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## Buy-In/Bendex Data

Each month the Department of Medical Assistance Services (DMAS) performs a data exchange with the Centers for Medicare and Medicaid Services (CMS) for Buy-In and another with the Social Security Administration for the Beneficiary and Earnings Data Exchange (BENDEX).

### Medicare and Medicaid relationship

Members who are enrolled in Medicare and Medicaid are called "dual eligible". To be eligible for Medicare the member must fall into one of the following eligible coverage groups:

- People 65 years of age or older;
- People who have been receiving monthly Social Security benefits based on disability for at least 24 consecutive months; or
- People with chronic end-stage renal disease or ALS (Lou Gehrig's disease).

There are other requirements within each group, requiring the Social Security Administration to determine eligibility for each individual. Once determined eligible, the individual will be given a Medicare claim number.

All individuals must apply for Medicare during one of two times described below:

- Initial Enrollment Period – a seven month period beginning three months before the individuals' 65th birthday, and ending three months after the birth month, and
- General Enrollment Period–January, February and March every year. Those who did not enroll during their Initial Enrollment Period will be required to pay a penalty in the form of an increased monthly premium.

Additionally, eligibility workers should ensure for their caseloads that every recipient age 65 or older, every member having received disability benefits for at least 24 months and/or those who are diagnosed with end stage renal disease are enrolled in Medicare.

**Aliens who have been in the country for five years, whether they become citizens or not, are eligible for Medicare when they are in an eligibility coverage group described above.**

If a Medicare eligible member does not have Medicare coverage and has not applied for it, the caseworker should insist that the member(s) go to their nearest Social Security office and apply. A member who is enrolled in Medicaid does not have to wait for open-enrollment to apply for Medicare Part B. Part B enrollment for Medicaid members can be any month of the year. Coordination between DSS, DMAS, and Social Security to ensure that the correct TPL is entered is vital to the case.

## Buy-In Overview

All Medicare members have a monthly premium for Part B coverage. Members who have not worked enough quarters to have paid into Social Security do not qualify for free Part A and have a Part A premium. They may be eligible for "conditional Part A", which means they will have Part A only if the state pays for the premium. When a member is dual eligible as a QMB, income <=100% FPL, and enrolled in Medicare, Medicaid pays Part B premiums as well as "conditional Part A".

Some Medicaid members do not want to sign up for Medicare Part A because of the cost of the premiums. Those members can apply for conditional Medicare coverage at the Social Security Administration office during the General Enrollment Period (GEP) or their Initial Enrollment Period (IEP). They sign a statement saying they agree to accept Part A coverage only if Medicaid will pay for it. Members who apply during the GEP do not receive the Part A coverage until July of that year.

The Medicaid program requires that members be enrolled in Part B if eligible. When entering Medicare TPL for enrollees who have Part A coverage but no Part B coverage add Part B using the current month as the Part B begin date. As a precautionary measure, if Part A coverage is added and there is no Part B coverage on the system, the MMIS will send an accretion request. If the CMS response file shows successful accretion, Part B coverage will be added automatically to the MMIS.

While there is a distinction between the terms "Buy-In", which refers to Medicaid payment of Part B premiums and "Group Payer", which refers to Medicaid payment of Part A premiums, to simplify the following discussion, we use the term "Buy-In" generically to refer to Medicaid payment of both Part A and Part B premiums.

### Process and Schedule

Following the Buy-In cutoff date, which is the 23rd of each month, DMAS sends files to CMS containing records of the Buy-In Transaction Codes to add, delete or change information about members who are (or were) eligible for Buy-In. Buy-In transactions are triggered by:

- Adding, reinstating or canceling eligibility,
- Adding, changing or deleting Medicare coverage,
- Updating key fields (Medicare claim number, name, date of birth or gender code) in the member file.

CMS processes the records against the master file upon receipt from DMAS. On the 7th of the following month, DMAS processes the data received from CMS, which subsequently updates the member files.

**Timing of Premium Payment**

Some Medicaid members have refused Medicare Part-B because of the cost of the premiums and/or penalties. They may have heard that they must wait for the next open enrollment period to sign up. **Medicaid-eligible individuals do not have to wait**. Their Part-B premium is set at the base rate (there is no late-enrollment penalty), and Medicaid will pick up the cost either immediately or within two months if they are enrolled in a non-QMB aid category requiring a two-month waiting period.

Below are listed categories and the Buy-in coverage begin date:

| Category | Buy-in Begin Date |
| --- | --- |
| Categorically Needy Cash Assistance Recipient | 1st month of eligibility |
| Medically Indigent (QMBs, SLMBs, QIs) | 1st month of eligibility |
| Categorically Needy Non-money payment and Medically Needy (Dually Eligible QMBs) | 1st month of eligibility |
| Categorically Needy Non-money-payment and Medically Needy (Non-Dually Eligible QMBs, 18,38,58,20,40,60,) | 3rd month of eligibility |

Because of the two month waiting period for non QMB aid categories it is important to overlap old coverage when reinstating coverage canceled incorrectly or canceled for Reason 008 or Reason 012. The member should be responsible for the first two months of coverage only when there is a new eligibility determination. Reinstating coverage effective the day after a reason-12 cancellation end date tells the MMIS that there has been a new determination of eligibility and therefore creates another 2-month period when the member is responsible for Buy-in premiums.

**Preventing Buy-In Interruption**

In the MMIS there is a new procedure for sending the information to the Centers for Medicare and Medicaid Services (CMS) to cancel payment of the Medicare premiums.

On the evening of the 23rd of each month, the Buy-In cut-off date, the system looks at the Medicaid members that are canceled and are on Buy-In. If the member has an end date of the current month, the system will **NOT** send a deletion to stop payment of the Medicare premiums.

If the member has an end date of the previous month or earlier, it **WILL** send a deletion to stop payment of the premiums. For example: on April 13th, a member's Medicaid case is canceled with an end date of April 30th. At Buy-In cut-off on April 23rd, a deletion will not be sent to stop Medicare payments. On May 23rd, if this member's Medicaid is still canceled, a deletion will be sent to CMS to stop the premium payment as of April 30th by Virginia Medicaid.

**For assistance with Buy-in or BENDEX (Beneficiary Data Exchange) please contact:**

- The Buy-In or BENDEX Coordinator at: MedicareBuyIn@dmas.virginia.gov, OR
- Call the Buy-In/Bendex Coordinators at (804) 786-7414 or (804) 371-8888

## BENDEX Overview

BENDEX is the Department of Medical Assistance Services monthly beneficiary data exchange with the Social Security Administration. After the data match Social Security returns benefit information about those identified and matching members to DMAS.

Around the end of the month DMAS sends SSA a file of records of members whom information is needed. Those transactions are triggered by updating key data elements, reinstating or canceling eligibility, adding Medicare TPL benefits, DMAS staff initiating an inquiry by setting the BENDEX query code and a yearly process of sending all active Medicaid records.

Social Security flags its records showing that DMAS has jurisdiction for the case. When DMAS receives return records from SSA the MMIS processes the matching files:

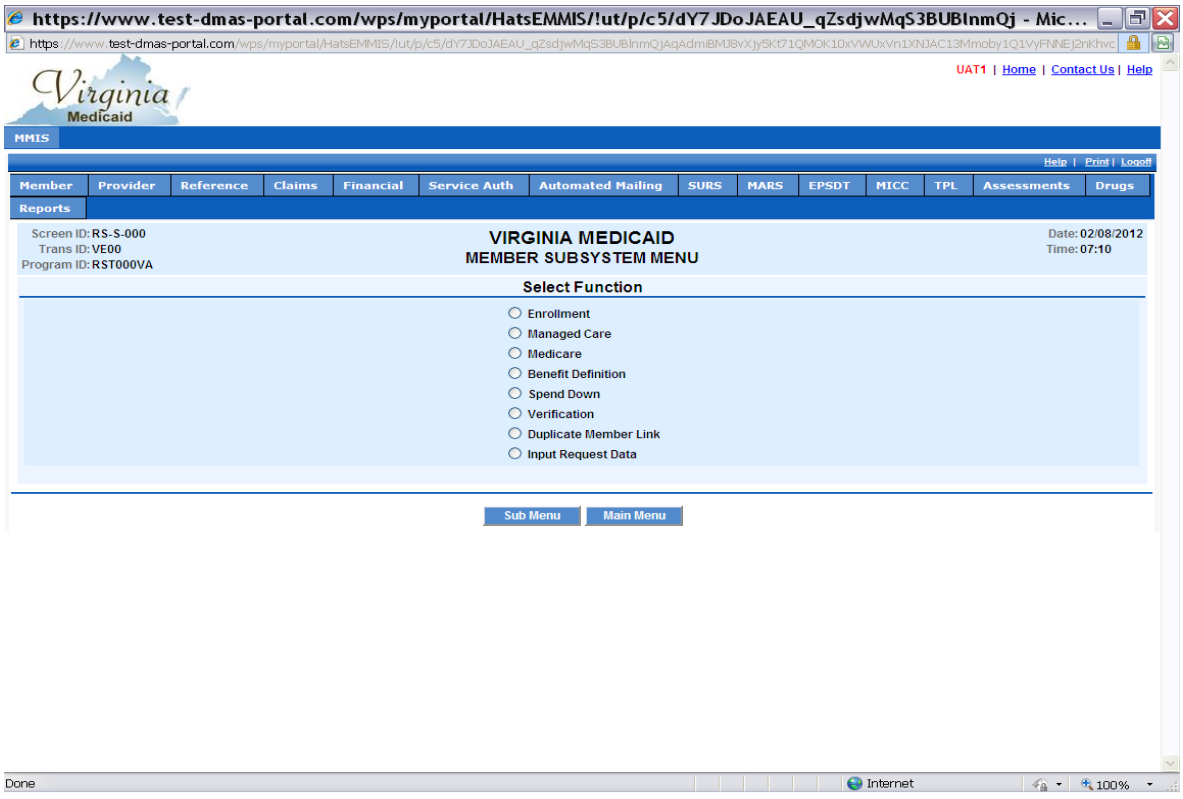
- in response to our having sent a query, *or*
- when it has changed data about members for whom DMAS has jurisdiction.

If this returned information includes unrecorded Medicare eligibility information, MMIS adds it as TPL coverage.

## Medicare Screens

In the MMIS Recipient subsystem there are four screens related to Medicare Buy-In Premium Payment and BENDEX. They are accessed off the member main menu by selecting Medicare. A copy of each screen screens that is pertinent has been included with certain values explained. All Medicare functions and screens are located in the Member Subsystem except for adding the Medicare Third Party Liability (TPL). Medicare TPL is entered in the TPL Subsystem in the MMIS.

Access to the Medicare Menu is achieved by selecting Medicare menu from the member subsystem menu.



## Medicare Menu

The following is a list of screen selections and the description of the information the screen provides from the Medicare Menu:

**Medicare Premium / BENDEX Data** - allows inquiry into Medicare Premium Processing data and Beneficiary and Earnings Data Exchange (BENDEX) information for a specified member.

**Medicare History** - provides on-line history of enrollee Medicare data allowing the user to research Medicare data of any member enrolled in the MMIS.

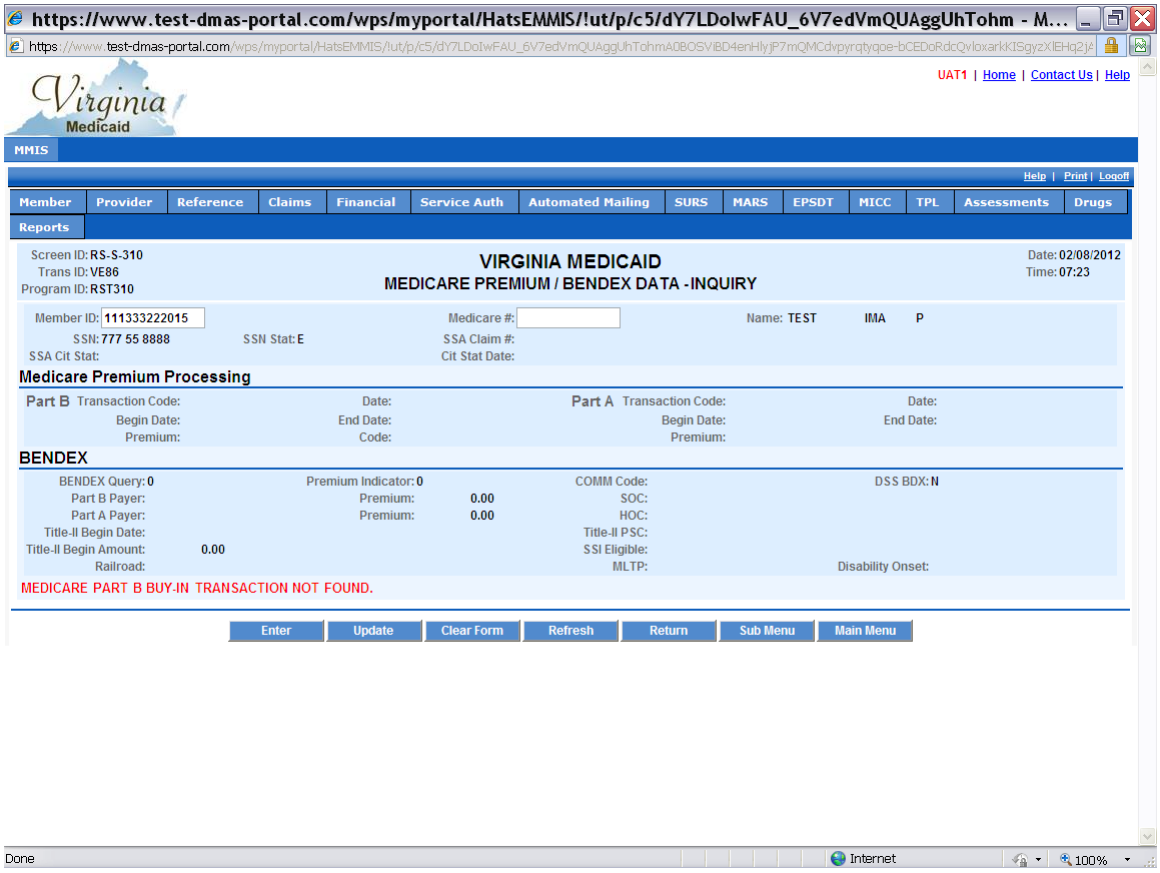
**Medicare Premium History** - provides on-line history for the member Medicare premium processing (Buy-In and Group Payer) data.

**Medicare Buy-In Transactions** - allows users to view transactions used in the processing of Medicare Premium data.


The four Medicare screens are accessed from the Medicare menu by selecting the appropriate option and the inquiry function. You can enter either the member ID or Medicare claim number for the member for which you are conducting an inquiry to display the record.

## Medicare Premium/BENDEX Data

The upper portion of the screen is related to Medicare Premium information and is addressed below. The second half of the screen is related to BENDEX and is also addressed in another segment.




## Medicare Premium/BENDEX Data Fields

**Member ID**: The permanent 12 digit Medicaid number for the chosen member.

**Name:** The member's name.

**Medicare #:** The number from Social Security of the individual on whose earnings benefits is established for Medicare coverage. Medicare numbers must contain a valid combination of digits and letters.

- It is necessary to distinguish between the use of the Social Security account number and the Social Security (and Medicare) claim number in the SSA processes. The Social Security account number is used throughout a wage earners lifetime to identify

earnings under the Social Security program. This account number consists of nine digits

- The Social Security claim number is the account number of the individual on whose earnings benefits are being paid followed by a suffix (sometimes as many as three characters) designating the type of beneficiary—*e.g.* wife, widow, child, etc.

- Two types of claim numbers are used as Medicare numbers. One is based on a Social Security Account (SSA) number, and the other is based on a Railroad Retirement Board (RRB) annuity claim number. To be valid, both types of Medicare claim numbers must contain numeric and alpha characters.

- Social Security claim numbers always begin with nine digits *e.g.*, 123456789 followed by either alpha or alpha/numeric characters. The most common suffixes, called Beneficiary Identification Codes (BICs) are A, B, D, E, M, T, and W.

- Railroad Retirement Board annuity claim numbers contain an alphabetic prefix. RRB annuity claim numbers consist of both an alpha prefix and a six-digit number (*e.g.*, A123456), or an alpha prefix and a nine-digit number *e.g.*, WCD123456789. The most common RRB prefixes are A, CA, MA, WCA, WCD, WCH, and WD.

- The first nine digits of a Medicare number ending with A, J1, J2, J3, J4, M, or T must equal the individual's Social Security account number.

- The first nine digits of a Medicare number ending in any other characters must not equal the Social Security account number.

- If the recipient has more than one Medicare claim number, verify the correct number with Social Security. For Buy-In purposes the number must be the current claim number.

## Valid BIC's

| | |
| --- | --- |
| A | Primary Beneficiary |
| B | Wife, age 62 or over (lst claimant) |
| B1 | Husband, age 62 or over (lst claimant) |
| B2 | Wife, under 65, with a child in her care (lst claimant) |
| B3 | Same as B (2nd claimant) |
| B4 | Same as B1 (2nd claimant) |
| B5 | Same as B2 (2nd claimant) |
| B6 | Divorced wife, age 62 or over (lst claimant) |
| B7 | Same as B2 (3rd claimant) |
| B8 | Same as B (3rd claimant) |
| B9 | Same as B6 (2nd claimant) |
| BA | Same as B (5th claimant) |
| BD | Same as B (5th claimant) |
| BG | Same as B1 (3rd claimant) |
| BH | Same as B1 (4th claimant) |
| BJ | Same as B1 (5th claimant) |
| BK | Same as B2 (4th claimant) |
| BL | Same as B2 (5th claimant) |
| BN | Same as B6 (3rd claimant) |
| BP | Same as B6 (4th claimant) |
| BQ | Same as B6 (5th claimant) |
| BR | Divorced husband (lst claimant) |
| BT | Divorced husband (2nd claimant) |
| BW | Young husband (2nd claimant) |
| BY | Young husband (1st claimant) |
| C1-C9<br>CA-CK | Child (includes minor child, disabled child, and student child) |
| D | Widow, age 60 or over (lst claimant) |
| D1 | Widower, age 60 or over (1st claimant) |
| D2 | Same as D (2nd claimant) |
| D3 | Same as D1 (2nd claimant) |
| D4 | Widow who has remarried after attaining age 60 |
| D5 | Widower who has remarried after attaining age 60 |
| D6 | Surviving divorced wife, age 60 or over (lst claimant) |
| D7 | Same as D6 (2nd claimant) |
| D8 | Same as D (3rd claimant) |
| D9 | Same as D4 (3rd claimant) |
| DA | Same as D4 (3rd claimant) |

| | |
| --- | --- |
| DC | Surviving divorced husband (1st claimant) |
| DD | Same as D (4th claimant) |
| DG | Same as D (5th claimant) |
| DH | Same as D1 (3rd claimant) |
| DJ | Same as D1 (4th claimant) |
| DK | Same as D1 (5th claimant) |
| DL | Same as D4 (2nd claimant) |
| DM | Same as DC (2nd claimant |
| DN | Same as D4 (5th claimant) |
| DP | Same as D5 (2nd claimant) |
| DQ | Same as D5 (3rd claimant) |
| DR | Same as D5 (4th claimant) |
| DS | Same as DC (3rd claimant) |
| DT | Same as D5 (5th claimant) |
| DV | Same as D6 (3rd claimant) |
| DW | Same as D6 (4th claimant) |
| DX | Same as DC (4th claimant) |
| DY | Same as D6 (5th claimant) |
| DZ | Same as DC (5th claimant) |
| E | Mother (widow) (lst claimant) |
| E1 | Surviving divorced mother (lst claimant) |
| E2 | Same as E (2nd claimant) |
| E3 | Same as E1 (2nd claimant) |
| E4 | Father (widower) (lst claimant) |
| E5 | Surviving divorced father (widower) (lst claimant) |
| E6 | Father (widower) (2nd claimant) |
| E7 | Same as E (3rd claimant) |
| E8 | Same as E (4th claimant) |
| E9 | Same as E5 (2nd claimant) |
| EA | Same as E (5th claimant) |
| EB | Same as E1 (3rd claimant) |
| EC | Same as E1 (4th claimant) |
| ED | Same as E1 (5th claimant) |
| EF | Same as E4 (3rd claimant) |
| EG | Same as E4 (4th claimant) |
| EH | Same as E4 (5th claimant) |

| | |
| --- | --- |
| EJ | Same as E5 (3rd claimant) |
| EK | Same as E5 (4th claimant) |
| EM | Same as E5 (5th claimant) |
| F1 | Father |
| F2 | Mother |
| F3 | Stepfather |
| F4 | Stepmother |
| F5 | Adopting father |
| F6 | Adopting mother |
| F7 | Second alleged father |
| F8 | Second alleged mother |
| G1-G9 | Claimants of lump-sum death payments |
| J1 | Primary Prouty entitled to Medicare Part A |
| J2 | Primary Prouty entitled to Medicare Part A |
| J3 | Primary Prouty not entitled to Medicare Part A |
| J4 | Primary Prouty not entitled to Medicare Part A |
| K1 | Prouty wife entitled to Medicare Part A |
| K2 | Prouty wife entitled to Medicare Part A |
| K3 | Prouty wife not entitled to Medicare Part A |
| K4 | Prouty wife not entitled to Medicare Part A |
| K5 | Same as K1 (2nd claimant) |
| K6 | Same as K2 (2nd claimant) |
| K7 | Same as K3 (2nd claimant) |
| K8 | Same as K4 (2nd claimant) |
| K9 | Same as K1 (3rd claimant) |
| KA | Same as K2 (3rd claimant) |
| KB | Same as K3 (3rd claimant) |
| KC | Same as K4 (3rd claimant) |
| KD | Same as K2 (4th claimant) |
| KE | Same as K2 (4th claimant) |
| KF | Same as K3 (4th claimant) |
| KG | Same as K4 (4th claimant) |
| KH | Same as K2 (5th claimant) |
| KJ | Same as K2 (5th claimant) |
| KL | Same as K3 (5th claimant) |
| KM | Same as K4 (5th claimant) |
| M | Primary beneficiary not entitled to Social Security or Railroad Retirement benefits (at the time of filing) - NOT entitled to premium free Medicare Part A. |

| | |
| --- | --- |
| M1 | Similar to M, but is qualified for automatic Medicare Part A but has filed for Medicare Part B only |
| T | • Fully insured beneficiary who has elected entitlement only to Part-A Medicare (usually but not always along with Part-B)<br>• Uninsured beneficiary or renal-disease beneficiary only<br>• Deemed insured (Part-A Medicare only) |
| TA | Medicare Qualified Government Employee (MQGE) primary beneficiary |
| TB | MQGE aged spouse (1st claimant) |
| TC | MQGE childhood disability benefits (CDB) (1st claimant) |
| TD | MQGE aged widow(er) (1st claimant) |
| TE | MQGE young widow(er) (1st claimant) |
| TF | MQGE parent (male) |
| TG | MQGE aged spouse (2nd claimant) |
| TH | MQGE aged spouse (3rd claimant) |
| TJ | MQGE aged spouse (4th claimant) |
| TK | MQGE aged spouse (5th claimant) |
| TL | MQGE aged widow(er) (2nd claimant) |
| TM | MQGE aged widow(er) (3rd claimant) |
| TN | MQGE aged widow(er) (4th claimant) |
| TP | MQGE aged widow(er) (5th claimant) |
| TQ | MQGE parent (female) |
| TR | MQGE young widow(er) (2nd claimant) |
| TS | MQGE young widow(er) (3rd claimant) |
| TT | MQGE young widow(er) (4th claimant) |
| TU | MQGE young widow(er) (5th claimant) |
| TV | MQGE disabled widow(er) (5th claimant) |
| TW | MQGE disabled widow(er) (1st claimant) |
| TX | MQGE disabled widow(er) (2nd claimant) |
| TY | MQGE disabled widow(er) (3rd claimant) |
| TZ | MQGE disabled widow(er) (4th claimant) |
| T2–T9 | MQGE CDB (2nd–9th claimant) |
| W | Disabled widow, age 50 or over (last claimant) |
| W1 | Disabled widower, age 50 or over (lst claimant) |
| W2 | Same as W (2nd claimant) |
| W3 | Same as W1 (2nd claimant) |
| W4 | Same as W (3rd claimant) |
| W5 | Same as W1 (3rd claimant) |
| W6 | Disabled surviving divorced wife (lst claimant) |
| W7 | Same as W6 (2nd claimant) |
| W8 | Same as W6 (3rd claimant) |
| W9 | Same as W (4th claimant) |
| WB | Same as W1 (4th claimant) |
| WC | Same as W6 (4th claimant) |
| WF | Same as W (5th claimant) |
| WG | Same as W1 (5th claimant) |
| WJ | Same as W6 (5th claimant) |
| WR | Disabled surviving divorced husband (1st claimant) |
| WT | Disabled surviving divorced husband (2nd claimant) |

**SSN:** Enrollee Social Security Number - The number used by SSA throughout a wage earner's lifetime to identify earnings under the Social Security Program.

**SSN STAT:** Social Security Number Status Code - Indicates whether or not a member's SSN has been verified by the Social Security Administration. SSA verifies an SSN by comparing the member's name, birth date and sex to the SSA Master File.

**Valid Values Description**

| | |
| --- | --- |
| Space | SSN has not been verified and must be sent to SSA |
| 0 | SSN sent to SSA for verification |
| 1 | SSN is not on Numident file |
| 3 | Surname matched, DOB does not match Numident |
| 4 | Name matches, DOB and sex do not match |
| 5 | Name does not match, DOB was checked |
| & | Multiple SSNs were previously issued in individual |
| * | The input SSN was not verified |
| . | SSN has not been verified and must be sent to SSA |
| E | SSN has not been verified and must be sent to SSA |
| F | SSN is verified (surname ignored because no match on surname +/- 1 letter difference) |
| M | SSN verified via MBR or SSR rather than Numident (overlays Value "1") |
| P | SSN verified via MBR or SSR rather than Numident (overlays Value "3") |
| R | SSN verified via MBR or SSR rather than Numident (overlays Value "5") |
| V | SSN is verified |
| X | SSN is verified, Date of Death provided on Numident |
| Z | Verification code for records in which State submitted a CAN (claim account number) instead of an SSN. SSA found the CAN on MBR, but did not verify the SSN with the Numident |

**SSA Claim #:** A number used by SSA to identify an individual who is a claimant or a beneficiary.

**SSA Cit Stat:** This field displays the Citizenship Status based on the Social Security Administration (SSA).

## Valid Values Description

| | |
| --- | --- |
| & | Multiple SSNs were previously issued to individual |
| * | The input SSN was not verified |
| . | SSN has not been verified and must be sent to SSA |
| 0 | Record selected and sent to SSA for citizenship verification |
| 1 | SSN is not on Numident file |
| 3 | Surname matched, DOB does not match Numident |
| 5 | Name does not match, DOB was checked |
| A | SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data – returned for SCHIP requests only |
| B | SSN is verified, there is no indication of death, and the allegation of citizenship is NOT consistent with SSA data – returned for SCHIP requests only |
| Blank | Citizenship has not been verified and must be sent to SSA, when SSA Status has a date - failed SSA edits |
| C | SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data – returned for SCHIP requests only |
| D | SSN is verified, there is indication of death, and the allegation of citizenship is NOT consistent with SSA data – returned for SCHIP requests only |
| F | SSN is verified (surname ignored because no match on surname +/- 1 letter difference, citizenship cannot be determined by SSA |
| M | SSN verified via MBR or SSR rather than Numident (overlays Value "1"), citizenship cannot be determined by SSA |
| P | SSN verified via MBR or SSR rather than Numident (overlays Value "3"), citizenship cannot be determined by SSA |
| PV | Pending verification – citizenship previously verified; Name, DOB or SSN changed, citizenship must be reverified |
| R | SSN verified via MBR or SSR rather than Numident (overlays Value "5"), citizenship cannot be determined by SSA |

**SSA Cit Stat Date:** This Field displays the Citizenship Status Date based on the Social Security Administration (SSA).

**Part B Tran Code:** This is the Supplemental Medical Insurance Transaction Code. This code displays the Part B premium payment transaction code. The valid values are listed below.

| | |
| --- | --- |
| 11xx | Informs State that the individual was accreted to the State's account |
| 14 | CMS has deleted the Part A or Part B record due to internal system adjustment |
| 15 | CMS has deleted, individual doesn't meet all requirements of Medicare |
| 16 | CMS has deleted, individual is deceased |
| 17xx | Deleted from State's account, due to two-digit (xx) reason code |
| 20xx | Deletion action from State was rejected because no record of ongoing buy-in |
| 21xx | Accretion action from State was rejected because no match to the EDB - Enrollment Database (CMS Medicare beneficiary entitlement record) |
| 23xx | Informs State of a claim number change |
| 24xx | Informs State that accretion/deletion was rejected due to invalid effective date |
| 25xx | Informs State that accretion/deletion was rejected, duplicates a previous trans |
| 27xx | Informs State that accretion/deletion was rejected, due to invalid transaction code |

| | |
| --- | --- |
| 29xx | Accretion action from State was rejected due to death deletion on EDB |
| 30xx | Informs State that effective date on accretion required adjustment to later date |
| 41 | Informs State that the individual is on the State's account as ongoing item |
| 42 | Informs State of a Credit Adjustment due to duplicate billing on the TPM (Third Party Master) |
| 42xx | Informs State of a Credit Adjustment to the State's premium liability |
| 43xx | Informs State of a Debit Adjustment due to several possible reasons |
| 44 | Informs the State that the monthly premium was reduced, resulting in a credit to the State |
| 45 | Informs the State that the monthly premium was increased, resulting in a debit to the State |
| 4999 | Informs State that request to correct welfare ID number was rejected |
| 50 | Used by State to annul a code 1165 or 1167 accretion from CMS |
| 51 | Used by State to delete an individual, no longer a member of State account |
| 53 | Used by State to delete an individual, the individual is deceased |
| 61 | Used by State to accrete an individual to the State's account |
| 63 | Used by State to accrete an individual for subsequent State analysis |
| 75 | Used by State to request a simultaneous accretion/deletion action |
| 84 | Used by Alert State to accrete an individual in response to a transaction 86 alert |
| 86 | Informs Alert State that individual is entitled to SSI benefits |
| 87 | Informs State that SSI entitlement has terminated for the individual |
| 99 | Used by State to correct the eligibility code or welfare ID number |

**Part B Transaction Date**: Displays the effective date of the related transaction code as transmitted by CMS.

**Part B Begin Date:** Displays the Part B premium payment start date.

**Part B End Date**: Displays the Part B premium payment end date.

**Part B Premium:** Displays the Part B premium payment amount.

**Part B Code:** This is an alphabetic code describing the reason the beneficiary is eligible for Buy-In Part B.

| | |
| --- | --- |
| A | Federal SSI payments aged (CMS code) |
| B | Federal SSI payments blind (CMS code) |
| C | Entitled under Part A of Title IV (TANF) |
| D | Federal SSI payments disabled (CMS code) |
| E | SSA supplemental payment aged (CMS code) |
| F | SSA supplemental payment blind (CMS code) |
| G | SSA supplemental payment disabled member |
| H | One time payment of aged, blind, or disabled member |
| L | Specified Low Income Medicare Beneficiary (SLMB) |
| M | Entitled to Medical assistance only |
| P | Qualified Medicare Beneficiary (QMB) |
| U | Qualified Individual (QI1) |
| V | Categorically Needy (Aged, Blind, Disabled, TANF) |
| Z | Deemed categorically needy |

**Part A Tran Code:** This field displays the Hospital insurance Part A premium payment transaction code. The valid values are the same values previously included for Part B codes.

**Part A Transaction: Date:** Displays the effective date of the related transaction code as transmitted by CMS.

**Part A Begin Date:** Displays the Part A premium payment start date

**Part A End Date:** Displays the Part A premium payment end date.

**HI Premium:** Displays the Part A premium payment amount.

**BENDEX Query:** A code indicating that a query should be made for this t member to SSA through BENDEX, or the response that was received from SSA.

| | |
| --- | --- |
| 0 | Initial query |
| 1 | Cancel query |
| 2 | Outstanding query (no response) |
| 3 | Satisfactory response |
| 5 | Follow up annually |
| 6 | Unsatisfactory response |

**Prem Indicator:** This field displays whether a member is eligible for Medicare Part B or Social Security.

| | |
| --- | --- |
| 0 | Not eligible for Medicare or SSA |
| 1 | Receiving SSA Benefits, updated by BENDEX |
| 2 | Receiving Medicare, Eligible for State buy-in |
| 8 | Dialysis, Not Medicare eligible |
| 9 | Dialysis, Medicare pending or applied for |

**Comm Coded:** This field displays the BENDEX SSA information codes to interpret data exchanged between BENDEX and DMAS.

| | |
| --- | --- |
| BDA | Recipient has an initial query or outstanding query or Unsatisfactory response. |
| B-I TERM | Beneficiary was deleted from state's buy-in account. |
| BOAN UNM | This SSN was submitted by direct wire input and a match could not be made. |
| CF XXX | Last BENDEX record you will receive; exchange transferred to agency XXX. |
| CHILD SP | This is the initial child support enforcement for this beneficiary. |
| DELETED | A direct input record was processed with communication code DPA or DTH. |
| DIEDMMYY | The number holder on this account is deceased. |
| DOB UNM | Two or more beneficiaries with same surname and DOB match can't be made. |
| DPA | Recipient has an initial query and cancelled for reason other than death. |
| DTH | Recipient has an initial query and canceled due to death. |

| | |
| --- | --- |
| ENFORXXX | For your information, agency XXX has made a child support enforcement inquiry. |
| FIN MMYY | The benefits for this beneficiary are terminated for the month indicated. |
| GIV UNM | Surname match found, however, the first name and DOB do not match. |
| IMP CAN | The SSN/CAN on the BENDATA record is invalid or has not been issued by SSA. |
| IMP CODE | Positions 60-62 on the BENDATA record are invalid or blank. |
| JURISXXX | This is a child support enforcement inquiry for this beneficiary. |
| MATCHED | Current data was extracted from the Master Beneficiary Record. |
| NO AUTH | Position 51 (Direct Wire Input) on the BENDATA record was invalid. |
| NO DEX | Two requests for same beneficiary, one with BDA and the other with DPA/ DTH. |
| NO FILE | CAN/SSN is not on MBR. |
| NODELXXX | This is a requested deletion of beneficiary in which another state has jurisdiction. |
| NOTITLE2 | Recipient not entitled to SSA benefits; however, SSI, RR or BL may be involved. |
| REP PAYE | Fully processed record with current data extracted from the MBR. |
| SUR UNM | First name and DOB match, but surname unmatched. |
| UTL XREF | Pertinent data was extracted on this claim number, no MBR has been located. |
| WAS XXX | Exchange transferred to our agency; agency XXX will no longer receive exchange. |
| XREF NUM | Beneficiary is terminated on this record; there is no cross-reference MBR. |

**DSS BDX:** This field reveals the DSS inquiry status as to whether or not the member is active for DSS BENDEX inquiries.

| | |
| --- | --- |
| N | No, not active for DSS BENDEX inquiries. |
| Y | Yes, active for DSS BENDEX inquiries. |

**Part B Payer:** A code assigned by CMS indicating who is paying the SMI Part B premium.

| | |
| --- | --- |
| 010 thru 650 | The agency code for the State billed for SMI premium payments. |
| CIVIL | Civil Service is billed for SMI premium payments. |
| PRITP | Private third party is billed for SMI premium payments. |
| RRB | Railroad Board has jurisdiction. |
| SELF | Beneficiary is responsible for SMI premium payments. |
| space | Default. |

**Part B Premium:** This field contains the collectable premium amount for Part B.

**Part B Soc:** This field reveals the currently recorded SMI Option Code (SOC).

| | |
| --- | --- |
| C | No (Disability ceased). |
| D | No (Denied). |
| E | No (Dual/Technically entitled beneficiary not entitled to SMI) (derived value – when SMI Non Covered Reason Code (DE 3521) in input RSF325 file has spaces and Med-Status = "I") |
| G | Yes (Good cause). |
| I | No (Terminated for invalid enrollment) |
| M | Current SMI/Railroad Retirement Board has jurisdiction and collects the |

| | |
| --- | --- |
| | premium (derived value – when SMI Non Covered Reason (DE 3521) in input file RSF325 has spaces and Med-Status not equal to "I") |
| N | No (No longer under renal disease provision |
| P | No (Terminated for nonpayment of premiums) |
| R | No (Refused). Foreign Resident |
| | |
| space | SMI not involved. |
| | |
| V | Void Enrollment |
| W | No (Withdrawal). |
| | |

**Part A Payer:** A code assigned by CMS indicating who is paying the Part A premium.

| | |
| --- | --- |
| RRB | Railroad jurisdiction. |
| S01 thru S65 | The agency code for the State billed for Part A premium payments. |
| space | N/A. |
| T01 thru Z98 | Private third party billed for premiums (assigned by CMS). |
| Z99 | Conditional State Group Payer Enrollment. |

**Part A Premium:** This field contains the collectable premium amount for Part A.

**Part A Hoc:** This field reveals the currently recorded HI Option Code (HOC).

| | |
| --- | --- |
| C | No (Cessation of disability). |
| D | No (Denied). |
| E | Yes (Automatic entitlement, no premium necessary). |
| F | No (Terminated for invalid enrollment or enrollment voided). |
| G | Yes (Good cause). |
| H | No (Not eligible for free health insurance benefits (Part A). |
| P | Railroad jurisdiction. |
| R | No (Refused free Part A). |
| S | No (No longer under renal disease provision). |
| space | HI not involved. |
| T | No (Terminated for nonpayment of premiums). |
| W | No (Withdrawal from premium Part A). |
| X | No (Part A terminated due to title II termination, SMI benefits unchanged). |
| Y | Yes (Premium is payable). |

**Title II Begin Date:** The initial date of entitlement to Title II benefits

**Title II Begin Amount:** Displays the Title II monthly benefit amount.

**PSC:** Displays the status of the beneficiary's Social Security benefits.

| | |
| --- | --- |
| A- | Adjustment - Withdrawn from CP status to be placed in nonpayment status. |
| A& | Adjustment - Withdrawn from nonpayment status to place in CP status. |
| A0 thru A8 | Adjustment - Rate reduction is being figured. |
| A9 | Adjustment - Miscellaneous adjustment not separately defined. |
| AA | Adjustment - Withdrawal to split payments. |
| AC | Adjustment - Correction in benefit rate. |
| AD | Adjustment - Adjusted for dual entitlement. |
| AE | Adjustment - Withdrawn for re-computation. |
| AJ | Adjustment - Worker's compensation offset. |
| AM | Adjustment - Withdrawal from HI-only status. |
| AR | Adjustment - Withdrawal from S or T status to place in CP status. |
| AW | Adjustment - Worker's compensation offset. |
| B | Abatement - Claimant died prior to entitlement. |
| CA | Cur Payment Advance Filing - Claim has been adjudicated, entitlement is future date. |
| CP | Current Payment - Current payment status. |
| D1 | Deferred - Engaging in foreign work. |
| D2 | Deferred - Beneficiary overpaid because of work. |
| D3 | Deferred - Auxiliary's benefits withheld due D2 status of prime beneficiary. |
| D4 | Deferred - Failure to have child in care. |
| D5 | Deferred - Auxiliary's benefits withheld due D1 status of prime beneficiary. |
| D6 | Deferred - To recover overpayment for reason not connected to earnings. |
| D9 | Deferred – Miscellaneous. |
| DP | Deferred - Receipt of public assistance. |
| DW | Deferred - Receipt of worker's compensation. |
| K | Delayed - Advanced filing for deferred payment. |
| L | Delayed - Advanced filing. |
| N | Denied - Disallowed claim. |
| ND | Denied - Disability claim denied. |
| P | Delayed - Adjudication pending. |
| PB | Delayed - Benefits due but not paid. |
| PF, PH, PJ-PM | Delayed - beneficiary is to be placed in S payment status upon final adjudication. |
| PP, PW, P0-P9 | Delayed - beneficiary is to be placed in S payment status upon final adjudication. |
| PT | Delayed - Claim terminated from delayed status. |
| S0 | Suspended - Determination of continuing disability is pending. |
| S1 | Suspended - Beneficiary is engaged in work outside the U.S. |
| S2 | Suspended - Person working in US. expect to earn excess of annual allowable. |
| S3 | Suspended - Auxiliary's benefits withheld due to S2 status of primary benefit. |
| S4 | Suspended - Failure to have child in care. |
| S5 | Suspended - Auxiliary's benefits withheld due to S1 status of primary benefit. |
| S6 | Suspended - Check was returned - correct address being developed. |
| S7 | Suspended - Due refusal of vocational rehab; imprisoned; trial work period. |
| S8 | Suspended - Suspended while payee is being determined. |
| S9 | Suspended - Suspended for reason not separately defined. |
| SB | Suspended - Benefits due but not paid (less than $1.00). |

| | |
| --- | --- |
| SD | Suspended - Technical entitlement only. Benefic entitled on another claim. |
| SF | Suspended - Special age 72 beneficiary fails to meet residency requirement. |
| SH | Suspended - Special age 72 beneficiary is receiving a government pension. |
| SJ | Suspended - Alien suspension. |
| SK | Suspended - Beneficiary has been deported. |
| SL | Suspended - Beneficiary resides in a country to which checks cannot be sent. |
| SM | Suspended - Beneficiary refused cash benefits (entitled to HI-SMI only). |
| SP | Suspended - Special age 72 benefits suspended due to receiving pub assistance. |
| SS | Suspended - Post secondary student summer suspension. |
| SW | Suspended - Suspended because of worker's compensation. |
| T- | Terminated - Converted disability benefit to retirement benefit upon age 65. |
| T& | Terminated - The claim was withdrawn. |
| T0 | Terminated - Benefits are payable by some other agency. |
| T1 | Terminated - Due to death of the beneficiary. |
| T2 | Terminated - Auxiliary terminated due to death of the primary. |
| T3 | Terminated - Due to divorce, marriage or remarriage of beneficiary. |
| T4 | Terminated - Child attained age 18 or 22 and is not disabled. |
| T5 | Terminated - Beneficiary entitled to other benefits equal or larger. |
| T6 | Terminated - Child is no longer a student or disabled. |
| T7 | Terminated - Child beneficiary was adopted. |
| T8 | Terminated - Primary beneficiary or last disabled child no longer disabled. |
| T9 | Terminated - Terminated for reason not separately defined. |
| TA | Terminated - Terminated prior to entitlement. |
| TB | Terminated - Mom/Dad due to benefit entitled to disabled widow(er)s benefits. |
| TC | Terminated - Disabled widow now age 62 & is not entitled as aged widow. |
| TJ | Terminated - Advanced filed claim terminated after maturity. |
| TL | Terminated - Termination of post-secondary student. |
| TP | Terminated - Because of change in type of benefit or post entitlement action. |
| U | Uninsured - Beneficiary is entitled only to HI or SMI. |
| W | Withdrawal - Withdrawal before entitlement. |
| X0 | Other Adjust/Term - Claim transferred to RRB. |
| X1 | Other Adjust/Term - Beneficiary died. |
| X5 | Other Adjust/Term - Entitled to other benefits. |
| X7 | Other Adjust/Term - HIB/SMIB terminated. |
| X8 | Other Adjust/Term - Payee is being developed. |
| X9 | Other Adjust/Term - Terminated for reason not separately defined. |
| XD | Other Adjust/Term - Withdrawn for adjustment. |
| XF | Other Adjust/Term - Entitlement transferred to another PSC. |
| XK | Other Adjust/Term – Deportation. |
| XR | Other Adjust/Term - Withdraw from SMIB. |

**SSI Eligible:** This field contains the current date of entitlement to SSI benefits

**Railroad:** This is the Railroad Retirement Board benefit status.

| | |
|---|---|
| A | Active claim |
| F | Flagged for cross referral |
| S | Payment Suspended |
| space | Default |
| T | Claim terminated |

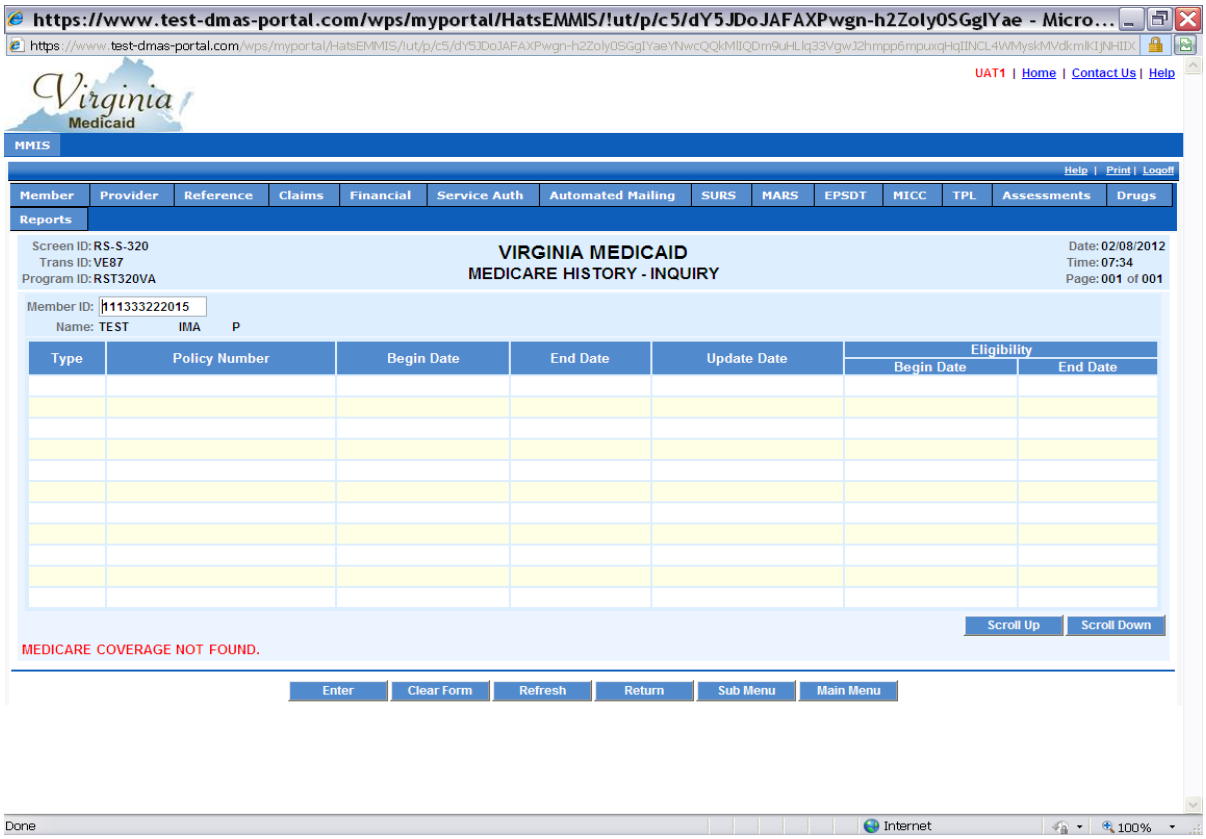
**MLTP:** A code indicating if the enrollee is entitled on more than one Claim Account number.

| | |
|---|---|
| D | Dual entitlement exists. |
| space | Default, no other entitlement. |
| T | Triple entitlement exists. |

**Disability Onset**: The date of onset of the member's disability.

## Medicare History Screen

This screen provides a record of the member's Medicare coverage.



**Member ID:** The permanent 12 digit Medicaid number for the chosen member.

**Name:** The member's name.

**Type:** A code that identifies the type of coverage a member has with the third party

| | |
| --- | --- |
| A | Medicare Part A |
| B | Medicare Part B |
| RD | Medicare Part D |

**Policy Number:** The number at the Social Security Administration (SSA) for an individual on whose earnings benefits are paid or eligibility is established for Medicare coverage. It is composed of a nine-digit Social Security Number or a six or nine -digit Railroad Retirement Board Number.

**Begin Date:** The date the Medicare coverage began.

**End Date:** The date the Medicare coverage ended.

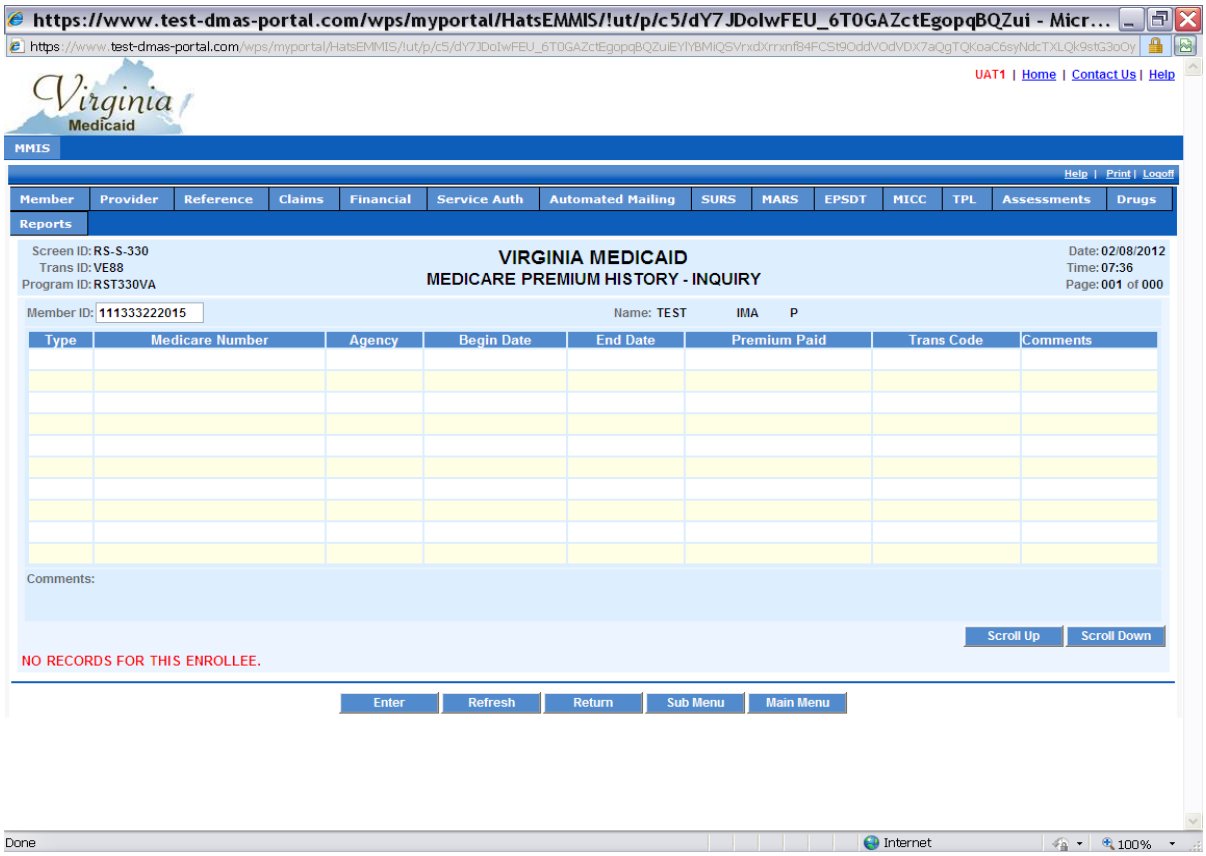
**Update Date:** Date this data was last updated.

**Eligibility Begin Date:** The date Part D Medicare eligibility began.

**Eligibility End Date:** The date Part D Medicare eligibility will end.

## Medicare Premium History

This screen provides on-line history for the member Medicare premium processing (Buy-In and Group Payer) data.




**Member ID:** The 12 digit DMAS-administered identification number that is used to tie all claims for a single enrollee together.

**Name:** Member's name.

**Type:** Indicates the type of segment as Medicare coverage Part A or Medicare Part B.

| | |
|---|---|
| A | Medicare Part A coverage |
| B | Medicare Part B coverage |

**Medicare Number:** The number at the Social Security Administration (SSA) of an individual on whose earnings benefits are paid or eligibility is established for Medicare coverage.

**Agency:** The State agency code as assigned by SSA or Group Payer. This code indicates the entity which has jurisdiction over the account. For Virginia, S49 is used for Part A, and 490 is used for Part B.

**Begin Date:** The beginning date (or effective date) of coverage that relates to the associated Transaction Code and Medicare premium amount or refund.

**End Date:** The effective end date of coverage that relates to the associated Transaction Code and Medicare premium amount or refund.

**Premium Paid:** The amount of money that DMAS pays to obtain Medicare Part A or B coverage for a member; the monthly Part A or Part B Medicare premium rate.

**Trans Code:** This field is also known as SSA Communications Code. Displays the code used to describe the premium payment transaction.

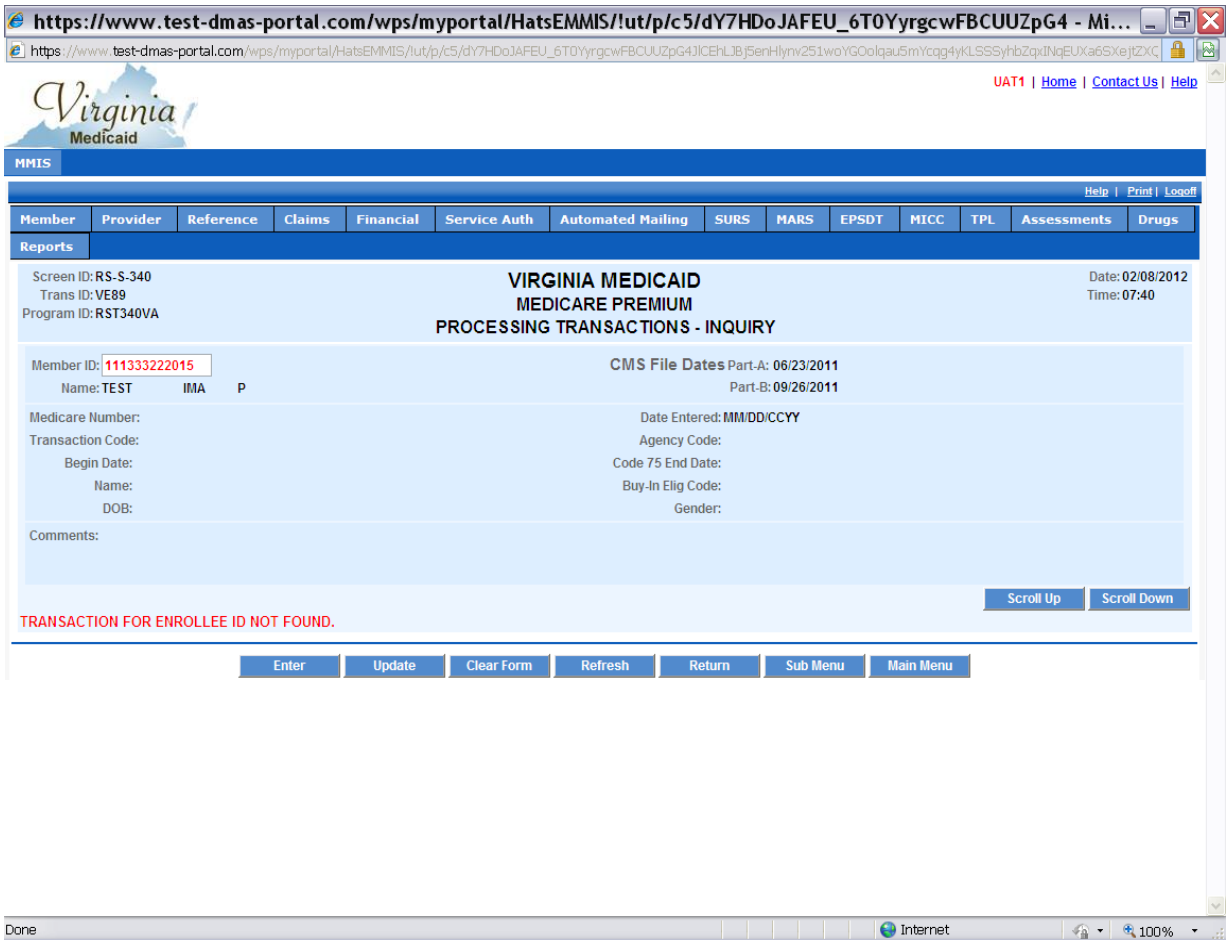
| | |
| --- | --- |
| 11xx | Informs State that the individual was accreted to the State's account |
| 14 | CMS has deleted the Part A or Part B record due to internal system adjustment |
| 15 | CMS has deleted, individual doesn't meet all requirements of Medicare |
| 16 | CMS has deleted, individual is deceased |
| 17xx | Deleted from State's account, due to two-digit (xx) reason code |
| 20xx | Deletion action from State was rejected because no record of ongoing buy-in |
| 21xx | Accretion action from State was rejected because no match to the EDB |
| 23xx | Informs State of a claim number change |
| 24xx | Informs State that accretion/deletion was rejected due to invalid eff date |
| 25xx | Informs State that accretion/deletion was rejected, duplicates a prev trans |
| 27xx | Informs State that accretion/deletion was rejected, due to invalid tran cd |
| 29xx | Accretion action from State was rejected due to death deletion on EDB |
| 30xx | Informs State that effective date on accretion required adj to later date |
| 41 | Informs State that the individual is on the State's account as ongoing item |
| 42 | Informs State of a Credit Adjustment due to duplicate billing on the TPM (Third Party Master) |
| 42xx | Informs State of a Credit Adjustment to the State's premium liability |
| 43xx | Informs State of a Debit Adjustment due to several possible reasons |
| 44 | Informs the State that the monthly premium was reduced, resulting in a credit to the State |
| 45 | Informs the State that the monthly premium was increased, resulting in a debit to the State |
| 4999 | Informs State that request to correct welfare ID number was rejected |
| 50 | Used by State to annul a code 1165 or 1167 accretion from CMS |
| 51 | Used by State to delete an individual, no longer a member of State account |
| 53 | Used by State to delete an individual, the individual is deceased |
| 61 | Used by State to accrete an individual to the State's account |
| 63 | Used by State to accrete an individual for subsequent State analysis |
| 75 | Used by State to request a simultaneous accretion/deletion action |
| 84 | Used by Alert State to accrete an individual in response to a tran 86 alert |
| 86 | Informs Alert State that individual is entitled to SSI benefits |

| | |
|---|---|
| 87 | Informs State that SSI entitlement has terminated for the individual |
| 99 | Used by State to correct the eligibility code or welfare ID number |

**Comments:** Text field displaying Remarks associated with this member.

## Medicare Buy-In Transaction Screen

This screen allows users, depending on authorization, to view, add, change and delete transactions used in the processing of Medicare Premium data which will be processed by the monthly Medicare Premium extract Program both for Part A and Part B accessed from the Medicare menu by selection and the Inquiry function



**Member ID:** The 12 digit DMAS-administered identification number that is used to tie all claims for a single member together.

**CMS File Dates** file **Part-A:** The date of the last run of program which creates the Part A extract for CMS containing currently eligible Medicaid members determined by the state to be eligible for Buy-In.

**Name:** The name of the enrollee.

**Part-B:** The date of the last run of program which creates the Part B extract file for CMS containing currently eligible Medicaid members determined by the state to be eligible for Buy-In.

**Medicare Number:** The number at the Social Security Administration (SSA) of an individual on whose earnings benefits are paid or eligibility is established for Medicare coverage.

**Date Entered:** Displays the date this transaction was entered.

**Transaction Code:** This two-position transaction code identifies what type of action will be communicated from DMAS to CMS. Each state is responsible for accreting those members whom the state has determined is eligible for premium payment.

| | |
| --- | --- |
| 50 | Cancelled (delete or annul a code 1165 or 1167) |
| 51 | Cancelled ineligible |
| 53 | Cancelled Death |
| 61 | Accretion |
| 63 | Re-accretion |
| 75 | Simultaneous accretion/deletion |
| 84 | Accretion (in response to a code 86 accretion alert) |
| 99 | Change of State data |

**Agency Code:** The State agency code as assigned by SSA or Group Payer. This code indicates the entity which has jurisdiction over the account. For Virginia, code S49 is used for Part A and 490 is used for Part B.

| A | B | |
| --- | --- | --- |
| S01 | 010 | Alabama |
| S02 | 020 | Alaska |
| S03 | 030 | Arizona |
| S04 | 040 | Arkansas |

| | | |
| --- | --- | --- |
| S05 | 050 | California |
| S06 | 060 | Colorado |
| S07 | 070 | Connecticut |
| S08 | 080 | Delaware |
| S09 | 090 | District of Columbia |
| S10 | 100 | Florida |
| S11 | 110 | Georgia |
| S12 | 120 | Hawaii |
| S13 | 130 | Idaho |
| S14 | 140 | Illinois |
| S15 | 150 | Indiana |
| S16 | 160 | Iowa |
| S17 | 170 | Kansas |
| S18 | 180 | Kentucky |
| S19 | 190 | Louisiana |
| S20 | 200 | Maine |
| S21 | 210 | Maryland |
| S22 | 220 | Massachusetts |
| S23 | 230 | Michigan |
| S24 | 240 | Minnesota |
| S25 | 250 | Mississippi |
| S26 | 260 | Missouri |
| S27 | 270 | Montana |
| S28 | 280 | Nebraska |
| S29 | 290 | Nevada |
| S30 | 300 | New Hampshire |
| S31 | 310 | New Jersey |
| S32 | 320 | New Mexico |
| S33 | 330 | New York |
| S34 | 340 | North Carolina |
| S35 | 350 | North Dakota |
| S36 | 360 | Ohio |
| S37 | 370 | Oklahoma |
| S38 | 380 | Oregon |
| S39 | 390 | Pennsylvania |
| S41 | 410 | Rhode Island |
| S42 | 420 | South Carolina |
| S43 | 430 | South Dakota |
| S44 | 440 | Tennessee |
| S45 | 450 | Texas |
| S46 | 460 | Utah |
| S47 | 470 | Vermont |

| | | |
| --- | --- | --- |
| S48 | 480 | Virgin Islands |
| S49 | 490 | Virginia |
| S50 | 500 | Washington |
| S51 | 510 | West Virginia |
| S52 | 520 | Wisconsin |
| 53 | 530 | Wyoming |
| N/A | 640 | Northern Mariana Islands |
| N/A | 650 | Guam |
| N/A | 700 | U.S. Civil Service Commission |
| Z99 | | Conditional Part A Enrollment |

**Begin Date:** The beginning date (or effective date) of coverage that relates to the associated Transaction Code and Medicare premium amount or refund.

**Code 75 End Date:** The effective end date of coverage that relates to the associated Transaction Code and Medicare premium amount or refund.

**Buy-In Elig Code:** An alphabetic code which describes the reason the member is eligible for Buy-In Part B.

| | |
| --- | --- |
| A | Federal SSI payments aged (CMS code) |
| B | Federal SSI payments blind (CMS code) |
| C | Entitled under Part A of Title IV (TANF) |
| D | Federal SSI payments disabled (CMS code) |
| E | SSA supplemental payment aged (CMS code) |
| F | SSA supplemental payment blind (CMS code) |
| G | SSA supplemental payment disabled Enrollee |
| H | One time payment of aged, blind, or disabled recipient |
| L | Specified Low Income Medicare Beneficiary (SLMB) |
| M | Entitled to Medical assistance only |
| P | Qualified Medicare Beneficiary (QMB) |
| U | Qualified Individual (QI1) |
| V | Categorically Needy (Aged, Blind, Disabled, TANF) |
| Z | Deemed categorically needy |

**Name:** The member's name.

**Date of Birth:** The member's date of birth.

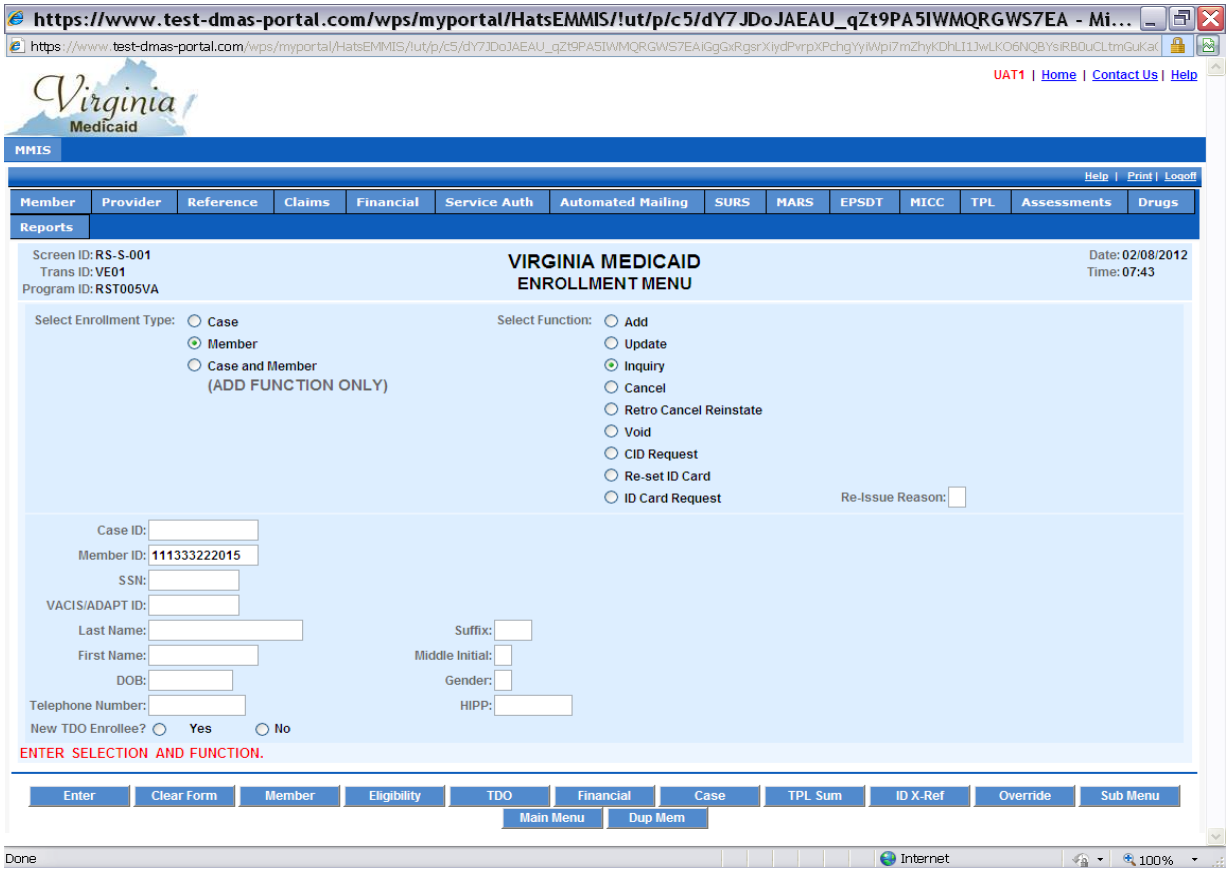
**Gender:** A code indicating the sex of the enrollee.

**Comments:** Text field for member -related comments.

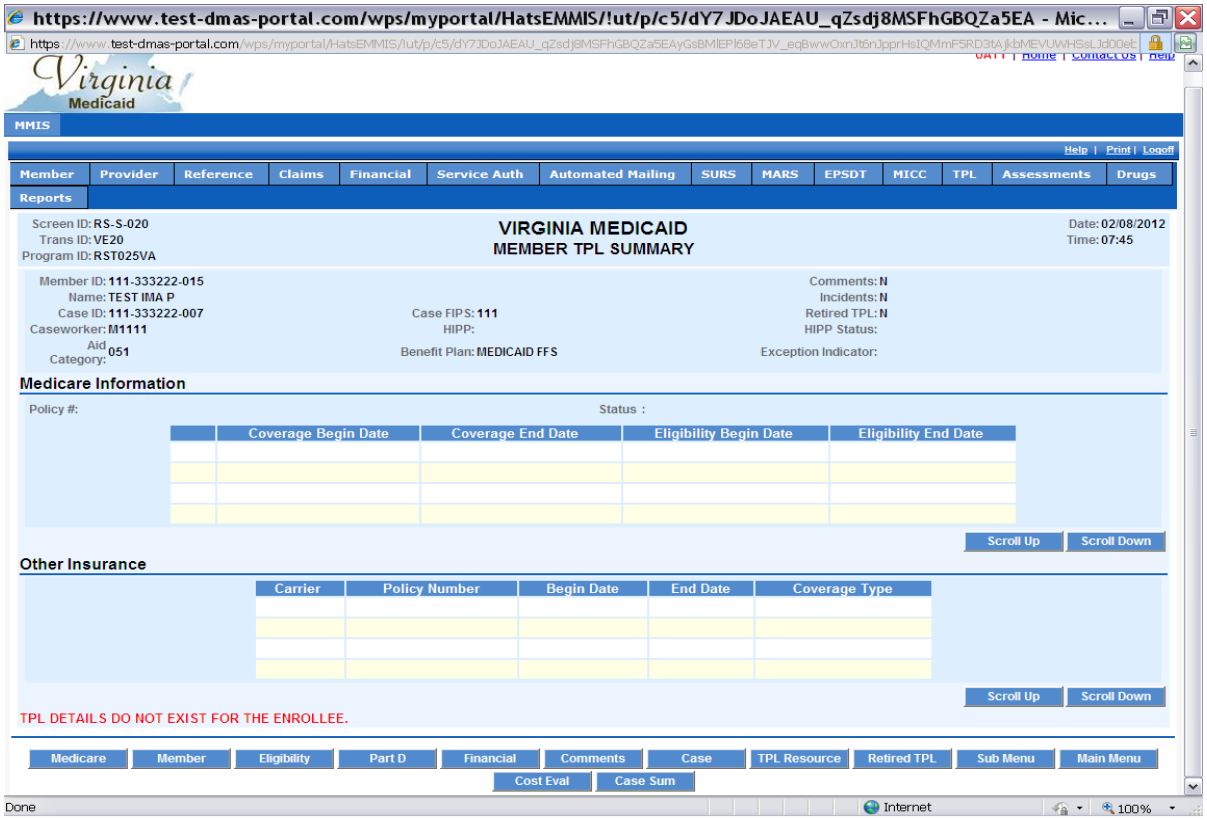
## Medicare Part D Screen

This screen is used to track member Part D eligibility. Only DMAS Buy-In staff can update data on this screen. The screen can be accessed either from the TPL Summary screen or from the TPL Resource screen.

Below is a demonstration of accessing this screen through TPL Summary off the Enrollment Menu.

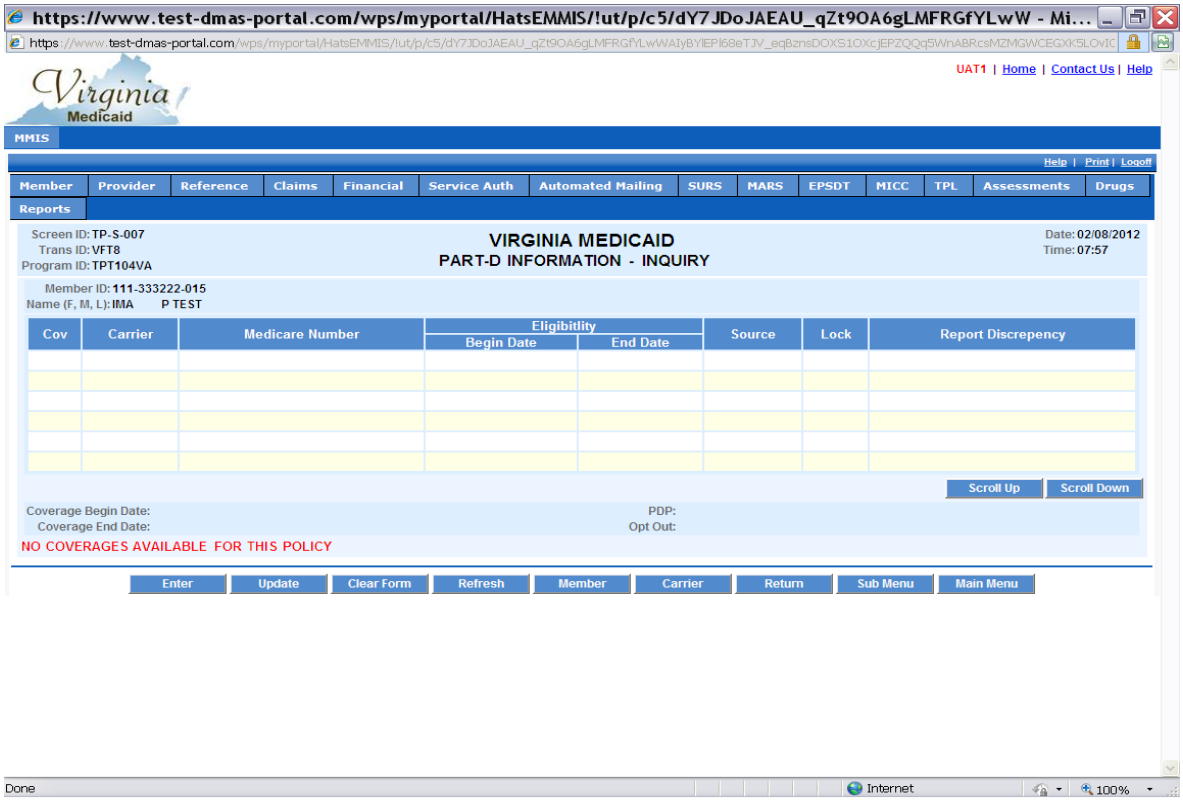



- Select Member, then Inquiry
- Enter member ID
- Select TPL Summary Button




- Select Part D Button

Please note that the TPL Summary Screen provides general information regarding the entire member's TPL record.




**Member ID:** The permanent 12 digit Medicaid number for the chosen member.

**Name:** The member's name.

**Cov:** A code that identifies the Medicare Part D eligibility (RD).

**Carrier Code:** The five character code that identifies the insurance carrier. For Medicare this will always be 00001.

**Medicare Number:** The number at the Social Security Administration (SSA) of an individual on whose earnings benefits are paid or eligibility is established for Medicare coverage.

**Part D Eligibility Begin Date:** The date Part D eligibility began. This date is derived from the earlier of the Part A or B begin dates but no earlier than 1/1/06.

**Part D Eligibility End Date:** The date Part D eligibility ended.

**Source:** A code that identifies the source that last updated or added Part-D eligibility data.

| | |
| --- | --- |
| B | BENDEX batch program |
| H | Buy-In |
| M | CMS MMA response file |
| N | One time batch program |
| S | DSS |

**Lock:** A code that designates whether CMS data can override data already present.

| | |
| --- | --- |
| N | Part D Data not locked |
| Y | Part D Data locked by Buy-In |

**Report Discrepancy:** This is a code that identifies if there is any discrepancy in Part D eligibility.

| | |
| --- | --- |
| N | No discrepancy to display on Buy-In Report |
| S | Discrepancy is valid, don't' display on Buy-In Report |
| Y | Display on Buy-In Report |

**Coverage Begin Date:** The date Part D coverage began. Not currently in use.

**Coverage End Date:** The date Part D coverage ended. Not currently in use.

**PDP:** A number that identifies the managed care benefit package. For Medicare Part-D, this number is a unique identifier for the agreement between CMS and a Medicare Part-D provider, enabling the Medicare Part-D provider to provide prescription drug coverage to eligible beneficiaries. Note: This field is for future use.

**Opt Out:** A code that indicates if the member wishes to opt out of Part-D coverage. Not currently in use.

| | |
| --- | --- |
| N | Not Declined |
| U | Unknown |
| Y | Declined |