# Customer Care Abbreviations, Definitions and Terms - A

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| **Abbreviation** | **Term** | **Definition** |
| **AI / AN** | American Indians & Alaska Natives | After the implementation of Health Insurance Exchanges, all Native Americans, and Alaska Natives (AI/AN) have access to health insurance, Medicaid, or Medicare. The Indian Health Service, tribally operated programs, and urban Indian clinics (I/T/U) can bill the insurance for services they provide, thus creating new sources of revenue.  While the law requires most Americans to acquire health insurance or pay a surcharge, AI / AN are exempt from these penalties. Premium subsidies will be available to low-income individuals enrolled in Exchange plans, up to 400 percent of the federal poverty level (FPL). Because there is a high rate of poverty in AI / AN communities, this benefit would apply to a high percentage who do not have another source of health coverage.  To access this subsidized health insurance, Tribal health programs may choose to pay the unsubsidized portion of the premium for some of their user population. In fact, the Indian Health Care Improvement Act (IHCIA) allows Tribes to make premium payments on behalf of members using federal funds. |
| **A/R or AR** | Accounts Receivable | The department which processes payment issues. |
| **A/R #** | Accounts Receivable number | Unique 6-digit number within the RECAP claim system identifying the plan sponsor responsible for reimbursement of claims and administrative fees. This number may span multiple Billing Account numbers and/or Carrier numbers. |
| **AA** | Allergy Alert | Indicates a possible drug sensitivity or allergy to the prescribed medication. |
| **AAC** | Actual Acquisition Cost | The price a pharmacy pays for a drug. The net payment by a pharmacy to purchase a medication after allowances, discounts, or rebates. |
| **AAD** | After Adjudication | Order stops in this queue when payment is required. |
| **ADR** | Address | The place where prescriptions are mailed to and can vary for each member. |
| **AAM** | Adopt a Member | The Adopt a Member program offers membership the ability to work with a single point of contact. Enrollment is dependent upon historical conflicts. If qualified, the member is placed into a 6-month enrollment and assigned to a dedicated coordinator to help facilitate their account. During this time frame, the coordinator will work with the member to help them understand their benefits and our processes so that they are able to self-serve, without conflict once their enrollment expires.  Icon - Important It is critical that you do not mention the AAM program to members who are not actively enrolled. If you have a member who has consistent historical conflicts and/or multiple escalations, please contact the Senior Team or Supervisor for assistance.  **MED D Note:** If you have a member who has consistent historical conflicts and/or multiple escalations, please contact the Senior Team for assistance. |
| **AAPCC** | Adjusted Average Per Capital Cost | Known as M+C rates. |
| **AAV** | Agent Application Verification | Process to ensure that for each copy of an Agent-Assisted Paper Enrollment application is received and verified, and there is a matching Enrollment Portal record. |
| **AB** | Account Balance | **Types:**  **Maximum Allowable Benefit (MAB):** Refers to the maximum amount that will be covered, during a specified time frame, under a member’s benefit. Once the dollar limit has been reached, the member must pay all prescription costs. This feature can be for any combination of delivery systems as well as specific time frames (lifetime, calendar year, rolling year); specific drug; class of drug; or members at individual level or family level.  **Rationale for feature:** Maximum Allowable Benefits (MABs) are used as a means of offering members freedom of choice in their use of the drug benefit while still reducing the cost exposure to the plan. With coverage maximums, the plan caps the pharmacy program’s spending on an individual member and/or family to a specified monthly, annual, or lifetime amount. Annual maximums are most common. Maximums can also be established for specific drugs or therapeutic classes (for example, fertility MABs can range from $5000 to $10,000 per year). MABs can promote cost effective use of the pharmacy plan - for instance, generic and formulary choices, home delivery preferences, etcetera, since it is to the member’s benefit to reduce prescription spending and make the benefit last longer.    **Maximum Out of Pocket (MOOP):** Refers to the maximum amount that must be paid out-of-pocket toward prescription costs. Once the dollar limit has been reached, all prescription costs are covered at 100%. This feature can be for any combination of delivery systems as well as specific time frames (lifetime, calendar year, rolling year); specific drug; class of drug; or members at individual level or family level.    **Rationale for feature:** Maximum Out of Pocket is a plan design feature selected to protect plan members against an illness that incurs catastrophic prescription costs. To help reduce the cost for both the member and the plan sponsor, the member should consider Generic or Formulary drugs when available.  **Deductible:** Refers to the dollar amount to be paid “out of pocket” prior to co‑payments being affected. This feature can be for any combination of delivery systems as well as specific time frames (lifetime, calendar year, rolling year); specific drug; class of drug; or members at individual level or family level.  **Rationale for feature:** Deductibleis a plan design feature that we offer to help control the rising cost of prescription drugs so that companies can continue to offer the prescription drug benefit. To help reduce the cost for both the member and the plan sponsor, the member should consider Generic or Formulary drugs when available. |
| **ABA** | Abandoned Calls  or  Acknowledgments | Abandoned Calls - Number of callers who hang up before a call is answered.  or  Acknowledgments Time – Scheduled time for Acknowledgements review. |
| **ACA** | Affordable Care Act | The ACA is intended to provide access to healthcare coverage for all, with a goal of lowering the number of uninsured citizens and thus reducing overall healthcare costs. This law also requires insurance companies to cover all applicants within mandated standards regardless of preexisting conditions and policies are marketed through the government website. The Affordable Care Act refers to the federal statute signed into law by President Barack Obama on March 23, 2010. This statute represents one of the most significant revisions of the U.S. healthcare system since the passage of the Social Security Amendments in 1965, which resulted in Medicare and Medicaid. |
| **ACC** | Annual Care Certification | Annual Care Certification courses were created to review the most common call types to enhance effectiveness of the Customer Care Representatives by: Improving skills, reducing average handle time, reducing transfer rate, and improving the member experience. |
| **A&C** | Advice & Counsel | Legal assistance team |
| **ACD** | Automatic Call Distribution | Time spent talking on ACD calls for the corresponding split/skill. |
| **ACCT** | Account | A record containing member information such as ID number, group number, and payment information. |
| **ACH** | Automated Clearing House | Electronic check processing, also known as Electronic Funds Transfer (EFT) or Automated Clearing House (ACH). Allows the beneficiary to pay for premiums via a checking or savings account on a recurring basis.  **Note:** SilverScript beneficiaries can access and print the EFT form:  [www.silverscript.com](http://www.silverscript.com) SNAGHTML1107f639 Documents SNAGHTML1107f639 Automatic Bank Withdrawal Form.  Customer Care Representative(s) (CCRs) cannot obtain the beneficiary’s banking info for Premium Billing Electronic Funds Transfer (EFT/ACH) Payments over the phone. This includes changing bank account numbers for current Stock ID of EFT. Electronic Funds Transfer (EFT/ACH) Payment requests and/or updates are only handled with the beneficiary’s signature and voided check or savings account deposit slip. |
| **ACK** | Acknowledgement | Setting in theSource that allows for the collecting of data when an individual user clicks a button to confirm that they have read updated information. Data regarding which document Acknowledgements have been completed in theSource can be collected and compiled into reports available for access by Supervisors and above who have direct reports or department oversight responsibilities. |
| **ACIP** | Advisory Committee on Immunization Practices | A committee which analyzes a vaccine’s safety and effectiveness and makes recommendations for its safe use by the public. |
| **AH** | ActiveHealth | Management |
| **ACSF** | Advance Control Specialty Formulary | This is a guide with select therapeutic categories for clients, plan members and health care providers. Generics should be considered the first line of prescribing.  If there is no generic available, there may be more than one brand-name medicine to treat a condition. |
| **ACT** | Automatic Continuation of Therapy | This program allows members to enroll prescriptions from a maintenance medication list that they would like CVS Caremark to automatically refill and/or renew. The program is now called Automatic Refill and Renewal. |
| **ACW** | After Call Work | After Call Work may be pressed before hanging up from an ACD call to remove the user from the incoming call queue for only brief periods of time to allow:   * Logging a call appropriately in PeopleSafe. * Entering additional notes where necessary.   **Note:**  ACW should be used sparingly by capturing activity during the call and only to complete actions when a plan member is unable or unwilling to remain on the phone for the total duration of the call.  Time spent working in after call work activities for the corresponding split/skill; refer to Using AFTER CALL WORK - All sites. |
| **ADD** | Attention Deficit Disorder | ADD is an outdated term for what is now called ADHD (attention-deficit hyperactivity disorder). |
| **AD - 2** | San Antonio - Alamo Downs Call Center | Abbreviation refers to San Antonio - Alamo Downs Call Center. |
| **ADHD** | Attention Deficit Hyperactivity Disorder | A syndrome characterized by a persistent pattern of impulsiveness, a short attention span, and hyperactivity. |
| **ADJ** | Adjustment | A change made. |
| **ADL** | Activities of Daily Living | Activities of daily living (ADLs) are basic tasks that must be accomplished every day for an individual to thrive. Generally, ADLs can be broken down into the following categories:   * Personal hygiene - Bathing, grooming, oral, nail and hair care * Continence management - A person’s mental and physical ability to properly use the bathroom. * Dressing - A person’s ability to select and wear the proper clothes for different occasions. * Feeding - Whether a person can feed themselves or needs assistance. * Ambulating - The extent of a person’s ability to change from one position to the other and to walk independently. |
| **Ad Lib.** | At Liberty | Free to perform an action whenever necessary. |
| **ADMIN** | Administrator | A person responsible for running a business, organization, etcetera. |
| **ADMIN Asst** | Administrative Assistant | Support role position. |
| **AADR** | Address | The place where prescriptions are mailed to and can vary for each member. |
| **ADR Ok** | Address Correct | Verified that the location where medication is being sent is correct. |
| **ADV** | Advanced Care Weight Management Program | A clinical program that monitors weight loss drugs and member response to weight loss drugs. |
| **AE** | Account Executive or Auto Enrollment | Account Executive – The person who oversees and manages client accounts.  Auto Enrollment - The process by which full benefit dual eligible individuals are enrolled into a part D plan by Centers for Medicare and Medicaid Services (CMS). |
| **AEP** | Annual Coordinated Election Period/Annual Enrollment Period | The yearly time period from October 15 until December 7 when a Medicare enrollee can renew their existing Medicare Part D plan or change to another Medicare Part D plan. |
| **AER** | Aerosol | A suspension of fine solid or liquid particles that typically come in a spray can for administration. |
| **AF** | Auto Fax | Written communication sent via LINKS to a prescriber. It can request clarification, changes, or further information needed to process a prescription. |
| **AFL** | Annual Fill Limit | Approved number of refills the member can get at the local pharmacy before mandatory MOR is required. |
| **AFW** | Alliance Fort Worth Mail Facility | Fort Worth pharmacy and mail order facility. |
| **AHT** | Average Handle Time | The average duration of the entire customer call transaction, from the time the customer initiates the call to ending the call, including all hold times and transfers, as well as after call work. Usually calculated in seconds. |
| **ALG** | Allergy | Hypersensitivity to a substance. |
| **ALT** | Alternative | A different option. |
| **ALTD RX** | Altered Prescription | A drug order from a prescriber that has changes that may not have been made by the prescriber or his/her authorized agent. |
| **AM** | Account Manager | Account Manager (AM) is an individual who works for us and is responsible for the management of relationships with particular clients. He or she has a shared responsibility to maintain lines of communication with their assigned clients, as well as their PBM partners, including Sales, Client Implementation, Customer Care, Training, and other departments that impact their clients. |
| **AME** | Alleged medical error | If all qualifications are met, a process that allows Prescribers to correct a prescribing error. |
| **AMEX** | American Express | A type of credit card. |
| **AMOS** | AdvancePCS Mail Operating System (Legacy AdvancePCS) | The computer system used to process mail order prescriptions at the Legacy AdvancePCS pharmacies. |
| **AMT** | Amount | A quantity. |
| **ANDA** | Abbreviated New Drug Application | Drug application containing data that, when submitted to Federal Drug Administration’s (FDA's) Center for Drug Evaluation and Research, Office of Generic Drugs, provides for the review and ultimate approval of a generic drug product.   * Generic drug applications are called abbreviated because they are generally not required to include preclinical (animal) and clinical (human) data to establish safety and effectiveness.   + Instead, a generic applicant must scientifically demonstrate that its product is bioequivalent. **Example:**  Performs in the same manner as the innovator drug.   Once approved, an applicant may manufacture and market the generic drug product to provide a safe, effective, low-cost alternative to the American public.  NORMALLY Generic drugs |
| **ANOC** | Annual Notice of Changes | Notification of benefit change to be sent to existing MED D beneficiaries before the upcoming coverage year to identify any changes. The contents of the ANOC generally includes:   * Summary of Benefits * Low Income Subsidy Rider (when applicable) * Pharmacy List * Evidence of Coverage * Abridged Formulary * Multi-language interpreter service letter |
| **ANI** | Automatic Number Identification | A telephony service that allows the receiver of a phone call to capture and display the phone number of the phone that originated the call and is mainly in place for billing purposes. |
| **AOB** | Assignment of Benefits | A form a MED B member or person authorized on their behalf must sign or authorize verbally to give the pharmacy permission to submit claims to Medicare.  Most commonly seen in paper claims (PCL), an AOB allows direct reimbursement for the cost of medications administered (or supplied) in a prescriber’s office or other treatment facility (such as nursing home, rehabilitation facility, cancer treatment center, etcetera) to the provider.  **Example:** Surviving spouse, power of attorney-nursing home situation, provider submitted claims (i.e., hospital take home drugs). |
| **AOC** | Auto Order Creation | As a part of the Automatic Refill Program, a member’s account will automatically create an order for an enrolled prescription 23 days prior to running out of the medication, providing the member with enough time to confirm or cancel the refill. |
| **AOM** | Anti-Obesity Medication | Anti-obesity medication, or weight loss medications, are pharmacological agents that reduce or control excess body fat. Some examples include, but not limited to: Wegovy, Saxenda, Zepbound. |
| **AOR** | Appointment of Representative (appointed representative) | A person selected by the MED D member/beneficiary for a term of a year who can make decisions, file a Grievance or Coverage Determination on their behalf.  MED D Appointed Representative Form (CMS #1696) or equivalent form with required information.    **Example:**   * Client Specific Form * Handwritten Paper with Government required elements.     **Requirements for equivalent form:**   * Beneficiary name * Beneficiary Address * Beneficiary Phone number * Beneficiary Medicare Beneficiary Identifier (MBI)/HICN * AOR Name * AOR Address * AOR Phone Number * Statement that beneficiary is authorizing the representative to act on his/her behalf for the claim(s) at issue and a statement authorizing disclosure of individually identifying information to the representative. * Signed and dated by the enrollee. * Signed and dated by the individual being appointed as representative and accompanied by a statement by the beneficiary.   **Sample Form:** [MED D - Appointment of Representative (AOR) form (096099)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=577a556f-330c-4ea1-b1c6-200d85b736cf) |
| **AMP** | Average Manufacturer Price | Average price paid by drug wholesalers for medications distributed for sale to a retail or hospital pharmacy. |
| **AOT** | Auto Order Translation |  |
| **APE** | Already Paid Edits | Edits performed on claims to ensure the same claim has not already been paid either under a different “date-of- fill” or with a different NDC (within the same generic class of the drug). |
| **API** | Application Programming Interface | A set of rules and specifications that allows different software systems to communicate and interact with each other. |
| **APO** | Army Post Office | Associated with Army or Air Force installations. |
| **Approx** | Approximately | An estimate made that may be close to the actual value. |
| **APPS** | Automated Plan Payment System |  |
| **ARB** | Angiotensin II Receptor Blockers | Medication used to treat high blood pressure. It helps relax veins and arteries to lower blood pressure and make it easier for a heart to pump blood. |
| **ARP** | Auto Refill Program | The ARP prescription refill program allows members to enroll prescriptions from a maintenance medication list that they would like us to automatically refill. Auto Refill allows us to automatically dispense refills without the member initiating the refill request. (Formerly referred to as ARR: Auto Refill/Renew)  **Note:** Not all drugs are available. Certain restrictions and safeguards apply. Client option, refer to CIF and/or Client Program Offerings. |
| **ARxHD** | Aetna Rx Home Delivery |  |
| **AS400** | Application System 400 | Refer to RxClaim. System used to process prescriptions. |
| **ASA** | Average Speed of Answer | Average time it takes to answer the call after the customer has been through the greeting and prompting. |
| **ASCF** | Advanced Control Specialty Formulary | A guide within select therapeutic categories for clients, plan members and health care providers. |
| **ASO** | Administrative Services Only | Agreement that companies use when they fund their employee benefit plan but hire a vendor to administer it. |
| **ATT** | Actual Talk Time | The actual amount of time within a call that is spent speaking with the member/caller. |
| **Att** | Attempt | An effort made to contact the prescriber and questions were discussed. |
| **ATTN** | Attention | Used to bring extra emphasis. |
| **AUTH** | Authorized | Permission given to perform a function. |
| **AUX** | AUX Time | Time spent in non-call taking work. |
| **AVAIL** | Available | Obtainable or Time spent waiting for an ACD call for the corresponding split/skill. |
| **AW ACC** | Awaiting Acceptance | Awaiting Acceptance order in status, indicating possible inventory problem. |
| **AW PROC**  **ACCEPTED** | Awaiting Processing Accepted | Awaiting Acceptance order in status is corrected, no further issues ready for next step of order. |
| **AWP** | Average Wholesale Price | The average or most common price a retail pharmacy would pay a wholesaler to buy a specific quantity of a drug. It is the composite wholesale price charged on a specific commodity. It is assigned by the drug manufacturer and is listed in the red book and on the as400 drug master.  Every drug, brand or generic, has an AWP. In most cases, the AWP is only used for brand medications, but the pricing of a generic claim may be based on the AWP if MAC pricing is not available at the time. |

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| **Term** | **Definition** |
| Agent ID | 5- or 7-digit AVAYA login |
| Accumulator | When a certain dollar amount is reached, the plan parameters regarding that particular accumulator change.  **Note:**  Some plans do not list the total deductible, MAB or MOOP amounts to be met within the **Account Balance** screen. Some members may confuse the abbreviations such as meaning out of pocket when saying deductible so you may have to ask probing questions.  Individual accumulators contain deductible, MAB, and MOOP amounts for a single member on the account. For accounts that have multiple members, family accumulators may contain Personal Health Information (PHI) that should not be released to other members on the account.  Plan features which are based on dollars spent, either by the member or the client. They are based on drug spend. The drug spend is tracked by paid claims and are added up until they reach the dollar limit set by the plan. |
| Abuse | Activities that are inconsistent with typical practices, and that result in an unnecessary cost to the Medicare program, or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. |
| AB rated | AB rating indicates a generic medication that demonstrates to the FDA therapeutic equivalence to the brand it substitutes. |
| Abridged Formualry | List of the most common drug which are covered by the member’s plan. The Abridged Formulary should always be ordered when the beneficiary requests a Formulary unless they specifically request a Comprehensive Formulary. |
| Access to Care | Access to Care is defined as a situation where the member is without, or has the potential to run out of, medication regardless of the reasons. |
| Accordant | This service offers a portfolio of Disease State Management Programs aimed at reducing medical costs through monitoring and educating plan members, one-on-one, and by supporting national, independent treatment guidelines. Plan member-specific customization and frequent telephone communications, via nurse educators, help turn high-risk plan members into low-risk, empowered plan members. |
| Accreditation | Official authorization or approval to an organization determined by an industry-accepted standard(s) and granted by a recognized agency chartered to do so, such as the National Committee for Quality Assurance (NCQA), the Joint Council on the Accreditation of Healthcare Organizations (JCAHO) or the Utilization Review Accreditation Commission (URAC). |
| Acumen | CVS vendor that handles LIS reconciliation process. |
| Acute Conditions and Chronic Condition | Most prescriptions are dispensed for either acute conditions or chronic conditions.  **Acute** conditions are immediate and short-term such as an ear infection. Medications to treat these conditions (such as an antibiotic for an ear infection) are usually needed right away, and because of the time involved, plan members are seldom able to use our mail order service for these medications. Therefore, it is most often best for plan members to have prescriptions for acute conditions filled at a retail pharmacy that is part of our network.  **Chronic** conditions are continuous and long-term such as diabetes. Medications to treat these conditions are needed every day over an extended time period; in some cases, such as diabetes, medication will be needed for the rest of the plan member’s life. It is ordinarily best to have prescriptions for chronic conditions filled through our mail order pharmacy, because the plan member can usually receive a greater days’ supply of medication at a lower cost. |
| Acute Medication | Short term medications. Medications taken over a limited period of time to treat things like strep throat or flu.  **Example:** Antibiotics |
| Adherence | The extent to which members follow a prescribed medication treatment over a selected time period. Refer to Compliance. |
| Additional Drug Benefit list | (Maintenance drug list) A list of medications approved for dispensing in larger quantities for long-term use, versus those that may be purchased one time only, such as for chronic disease conditions (diabetes, hypertension) or ongoing disease maintenance prescription products. |
| Adjustment Services | CVS Health Team responsible for processing claim adjustment. |
| Adjudication | The process of making medication claims payment decisions to determine proper payment, usually accomplished through a series of edits. |
| Adjudication Adverse Drug Reaction | The process of making claims payment decisions that occurs when a particular drug is harmful to a member. |
| Adjudication Claim | The process involving the examination of a claim for eligibility and coverage resulting in payment, denial, or suspension. The Claim system moves through extensive component of eligibility, plan design, network, and clinical edits to prepare a claim for return response to the pharmacy. |
| Adjustment | A credit or debit amount appearing claim level on adjustment advices sent to pharmacies. An adjustment can result from claims processing and/or billing errors (i.e., incorrect dispensing fee paid, incorrect pharmacy paid, incorrect admin fee billed, incorrect Carrier/Group billed). Adjustment transactionsare posted for pharmacies, plan sponsors and general ledger accounts daily and are processed each payment cycle. |
| Administration Fees | A prescriber’s charges for injecting or administering a drug. |
| Administrative Fee Per Prescription | Amount agreed upon between sponsor and PBM for processing each prescription. This is also referred to as “Fee-Per-Claim” which equates to per prescription. |
| Advanced Care | Promoting plan member wellness and quality of life, our new suite of pharmacist-driven wellness programs reduces both pharmacy and medical costs and enhances member productivity. Advanced Care optimizes treatment through health risk assessments, plan member and prescriber education, pharmacist interventions, and ongoing quality of life surveys and reporting. |
| Advanced Care Validation | All CII prescriptions are routed to the ADV queue to validate information on the hardcopy (i.e., prescriber address, prescriber’s license to fill CII’s). |
| Adverse Selection | A term describing what happens when a carrier disproportionately enrolls a population that is a higher user of benefits or services than the norm, which increases the costs associated with care of that population. |
| Affiliate Pharmacy | An independent retail pharmacy contracts with a third-party organization (Affiliation) that represents the independent pharmacy interests, as a united group, to Pharmacy Benefit Managers (PBM’s) or other organizations concerned with retail pharmacy business. Services provided by the Affiliations by contracting with us may vary widely but may include negotiating pricing, centralized billing, payment reconciliation, etcetera. |
| After Max Benefit | Amount paid by the cardholder (cost share) after meeting the predetermined annual benefit maximum. |
| Age Limitation | A restriction of coverage for certain drugs to a specific age. |
| Algorithm | A series of steps that are part of a protocol for a particular drug therapy that indicates the optimal selection of one medication versus another for a particular diagnosis. |
| Algorithms Allowed Charges | Set of steps or protocols for a particular drug therapy. These are charges for services rendered or supplies furnished by a health care provider, which would qualify as covered expenses and for which the insurer will pay in whole or in part, subject to any deductible or coinsurance. |
| Allergen | (Allergy serum) An injectable fluid administered to a member to reduce abnormal sensitivities to certain fluids or substances. Also referred to as biological sera. |
| Allergen Code | A code on ECLIPS defining whether allergens are covered and which formula to use when processing allergen claims. |
| Allowable Charge | The maximum fee (charge) allowed for payment to a provider. |
| Alternate Address | * Member’s “secondary” address. * May represent an address for a purpose such as a seasonal home or a school address. * Requires an effective date and expiration date.   Option available for selection; however, during the effective period, the alternate address will be prioritized over the primary address for display and subsequent selection.  If member sends in correspondence, advise the caller you can **only** update his/her individual address and those for any minor children.  **Note:** Confirmation is required from the other adult members on the account before their individual addresses can be changed. |
| Alternate ID | Alternate ID to using the SSN on the prescription drug card. The alternate ID is normally supplied by the client or their eligibility vendor. |
| Alternative Medicine | Therapies and hands-on practices outside of the traditional Western medicine accepted medical practice, such as acupuncture or herbal therapy. |
| Amount Paid | The amount paid for a claim is the ingredient cost payable, plus the dispensing fee, plus sales tax (if any), plus the product selection incentive (PSI) fee (if any), minus applicable deductible and/or copay. |
| Ampule/Ampoule | A single dose of medication pre-packaged in an injectable glass or plastic container.  **Example:** One **ampule** of bicarbonate is 50 meq (4.2 grams) in 50 mL, and one **ampule** of D50 is 25 grams dextrose in 50 mL. |
| Ancillary Fees | Additional copay charges due to drug being filled that was non-formulary. |
| Annual Benefit Maximum | A predetermined drug benefits payment level for an individual or family beyond which no coverage is available. This limitation is generally established on a one year, 12 calendar month basis. |
| Annual Fill Limit | Number of fills allowed by a plan before member must use home delivery or Maintenance Choice, depending on program offerings. |
| Anorexiant | Agent or a controlled drug which suppress the appetite, such as amphetamine. |
| Anti-Smoking Aids | Prescribed agents which provide nicotine (either through the skin or the mouth mucosa) as substitute for cigarettes or other smoking products. Most anti-smoking aids are considered over-the-counter products. |
| Any Willing Provider | A regulatory or legal requirement that an insurer or health plan must agree to accept any provider in the area that is willing to meet the terms of a contract to provide member care services in the geographic area. |
| Appeal | A request for a benefit that we partially or completely denied.  This applies to the procedures that deal with the review of Adverse Coverage Determinations made on the benefits under a Part D or MMP plan that the Enrollee believes he or she is entitled to receive. This includes a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage.  **There are five levels of appeal:**  1. Appeal Level 1 Redetermination (RD) - Part D  2. Independent Review Entity (IRE), C2C Innovative Solutions  3. Administrative Law Judge (ALJ) Hearing  4. Appeal Level 4 - Medicare Appeals Council (MAC) Review.  5. Appeal Level 5 - Judicial Review by a Federal District Court.  Medicaid Reconsiderations and Redeterminations will follow state specific requirements.  As of February 1st 2021, all appeals, reconsiderations, and 2nd Level of Part D appeals are handled by “C2C Innovative Solutions, Inc.” (C2C), a Qualified Independent Contractor (QIC) / Independent Review Entity (IRE). |
| Appeals Process | An Appeal is a request to reprocess a denied review.  Plan specific steps to request an appeal are provided to the member and prescriber within the denial letter. To request an appeal, there must be a Prior Authorization (PA), Exception, or Initial Benefit Review (IBR) denial on file. If there is no denial, there is nothing to Appeal. |
| Appropriateness | Characteristics of drug therapy referring to the ability to produce desired clinical outcomes through documented and accepted therapeutic protocols. |
| Assist | When a CCR has exhausted all resources but is still unable to resolve an issue and needs additional help/assistance, or work instructions direct CCR to contact a Senior.  **Examples:**   * Job Knowledge * Procedure requires Senior Team outreach |
| Attestation Form | “To attest” means to affirm to be true or genuine and more specifically, to authenticate by signing as a witness.  An attestation form is swearing or affirming information on paper form.  By completing the Declaration of Prior Prescription Drug Coverage, Attestation Form, the beneficiary is swearing to the fact they did or did not have Creditable Coverage during the time frame in question. |
| ATT Language Line | A company that we contract with to provide language assistance beyond English except for Spanish.  **Note:**  For MED D calls, we have a dedicated Bi-lingual line for Spanish calls. |
| Audit Element | Various audible factors of Medicare Part C & Part D programs listed in a CMS Audit Guide and that contain cross references to the Code of Federal Regulations and CMS publications that provide guidelines for Prescription Drug Plans. |
| Audit Support | CVS Health Audit Support Team. |
| Authenticate | To prove genuine; to confirm. Refer to [Universal Care - Caller Authentication (004568)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=bcb8da72-5501-4631-b9fd-fe675bc4a1fd) and [HIPAA (Health Insurance Portability and Accountability Act) Grid - CVS (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce). |
| Authorized Party | An individual authorized under State or other applicable law which has authority to act on behalf of an individual or party who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.  This may include a Power of Attorney (POA), State Health Insurance Assistance Program (SHIP) Counselor, Family Member, etcetera. |
| Authorization Hold | Our home delivery pharmacies will now be processing a credit card authorization upon the receipt of an order and charging the credit card upon completion of the order. In some cases, the authorization amount may remain reflective on an account for up to seven days. |
| Automatic Enrollment | Enrollment process for Full Benefit Dual Eligibles who qualify for Extra Help and assigned to a Prescription Drug Plan (PDP) at random by CMS. |
| Auto Refill | A component of the Auto Refill program, in which we will automatically process a prescription refill when the refill date is reached. |
| Auto Substitution | Program maximizes members’ use of generics without sacrificing clinical efficacy or safety. We substitute only A rated generics from quality approved vendors. |
| Avaya Agent Number | Representatives Avaya ID number. Someone that uses the Avaya Phone system to perform their role. |

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