases, the claims system response will also provide the correct contact information in the subsequent message. If the prescriber feels the drug is medically necessary, they will need to call the number listed in the messaging to initiate coverage.

The provider must support all clinical programs and services and inform the plan member when a drug designated for prior authorization has been prescribed. The provider must use its best efforts to contact and inform the prescriber when prior authorization messaging occurs.

Providers may also call the Citizens Rx Member Help Desk at **(877) 532-7912** which is staffed with PA triage specialists Monday through Friday from 7:00 a.m. to 11:00 p.m. CDT.

Appeals/Grievance Process

Citizens Rx provides customer service to both providers (e.g., located primarily at pharmacies and medical offices) as well as plan members. The following grievance/appeals process details the steps needed for review and follow-up of an oral or written grievance and/or appeal from either the provider or the plan member.

Provider Grievance Process

When a provider contacts the call center at **(888) 316-6510** and presents a formal oral or written concern about our service(s), the customer service representative fills out a Provider Service Tracking Log.

The Provider Service Tracking Log includes:

- Provider name
- Member ID
- NABP # (Pharmacy), DEA # (Physician) or other identification #
- Date of complaint
- Type and description of complaint
- Attempted resolution
- If call is escalated, this is notated on the document
- Escalation resolution
- Status of provider satisfaction at the end of the call

If the customer service representative is unable to resolve issue with the provider, the provider will be immediately referred to the manager. The issue is discussed and an effective problem resolution sought.

If the manager is unable to resolve the issue/concern with the provider, an acknowledgement letter will be sent to the provider within five (5) business days of receipt of the call. This acknowledgement letter includes a description of the issue, a description of the grievance procedures, a description of the appeal procedures, and relevant time frames.

Citizens Rx has thirty (30) days to acknowledge, investigate, and resolve the issue after either the oral or written outreach. The resolution letter includes a description of the appeal process and time frames for the grievance/appeals process and final decision.

If the provider chooses to appeal the final decision, a letter acknowledging the appeal request is sent to the complainant within five (5) business days of receipt of appeal request.

Following a thorough investigation, a letter informing the complainant of the final decision on the appeal is sent, and includes a statement of the specific medical, clinical, and/or contractual criteria used to make the final decision.

Member Grievance/Appeal Process

If a plan member is unhappy with anything about Citizens Rx or its pharmacy network, he/she should contact Citizens Rx via the following method:

- Call the Citizens Rx Member Help Desk at (877) 532-7912;
- Fill out the Grievance/Appeals Form, which can be requested from the call center; or
- Write a letter to Citizens Rx that includes the plan member's first and last name, member identification number, address, and telephone number. It should also include any information that helps explain the issue. The form should be mailed to:

Citizens Rx
Director, Quality Assurance
1144 Lake Street, 4th Floor
Oak Park, Illinois 60301

Grievances sent to Citizens Rx will be reviewed and investigated by the Director of Quality Improvement. If needed, the Director will share the grievance with managers at Citizens Rx. The Director will contact the plan member by mail or phone within 48 hours and tell them the result of the review.

If the plan member is unhappy with a prior authorization decision or the terms of his/her benefit plan, he/she has to file an appeal. Decisions about benefit coverage are made by the health plan sponsor. The plan member should refer to their health plan member handbook or health plan's member advocate to learn how to file for an appeal with the health plan.

If a plan member contacts the Citizens Rx Call Center to register a concern, the call center staff will refer the plan member to the health plan sponsor's member advocate. The member advocate bears the responsibility to assist members in understanding and using the grievance/appeals process of adverse determination.

Audit Policy

Inspections Rights

Citizens Rx or its authorized agent, shall have the right to audit compliance with the provider during the term of the Pharmacy Participation Agreement and for one (1) year following termination of the Agreement for any reason. This includes, but is not limited to, prescriptions for covered items for plan members, U&C submissions, and claims paid to the provider by Citizens Rx. Citizens Rx reserves the right to inspect all provider records relating to the Agreement.

Audit Types

Citizens Rx's claims adjudication system audits every pharmacy claim concurrently.

Retrospective audits may be conducted in the form of a telephone inquiry, an investigational (desk-top) audit, and/or an on-site audit.

Telephone Inquiries

Citizens Rx monitors claims data for reasonableness and potential billing errors on a daily basis. If a discrepancy is found, a representative from Citizens Rx will contact the provider via telephone to inquire about, validate and help resolve the discrepancy.

Most of these discrepancies can be validated over the telephone and resolved through a claim reversal and resubmission. In this case, no documentation is requested, and an on-site visit would not be necessary.

Investigational (Desk-Top) Audits

For an investigational (desk-top) audit, providers are contacted via telephone or through the mail, and asked to provide photocopies of specific documents and records related to claims paid to the provider by Citizens Rx during a specified period. Documentation may include, but not be limited to original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

Citizens Rx will identify any discrepancies found in the documentation and request that the provider review and respond to the discrepancies.

On-site Audits

For an on-site audit, Citizens Rx will typically notify provider approximately two weeks prior to a scheduled audit date. Auditors will generally review specific documents and records related to claims paid to provider by Citizens Rx during the previous three (3) years.

Auditable Documents and Records

The provider will allow Citizens Rx health plan sponsors, governmental agencies, and departments and/or their representatives or agents access to examine, audit, and copy any and all records deemed by Citizens Rx as necessary to determine compliance with the terms of the agreement. Documents and records must be readily accessible. The provider must give auditors access to examine and copy any and all documents and records that Citizens Rx deems necessary to determine whether the provider is compliant with the provisions and terms set forth in the provider agreement, including all Citizens Rx documents. Such documents and records may include, but are not limited to, the following:

- Original prescriptions
- Signature logs
- Daily prescriptions logs
- Wholesaler, manufacturer and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/doctor orders

Documents and Records Access

The provider must make available to the auditor a clutter free work area, located away from the busiest area of the pharmacy, but with ease of access to the documents and records that are required for the audit.

The provider must maintain proper staffing on the scheduled audit date to ensure that the provider is reasonably available for questions and the retrieval of information.

The provider authorizes the release of information deemed necessary to determine the provider's compliance with the Pharmacy Participation Agreement to appropriate agencies and parties – including, but not limited to, governmental authorities, third party payers, wholesalers, professional review organizations, and other such parties – as requested by the aforementioned agencies and parties, or by Citizens Rx.

Citizens Rx will try to minimize the burden on the provider while requesting the necessary information to perform an audit. However, if a Citizens Rx auditor is denied access to the provider or if the provider fails to release all the requested documentation, 100 percent of the amount for the paid claims in question will become immediately due and owing and Citizens Rx may offset such amounts against any amounts owed by Citizens Rx to the provider.

Provider must promptly comply with all requests for documentation and records.

Document Requirements

All prescription documentation, including telephone, oral and computer-generated orders, must contain the following information:

- Full name of the patient for whom the prescription was written by the prescriber and the address at which the patient resides
- Full name, address and telephone number of the prescriber
- Name, quantity and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when patient requests that a multisource brand medication be dispensed
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable law(s)
- Prescription hard copies for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use
- Prescription records must be stored for at least three years or ~~such~~ longer period as required by federal and state law
- Hard copies of prescriptions must be renewed at least annually, or such shorter period as required by applicable law

NOTE: *Network pharmacy provider dispensing compound claims may be required to provide a copy of any compound recipe worksheets identifying ingredients used in a compound drug.*

During the audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Citizens Rx recommends that providers document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the auditor or help to resolve the discrepancy.

Signature Log

Participating providers that contract with Citizens Rx are required to maintain a log of signatures of plan members or their authorized representative, receiving prescriptions **(directly or by mail order)** that contains all information required at that time by Citizens Rx's plan sponsors and industry standards. The information must include, but is not limited to:

- Date the prescription was picked up by the member of their representative;
- Prescription number;
- Signature of the member to whom the prescription was dispensed or their representative; and
- Any other information required by law to be included on the signature log.

For each claim adjudicated through the claims system, the provider must obtain the signature of the plan member (or their authorized representative) on the third party signature log to confirm that they have received the medication recorded and have read and agrees with the certification statement (NCPDP-approved patient disclaimer).

The third party signature log must be in date order and readily accessible for a minimum of three years (or as required by federal or state law) from the date of the last signature, corresponding with the length of time required for retaining prescription hard copies. Any claims submitted to Citizens Rx for reimbursement for which a valid entry in the provider's signature log (including mail order prescriptions) cannot be obtained will not be considered valid and any reimbursement made to the participating provider for such claims will be recovered by Citizens Rx.

Plan members whose plan sponsor requires 100 percent co-payment at the point of service or who have prescriptions delivered or mailed must also sign the third party signature log.

Options for delivered or mailed prescriptions include:

- If delivered to a home or business address, network pharmacy provider must obtain the signature of the member or their authorized representative at the time of delivery
- If plan member is sent monthly billing statements, the provider may insert a form listing the
- Date of fill and prescription number for each prescription; the plan member or authorized representative should be instructed to sign and return the form with their payment.
- Network providers using mail services must include information to document tracking of shipment, confirmation of delivery or other proof of delivery.
- These prescriptions signature logs must be in date order where appropriate and readily accessible.

Wholesaler, Manufacturer and Distributor Invoices

Wholesaler, manufacturer and distributor invoices must be maintained for a minimum of three years (or as required by federal of state law) to substantiate that the drugs dispensed were purchased from an authorized source. Citizens Rx may request that the provider gives authorization to the wholesaler, manufacturer or distributor to release corresponding purchase invoices to Citizens Rx to facilitate the purchase verification process. The provider must promptly comply with such requests. If the provider fails to promptly provide such authorization, Citizens Rx has the right to charge back to the provider 100 percent

of the amount for any paid claims in question.

Audit Resolution

If discrepancies are found during an audit, Citizens Rx will send the provider a report listing all of the discrepancies along with documentation guidelines that show how to address a discrepancy and validate the paid claims in question.

The provider must respond to Citizens Rx in writing within 30 days with proper supporting documentation for the paid claims in question. Documentation must be mailed to Citizens Rx via certified mail, Federal Express, United Parcel Service, or any other certified carrier, and must be received by the final due date specified by Citizens Rx.

Any claims that are not documented and validated in accordance with the Citizens Rx requirements shall become due and owing to Citizens Rx by the provider at the expiration of the 30-day period. In addition, if an audit chargeback exceeds $2,500, the provider will reimburse Citizens Rx $250 for the cost of the audit. Any and all such amounts shall become immediately due and owing by the provider to Citizens Rx.

Any such amounts owing to Citizens Rx for discrepant claims or other charges for noncompliance and audit-related costs will be offset against any amounts Citizens Rx owes to the provider. Methods used to collect amounts due as a result of audit discrepancies may include, but are not limited to, a request for check, or be offset against the provider's future accounts payable.

When Citizens Rx collects from the provider amounts due as a result of audit discrepancies, the provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against plan member or plan sponsor in relation to such adjustment or chargeback.

The provider may be terminated from participation in the Citizens Rx Pharmacy Network if Citizens Rx determines that the provider is not in compliance with the provisions and terms set forth in the Pharmacy Participation Agreement.

Citizens Rx may report its audit findings to plan sponsors, appropriate governmental entities, regulatory agencies, professional review and audit organizations, and other such entities.