



Pharmacy Fax Request to the CMS Regional Office For Point-of-Sale Facilitated Enrollment Claims Over 90 Days Old

Fax to: Regional Office Name: _____
 Fax Number: _____

Please note that the Centers for Medicare & Medicaid Services (CMS) has redesigned the program known as the WellPoint Point-of-Sale Facilitated Enrollment (POS FE) process. Effective January 1, 2010, the program will be known as the Limited Income Newly Eligible Transition program, or Limited Income NET, and will be administered by Humana. WellPoint will continue to accept claims through midnight (EST), December 31, 2009. Pharmacy providers with questions about claims submitted to the POS FE process prior to January 1, 2010 will need to call the NextRx Pharmacy Benefits line at 1-800-957-5147. Effective January 1, 2010, pharmacy providers will need to use the following BIN/PCN to submit claims for the 2010 Limited Income NET program: BIN = 610649, PCN = 05440000. More information on the Limited Income NET program is available online at the following location: http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLINET.asp#TopOfPage.

CMS Regional Office (RO) Number and Name	States/Territories Served	Regional Office Caseworker Fax Number	Regional Office Caseworker Phone # <small>(For follow-up if the pharmacy has not been contacted in 3 bus. days)</small>
RO 1 Boston	CT, MA, ME, NH, RI, VT	617-565-3856	617-565-1232
RO 2 New York	NJ, NY, PR, USVI	212-265-2665	212-616-2222
RO 3 Philadelphia	DE, DC, MD, PA, VA, WV	215-861-4176	215-861-4226
RO 4 Atlanta	AL, FL, GA, KY, MS, NC, SC, TN	404-562-7386	404-562-7500
RO 5 Chicago	IL, IN, MI, MN, OH, WI	312-886-5705	312-353-1102
RO 6 Dallas	AR, LA, NM, OK, TX	214-767-0323	214-767-6401
RO 7 Kansas City	IA, KS, MO, NE	816-426-7604	816-426-5783
RO 8 Denver	CO, MT, ND, SD, UT, WY	303-844-2776	303-844-4024
RO 9 San Francisco	American Samoa, AZ, CA, Northern Mariana Islands, Guam, HI, NV	415-744-3761	415-744-3617
RO 10 Seattle	AK, ID, OR, WA	206-615-2363	206-615-2354

Beneficiary Medicare Number _____
Beneficiary First Name _____
Beneficiary Last Name _____
Date of Birth _____
Gender _____
Street Address _____
Zip Code _____
Date of Service _____
The beneficiary has Medicare and (Please check one):
Medicaid Low Income Subsidy (LIS)
Pharmacy Name _____
Pharmacy Contact _____
Pharmacy Phone Number _____
Pharmacy Email Address _____