NEW YORK STATE
MEDICAID PROGRAM

CLINICAL SOCIAL WORKER

150002
BILLING GUIDELINES

TABLE OF CONTENTS

Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Clinical Social Workers and should be used by the provider as an instructional as well as a reference tool.

Section II – Claims Submission

Clinical Social Workers can submit their claims to NYS Medicaid in electronic or paper formats.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and a Certification Statement before submitting claims to NYS Medicaid. Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

Before submitting claims to NYS Medicaid, all providers need the following:

- An ETIN
- A Certification Statement

ETIN
This is a submitter identifier issued by the eMedNY Contractor. All providers are required to have an active ETIN on file with the eMedNY Contractor prior to the submission of claims. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Certification Statement
All providers, either direct billers or those who bill through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Clinical Social Workers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- **HIPAA 837P Implementation Guide (IG)** explains the proper use of the 837P standards and program specifications. This document is available at www.wpc-edi.com/hipaa.

- **NYS Medicaid 837P Companion Guide (CG)** is a subset of the IG which provides specific instructions on the NYS Medicaid requirements for the 837P transaction.

- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications.

These documents are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Pre-requirements for the Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting electronic claims to NYS Medicaid:

- A User ID and Password

- A Trading Partner Agreement

- Testing

User ID and Password

Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement

This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions.

The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Testing

Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims.

Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

ePACES

NYS Medicaid provides a HIPAA-compliant web-based application that is customized for specific transactions, including the 837I. ePACES, which is provided free of charge, is ideal for providers with small-to-medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 - Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

ePACES also features the **real time claim submission** functionality under the 837 Professional transaction, which allows immediate adjudication of the claim. When this functionality is used, a claim adjudication status response is sent to the submitter shortly after submission.

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

Self Help

eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website at www.emedny.org.**

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

CPU to CPU

This method consists of a direct connection established between the submitter and the processor and it is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.

Paper Claims

Clinical Social Workers who choose to submit their claims on paper forms must use the New York State eMedNY-150002 claim form. To view the eMedNY-150002 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Clinical Social Worker - Sample Claim

An ETIN and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and associated certification qualifies the provider to submit claims in both electronic and paper formats.

General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As	
6. C 0	6.00	6. 6 0	→ Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

Written As	Intended As	Interpreted As	
2	2	7	→ Two interpreted as seven
3	3	2	→ Three interpreted as two

- Characters should not touch each other. Example:

Written As	Intended As	Interpreted As	
23	23	illegible	→ Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000 not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If entering information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

COMPUTER SCIENCES CORPORATION
P.O. Box 4601
Rensselaer, NY 12144-4601

Claim Form eMedNY-150002

To view the eMedNY-150002 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Clinical Social Worker - Sample Claim

General Information About the eMedNY-150002

Shaded fields are not required to be completed **unless noted otherwise**. Therefore, shaded fields that are not required to be completed in any circumstance are not listed in the instructions that follow.

Most claim form fields have been sized to contain the exact number of characters for the required information. However, some fields have been sized to accommodate potential future changes. For example, the Provider ID number has more spaces than the current number of characters for the required information. In this case, the entry must be **right justified (unless otherwise noted in the field instructions)**, that is, the extra spaces must be left blank at the left side of the box. For example, Medicaid Provider ID number 02345678 should be entered as follows:

		0	2	3	4	5	6	7	8

Billing Instructions for Clinical Social Worker Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Clinical Social Workers. Although the instructions that follow are based on the eMedNY-150002 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

It is important that the providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

Field by Field Instructions for Claim Form eMedNY-150002

Header Section: Fields 1 through 23B
The information entered in the Header Section of the claim form (fields 1 through 23B) must apply to all claim lines entered in the Encounter Section of the form.

The following two fields (unnumbered) should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

ADJUSTMENT/VOID CODE (Upper Right Corner of Form)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

- If submitting an **adjustment** (replacement) to a previously paid claim, enter 'X' or the value 7 in the 'A' box.
- If submitting a **void** to a previously paid claim, enter 'X' or the value 8 in the 'V' box.

ORIGINAL CLAIM REFERENCE NUMBER (Upper Right Corner of the Form)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record. For example, a document/record containing a single service date/procedure combination will be assigned a unique, single TCN; a document/record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claim lines submitted under that document/record.

Adjustment
An adjustment may be submitted to accomplish any of the following purposes:

- To change information contained in one or more claims submitted on a previously paid TCN
- To cancel one or more claim lines submitted on a previously paid TCN (except if the TCN contained one single claim line or if all the claim lines contained in the TCN are to be voided)

Adjustment to Change Information

If an adjustment is submitted to correct information on one or more claim lines sharing the same TCN, follow the instructions below:

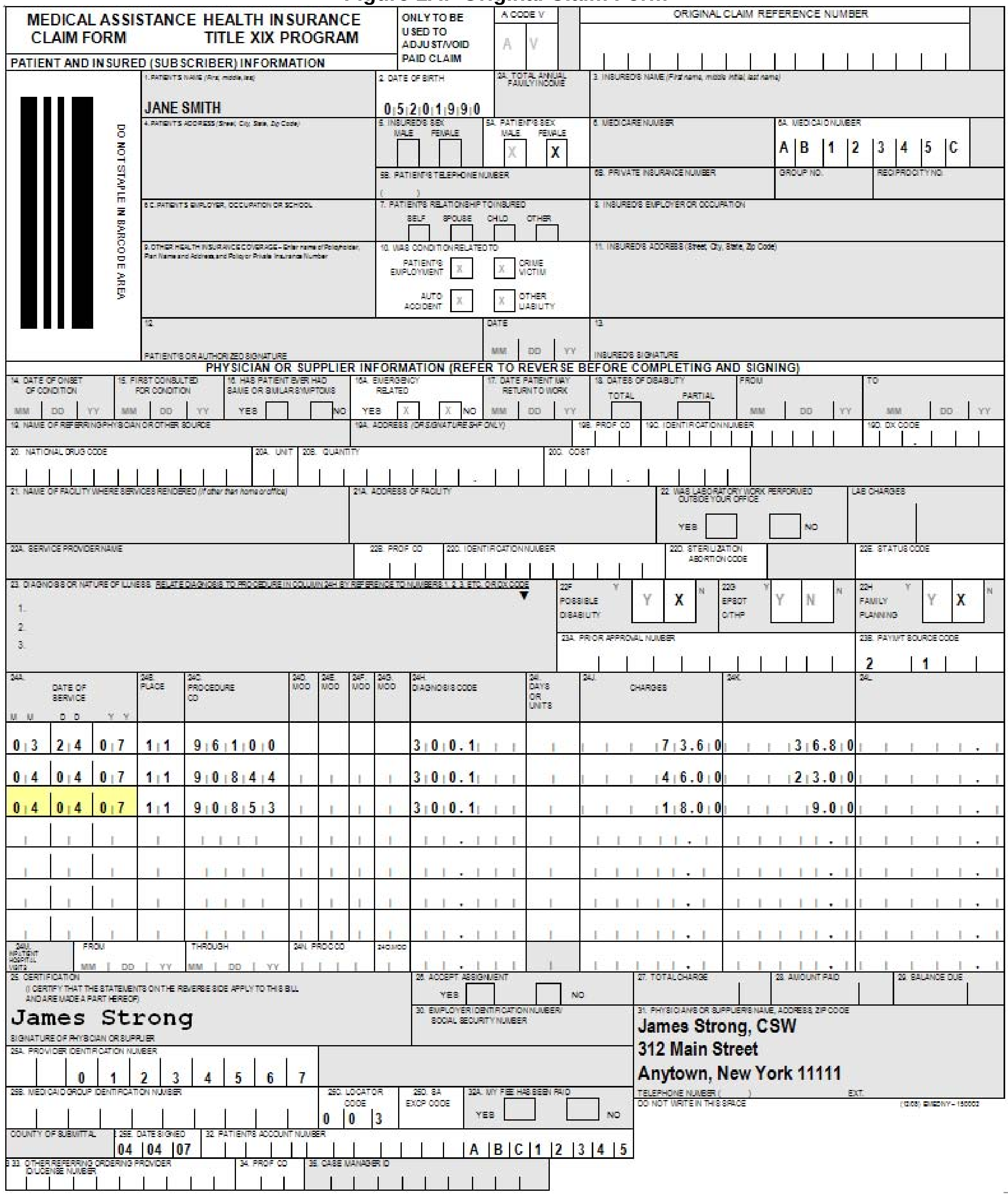
- The **Provider ID number**, the **Group ID number**, and the **Patient's Medicaid ID number** must not be adjusted
- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable)
- The adjustment must contain all claim lines originally submitted in the same document/record (all claim lines with the same TCN) and all applicable fields must be completed with the necessary changes

The adjustment will cause the correction of the adjusted information in the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the TCN based on the adjusted information.

Example:

TCN 0709819876543200 is shared by three individual claim lines. This TCN was paid on April 18, 2007. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Refer to Figures 1A and 1B for an illustration of this example.

Figure 1A: Original Claim Form



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | A CODE V: A V | ORIGINAL CLAIM REFERENCE NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JANE SMITH
2. DATE OF BIRTH: 0 5 2 0 1 9 9 0
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE FEMALE
5A. PATIENT'S SEX: MALE FEMALE X
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: A B 1 2 3 4 5 C
5B. PATIENT'S TELEPHONE NUMBER ( )
6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO.
8. C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policyholder, Plan Name and Address and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X | CRIME VICTIM X | AUTO ACCIDENT X | OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION MM DD YY | 15. FIRST CONSULTED FOR CONDITION MM DD YY | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES NO | 16A. EMERGENCY RELATED YES X X NO | 17. DATE PATIENT MAY RETURN TO WORK MM DD YY | 18. DATES OF DISABILITY TOTAL PARTIAL FROM MM DD YY TO MM DD YY
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE
20. NATIONAL DRUG CODE | 20A. UNIT | 20B. QUANTITY | 20C. COST
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office) | 21A. ADDRESS OF FACILITY | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES NO | LAB CHARGES
22A. SERVICE PROVIDER NAME | 22B. PROF CD | 22C. IDENTIFICATION NUMBER | 22D. STERILIZATION ABORTION CODE | 22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
22F POSSIBLE DISABILITY Y X N | 22G EPSDT C/THP Y N | 22H FAMILY PLANNING Y X N
23A. PRIOR APPROVAL NUMBER | 23B. PAYMT SOURCE CODE: 2 1

24A. DATE OF SERVICE MM	DD	YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
03	24	07	11	96100					300.1		73.60	36.80	
04	04	07	11	90844					300.1		46.00	23.00	
04	04	07	11	90853					300.1		18.00	9.00	

24M. INPATIENT HOSPITAL VISITS FROM MM DD YY THROUGH MM DD YY | 24N. PROC CD | 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

25A. PROVIDER IDENTIFICATION NUMBER: 0 1 2 3 4 5 6 7
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 0 0 3
25D. SA EXCP CODE
COUNTY OF SUBMITTAL | 25E. DATE SIGNED: 04 04 07 | 32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER | 34. PROF CD | 35. CASE MANAGER ID
26. ACCEPT ASSIGNMENT YES NO
27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
James Strong, CSW
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
32A. MY FEE HAS BEEN PAID YES NO
DO NOT WRITE IN THIS SPACE
(12/08) EMEDNY-150002

Figure 1B: Adjustment

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V: 7

ORIGINAL CLAIM REFERENCE NUMBER: 0 7 0 9 8 1 9 8 7 6 5 4 3 2 0 0

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JANE SMITH
2. DATE OF BIRTH: 05201990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE / FEMALE
5A. PATIENT'S SEX: MALE / FEMALE X
5B. PATIENT'S TELEPHONE NUMBER
5C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: AB12345C
6B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X / CRIME VICTIM X / AUTO ACCIDENT X / OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION
15. FIRST CONSULTED FOR CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES / NO
16A. EMERGENCY RELATED: YES X / X NO
17. DATE PATIENT MAY RETURN TO WORK
18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM / TO
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19A. ADDRESS (OR SIGNATURE SHF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER
19D. DX CODE
20. NATIONAL DRUG CODE
20A. UNIT
20B. QUANTITY
20C. COST
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES / NO
LAB CHARGES
22A. SERVICE PROVIDER NAME
22B. PROF CD
22C. IDENTIFICATION NUMBER
22D. STERILIZATION ABORTION CODE
22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
22F POSSIBLE DISABILITY: Y X N
22G EPSDT C/THP: Y N
22H FAMILY PLANNING: Y X N
23A. PRIOR APPROVAL NUMBER
23B. PAYMENT SOURCE CODE: 2 1

24A. DATE OF SERVICE (MM DD YY)	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
03 24 07	11	96100					300.1		73.60	36.80	
04 04 07	11	90844					300.1		46.00	23.00	
04 14 07	11	90853					300.1		18.00	9.00	

24M. INPATIENT HOSPITAL VISITS: FROM MM DD YY — THROUGH MM DD YY — 24N. PROC CD — 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

25A. PROVIDER IDENTIFICATION NUMBER: 01234567
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 003
25D. SA EXCP CODE
25E. DATE SIGNED: 05 23 07
COUNTY OF SUBMITTAL
26. ACCEPT ASSIGNMENT: YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong, CSW
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
32. PATIENT'S ACCOUNT NUMBER: ABC12345
32A. MY FEE HAS BEEN PAID: YES / NO
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER
34. PROF CD
35. CASE MANAGER ID
DO NOT WRITE IN THIS SPACE
(12/05) eMEDNY – 150002

Adjustment to Cancel One or More Claims Originally Submitted on the Same Document/Record (TCN)

An adjustment should be submitted to cancel or void one or more individual claim lines that were originally submitted on the same document/record and share the same TCN. The following instructions must be followed:

- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable)

- The adjustment must contain all claim lines submitted in the original document (all claim lines with the same TCN) **except for the claim(s) line(s) to be voided**; these claim lines must be omitted in the adjustment. All applicable fields must be completed

The adjustment will cause the cancellation of the omitted individual claim lines from the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the new TCN (Adjustment) based on the adjusted information.

Example:

TCN 0709818765432100 contained three individual claim lines, which were paid on April 18, 2007. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Refer to Figures 2A and 2B for an illustration of this example.

Figure 2A: Original Claim

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V: A V — ORIGINAL CLAIM REFERENCE NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JANE SMITH
2. DATE OF BIRTH: 05 20 1990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE FEMALE
5A. PATIENT'S SEX: MALE FEMALE X
5B. PATIENT'S TELEPHONE NUMBER
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: AB12345C
6B. PRIVATE INSURANCE NUMBER — GROUP NO. — RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policyholder, Plan Name and Address and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X; CRIME VICTIM X; AUTO ACCIDENT X; OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION — 15. FIRST CONSULTED FOR CONDITION — 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES NO — 16A. EMERGENCY RELATED: YES X NO — 17. DATE PATIENT MAY RETURN TO WORK — 18. DATES OF DISABILITY: TOTAL PARTIAL FROM TO
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE — 19A. ADDRESS (OR SIGNATURE SHF ONLY) — 19B. PROF CD — 19C. IDENTIFICATION NUMBER — 19D. DX CODE
20. NATIONAL DRUG CODE — 20A. UNIT — 20B. QUANTITY — 20C. COST
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) — 21A. ADDRESS OF FACILITY — 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES NO — LAB CHARGES
22A. SERVICE PROVIDER NAME — 22B. PROF CD — 22C. IDENTIFICATION NUMBER — 22D. STERILIZATION ABORTION CODE — 22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.

22F POSSIBLE DISABILITY: Y N — X
22G EPSDT C/THP: Y N
22H FAMILY PLANNING: Y N — X
23A. PRIOR APPROVAL NUMBER
23B. PAYMT SOURCE CODE: 2 1

24A. DATE OF SERVICE MM	DD	YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
03	24	07	11	96100					300.1		73.60	36.80	
04	04	07	11	90844					300.1		46.00	23.00	
04	04	07	11	90853					300.1		18.00	9.00	

24M. INPATIENT HOSPITAL VISITS — FROM MM DD YY — THROUGH MM DD YY — 24N. PROC CD — 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)
James Strong
SIGNATURE OF PHYSICIAN OR SUPPLIER
25A. PROVIDER IDENTIFICATION NUMBER: 01234567
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 003
25D. SA EXCP CODE
25E. DATE SIGNED: 04 04 07
26. ACCEPT ASSIGNMENT: YES NO
27. TOTAL CHARGE — 28. AMOUNT PAID — 29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong, CSW
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
32A. MY FEE HAS BEEN PAID: YES NO
32. PATIENT'S ACCOUNT NUMBER: ABC1234 5
DO NOT WRITE IN THIS SPACE
COUNTY OF SUBMITTAL
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER — 34. PROF CD — 35. CASE MANAGER ID

(12/05) EMEDNY – 150002

Figure 2B: Adjustment

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE: X V

ORIGINAL CLAIM REFERENCE NUMBER: 0 7 0 9 8 1 8 7 6 5 4 3 2 1 0 0

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last)	JANE SMITH
2. DATE OF BIRTH	05 20 1990
2A. TOTAL ANNUAL FAMILY INCOME	
3. INSURED'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	
5. INSURED'S SEX (MALE / FEMALE)	
5A. PATIENT'S SEX (MALE / FEMALE)	FEMALE: X
5B. PATIENT'S TELEPHONE NUMBER	
6. MEDICARE NUMBER	
6A. MEDICAID NUMBER	AB12345C
6B. PRIVATE INSURANCE NUMBER	
GROUP NO.	
RECIPROCITY NO.	
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL	
7. PATIENT'S RELATIONSHIP TO INSURED (SELF / SPOUSE / CHILD / OTHER)	
8. INSURED'S EMPLOYER OR OCCUPATION	
9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number	
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY	
11. INSURED'S ADDRESS (Street, City, State, Zip Code)	
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE (MM DD YY)	
13. INSURED'S SIGNATURE	

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION	
15. FIRST CONSULTED FOR CONDITION	
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS (YES / NO)	
16A. EMERGENCY RELATED (YES / NO)	
17. DATE PATIENT MAY RETURN TO WORK	
18. DATES OF DISABILITY (TOTAL / PARTIAL) FROM / TO	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
19A. ADDRESS (OR SIGNATURE SHF ONLY)	
19B. PROF CD	
19C. IDENTIFICATION NUMBER	
19D. DX CODE	
20. NATIONAL DRUG CODE	
20A. UNIT	
20B. QUANTITY	
20C. COST	
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)	
21A. ADDRESS OF FACILITY	
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE (YES / NO)	
LAB CHARGES	
22A. SERVICE PROVIDER NAME	
22B. PROF CD	
22C. IDENTIFICATION NUMBER	
22D. STERILIZATION ABORTION CODE	
22E. STATUS CODE	
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE	1. 2. 3.
22F. POSSIBLE DISABILITY (Y / N)	X (N)
22G. EPSDT C/THP (Y / N)	
22H. FAMILY PLANNING (Y / N)	X (N)
23A. PRIOR APPROVAL NUMBER	
23B. PAYMT SOURCE CODE	2 1

24A. DATE OF SERVICE (MM DD YY)	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
04 04 07	11	90844					300.1		46.00	23.00	
04 04 07	11	90853					300.1		18.00	9.00	

24M. INPATIENT HOSPITAL UNITS — FROM (MM DD YY) — THROUGH (MM DD YY) — 24N. PROC CD — 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) SIGNATURE OF PHYSICIAN OR SUPPLIER	James Strong
25A. PROVIDER IDENTIFICATION NUMBER	01234567
25B. MEDICAID GROUP IDENTIFICATION NUMBER	
25C. LOCATOR CODE	003
25D. SA EXCP CODE	
25E. DATE SIGNED	05 23 07
COUNTY OF SUBMITTAL	
26. ACCEPT ASSIGNMENT (YES / NO)	
27. TOTAL CHARGE	
28. AMOUNT PAID	
29. BALANCE DUE	
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE	James Strong, CSW 312 Main Street Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.	
32. PATIENT'S ACCOUNT NUMBER	ABC12345
32A. MY FEE HAS BEEN PAID (YES / NO)	
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER	
34. PROF CD	
35. CASE MANAGER ID	

DO NOT WRITE IN THIS SPACE

(12/03) EMEDNY – 150002

Void

A void is submitted to nullify **all** individual claim lines originally submitted on the same document/record and sharing the same TCN.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form (copy of the original form is unacceptable)
- The void must contain all the claim lines to be cancelled and all applicable fields must be completed

Voids cause the cancellation of the original TCN history records and payment.

Example:

TCN 0709811234567800 contained two claim lines, which were paid on April 18, 2007. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed, and the provider was paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

Figure 3A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | A CODE V: A V | ORIGINAL CLAIM REFERENCE NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): ROBERT JOHNSON
2. DATE OF BIRTH: 06 03 1956
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE FEMALE
5A. PATIENT'S SEX: MALE X FEMALE X
5B. PATIENT'S TELEPHONE NUMBER ( )
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: A B 1 2 3 4 5 C
6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X | CRIME VICTIM X | AUTO ACCIDENT X | OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION MM DD YY
15. FIRST CONSULTED FOR CONDITION MM DD YY
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES NO
16A. EMERGENCY RELATED: YES X X NO
17. DATE PATIENT MAY RETURN TO WORK MM DD YY
18. DATES OF DISABILITY: TOTAL PARTIAL FROM MM DD YY TO MM DD YY
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19A. ADDRESS (OR SIGNATURE SHF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER
19D. DX CODE
20. NATIONAL DRUG CODE | 20A. UNIT | 20B. QUANTITY | 20C. COST
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES NO
LAB CHARGES
22A. SERVICE PROVIDER NAME
22B. PROF CD
22C. IDENTIFICATION NUMBER
22D. STERILIZATION ABORTION CODE
22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
22F. POSSIBLE DISABILITY: Y N — X
22G. EPSDT C/THP: Y N
22H. FAMILY PLANNING: Y N — X
23A. PRIOR APPROVAL NUMBER
23B. PAYMENT SOURCE CODE: 2 1

24A. DATE OF SERVICE MM	DD	YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
03	24	07	11	96100					300.1		43.60	36.80	
04	04	07	11	90844					300.1		46.00	23.00	

24M. INPATIENT HOSPITAL UNITS | FROM MM DD YY | THROUGH MM DD YY | 24N. PROC CD | 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

25A. PROVIDER IDENTIFICATION NUMBER: 0 1 2 3 4 5 6 7
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 0 0 3
25D. SA EXCP CODE
26. ACCEPT ASSIGNMENT: YES NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong, CSW
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
32A. MY FEE HAS BEEN PAID: YES NO
DO NOT WRITE IN THIS SPACE
(12/05) EMEDNY – 150002
COUNTY OF SUBMITTAL
25E. DATE SIGNED: 04 04 07
32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER
34. PROF CD
35. CASE MANAGER ID

Figure 3B: Void

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V: A X

ORIGINAL CLAIM REFERENCE NUMBER: 0 7 0 9 8 1 1 2 3 4 5 6 7 8 0 0

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): ROBERT JOHNSON
2. DATE OF BIRTH: 0 6 0 3 1 9 5 6

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE / FEMALE

5A. PATIENT'S SEX: MALE X / FEMALE X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: A B 1 2 3 4 5 C

5B. PATIENT'S TELEPHONE NUMBER ( )

6B. PRIVATE INSURANCE NUMBER — GROUP NO. — RECIPROCITY NO.

5C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT X / CRIME VICTIM X / AUTO ACCIDENT X / OTHER LIABILITY X
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION — 15. FIRST CONSULTED FOR CONDITION — 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES / NO — 16A. EMERGENCY RELATED: YES X / X NO — 17. DATE PATIENT MAY RETURN TO WORK — 18. DATES OF DISABILITY: TOTAL / PARTIAL, FROM / TO

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE — 19A. ADDRESS (OR SIGNATURE SHF ONLY) — 19B. PROF CD — 19C. IDENTIFICATION NUMBER — 19D. DX CODE

20. NATIONAL DRUG CODE — 20A. UNIT — 20B. QUANTITY — 20C. COST

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) — 21A. ADDRESS OF FACILITY — 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES / NO — LAB CHARGES

22A. SERVICE PROVIDER NAME — 22B. PROF CD — 22C. IDENTIFICATION NUMBER — 22D. STERILIZATION ABORTION CODE — 22E. STATUS CODE

23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.

22F POSSIBLE DISABILITY: Y X N — 22G EPSDT C/THP: Y N — 22H FAMILY PLANNING: Y X N

23A. PRIOR APPROVAL NUMBER — 23B. PAYM'T SOURCE CODE: 2 1

24A. DATE OF SERVICE MM	DD	YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
03	24	07	11	96100					300.1		43.60	36.80	
04	04	07	11	90844					300.1		46.00	23.00	

24M. INPATIENT HOSPITAL VISITS: FROM MM DD YY — THROUGH MM DD YY — 24N. PROC CD — 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO — 27. TOTAL CHARGE — 28. AMOUNT PAID — 29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong, CSW
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 0 1 2 3 4 5 6 7

25B. MEDICAID GROUP IDENTIFICATION NUMBER — 25C. LOCATOR CODE: 0 0 3 — 25D. SA EXCP CODE — 32A. MY FEE HAS BEEN PAID: YES / NO

DO NOT WRITE IN THIS SPACE — (12/08) EMEDNY-150002

COUNTY OF SUBMITTAL — 25E. DATE SIGNED: 05 23 07 — 32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER — 34. PROF CD — 35. CASE MANAGER ID

Fields 1, 2, 5A, and 6A require information which should be obtained from the Client's (Patient's) Common Benefit Identification Card.

PATIENT'S NAME (Field 1)

Enter the patient's first name, followed by the last name.

DATE OF BIRTH (Field 2)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

Example: Mary Brandon was born on January 2nd, 1974.

2. DATE OF BIRTH							
0	1	0	2	1	9	7	4

PATIENT'S SEX (Field 5A)

Place an 'X' in the appropriate box to indicate the patient's sex.

MEDICAID NUMBER (Field 6A)

Enter the patient's ID number (Client ID number). Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

Example:

6A. MEDICAID NUMBER							
A	A	1	2	3	4	5	W

WAS CONDITION RELATED TO (Field 10)

If applicable, place an 'X' in the appropriate box to indicate that the service rendered to the patient was for a condition resulting from an accident or a crime. Select the boxes in accordance to the following:

- **Patient's Employment**
  Use this box to indicate Worker's Compensation. Leave this box blank if condition is related to patient's employment, but not to Worker's Compensation.

- **Crime Victim**
  Use this box to indicate that the condition treated was the result of an assault or crime.

- **Auto Accident**
  Use this box to indicate Automobile No-Fault. Leave this box blank if condition is related to an auto accident other than no-fault or if no-fault benefits are exhausted.

- **Other Liability**
  Use this box to indicate that the condition was an accident-related injury of a different nature from those indicated above.

If the condition being treated is not related to any of these situations, leave these boxes blank.

EMERGENCY RELATED (Field 16A)

Enter an 'X' in the Yes box **only** when the condition being treated is related to an emergency (the patient requires immediate intervention as a result of severe, life threatening or potentially disabling condition); otherwise leave this field blank.

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (Field 19)

If the patient was referred for treatment or a specialty consultation by another provider, enter the referring provider's name in this field.

If no order or referral was involved, leave this field blank.

ADDRESS [or Signature - SHF Only] (Field 19A)

If services were rendered in a **Shared Health Facility** and the patient was referred for treatment or a specialty consultation by another Medicaid provider in the same Shared Health Facility, obtain the Referring/Ordering Provider's signature in this field. If not applicable, leave blank.

PROF CD [Profession Code - Ordering/Referring Provider] (Field 19B)

If a license number is indicated in Field 19C, the Profession Code that identifies the ordering/referring provider's profession must be entered in this field. Profession Codes are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Crosswalks

IDENTIFICATION NUMBER [Ordering/Referring Provider] (Field 19C)

If the patient was referred for treatment or a specialty consultation by another provider, enter the referring provider's Medicaid ID number in this field. If the referring provider is not enrolled in Medicaid, enter his/her license number. New York State license numbers must be preceded by 00; license numbers from states other than New York must be preceded by the standard Postal Office abbreviation (refer to Appendix A-Code Sets).

If no referral was involved, leave this field blank.

Drug Claims Section: Fields 20 to 20C
The following instructions apply to drug code claims <u>only</u>:

- The NDC in field 20 and the associated information in fields 20A through 20C must correspond directly to information on the first line of fields 24A through 24L. Only the first line of fields 24A through 24L may be used for drug code billing.

- Only one drug code claim may be submitted per 150002 claim form; however, other procedures may be billed on the same claim.

NDC [National Drug Code](Field 20)

National Drug Code is a unique code that identifies a drug labeler/vendor, product and trade package size.

Enter the NDC as an 11-digit sequence of numbers. Do not use spaces, hyphens or other punctuation marks in this field.

Note: Providers must pay particular attention to placement of zeroes because the labeler of a particular drug package may have omitted preceding (leading) zeros in any one of the NDC segments. The provider must enter the required leading zeros within the affected segment.

Examples of the NDC and leading zero placement:

Package NDC Number Configuration	Correct Leading Zero Placement for 5-4-2 = 11	NDC Field Example:
XXXX-XXXX-XX *4 + 4 + 2 = 10*	***0****XXXX-XXXX-XX* *5 + 4 + 2 = 11*	20. NATIONAL DRUG CODE **0** | x | x | x | x | x | x | x | x | x | x
XXXXX-XXX-XX *5 + 3 + 2 = 10*	*XXXXX-****0****XXX-XX* *5 + 4 + 2 = 11*	20. NATIONAL DRUG CODE x | x | x | x | x | **0** | x | x | x | x | x
XXXXX-XXXX-X *5 + 4 + 1 = 10*	*XXXXX-XXXX-****0****X* *5 + 4 + 2 = 11*	20. NATIONAL DRUG CODE x | x | x | x | x | x | x | x | x | **0** | x

Unit (Field 20A)

Use one of the following when completing this entry:

UN = Unit
F2 = International Unit
GR = Gram
ML = Milliliter

Quantity (Field 20B)

Enter the numeric quantity administered to the client. Report the quantity in relation to the decimal point.

Note: The preprinted decimal point must be rewritten in blue or black ink when entering a value in this field. The claim will not process correctly if the decimal is not entered in blue or black ink.

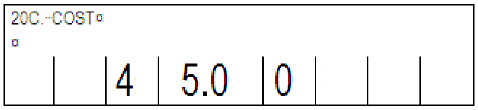
Example:

20B. QUANTITY								
							0.1	5	0

Cost (Field 20C)

Enter based on price per unit (e.g. if administering 0.150 grams **(GM)**, enter the cost of only one gram or unit):

Example:



Note: The preprinted decimal point must be rewritten in blue or black ink when entering a value in this field. The claim will not process correctly if the decimal is not entered in blue or black ink.

What follows is a sample of how a drug code claim would be submitted with another service rendered on the same day.

Sample Drug Code Claim

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | A CODE V | ORIGINAL CLAIM REFERENCE NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): JANE SMITH
2. DATE OF BIRTH: 05 20 1990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE / FEMALE
5A. PATIENT'S SEX: MALE / FEMALE X
5B. PATIENT'S TELEPHONE NUMBER
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: A B 1 2 3 4 5 C
6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION | 15. FIRST CONSULTED FOR CONDITION | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES / NO | 16A. EMERGENCY RELATED: YES / NO | 17. DATE PATIENT MAY RETURN TO WORK | 18. DATES OF DISABILITY: TOTAL / PARTIAL, FROM / TO

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE

20. NATIONAL DRUG CODE: 0 0 7 0 3 6 8 0 1 0 1 | 20A. UNIT: G R | 20B. QUANTITY: 0.1 5 0 | 20C. COST: 4 5.0 0

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) | 21A. ADDRESS OF FACILITY | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES / NO | LAB CHARGES

22A. SERVICE PROVIDER NAME | 22B. PROF CD | 22C. IDENTIFICATION NUMBER | 22D. STERILIZATION ABORTION CODE | 22E. STATUS CODE

23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.

22F POSSIBLE DISABILITY: Y / X | 22G EPSDT C/THP: Y / N | 22H FAMILY PLANNING: Y / X
23A. PRIOR APPROVAL NUMBER | 23B. PAYMENT SOURCE CODE: 1 1

24A. DATE OF SERVICE MM DD YY	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
01 29 09	11	J1955					162.9		6.75		
01 29 09	11	96410					162.9		35.00		

24M. INPATIENT HOSPITAL VISITS: FROM MM DD YY | THROUGH MM DD YY | 24N. PROC CD | 24O. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 0 1 2 3 4 5 6 7

25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE: 0 0 3 | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID: YES / NO

DO NOT WRITE IN THIS SPACE

COUNTY OF SUBMITTAL | 25E. DATE SIGNED: 01 29 09 | 32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER | 34. PROF CD | 35. CASE MANAGER ID

(12/08) EMEDNY – 150002

DX CODE (Field 19D)

Leave this field blank.

NAME OF FACILITY WHERE SERVICES RENDERED (Field 21)

This field should be completed **only** when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility.

ADDRESS OF FACILITY (Field 21A)

This field should be completed **only** when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility.

Note: The address listed in this field does not have to be the facility address. It should be the address where the service was rendered.

SERVICE PROVIDER NAME (Field 22A)

Leave this field blank.

PROF CD [Profession Code - Service Provider] (Field 22B)

Leave this field blank.

IDENTIFICATION NUMBER [Service Provider] (Field 22C)

Leave this field blank.

STERILIZATION/ABORTION CODE (Field 22D)

Leave this field blank.

STATUS CODE (Field 22E)

Leave this field blank.

POSSIBLE DISABILITY (Field 22F)

Place an ‘X’ in the Y box for YES or an ‘X’ in the N box for NO to indicate whether the service was for treatment of a condition which appeared to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months).

EPSDT C/THP (Field 22G)

Leave this field blank.

FAMILY PLANNING (Field 22H)

Leave this field blank.

PRIOR APPROVAL NUMBER (Field 23A)

Leave this field blank.

PAYMENT SOURCE CODE [Box M and Box O] (Field 23B)

This field has two components: Box M and Box O. Both boxes need to be filled as follows:

Box M

The values entered in this box define the nature of the amounts entered in fields 24J and 24K. Box M is used to indicate whether the patient is covered by Medicare and whether Medicare approved or denied payment. Enter the appropriate numeric indicator from the following list.

- **No Medicare involvement – Source Code Indicator = 1**
  Clinical Social Workers should not submit claims to Medicaid if the patient does not have Medicare coverage.

- **Patient has Medicare Part B; Medicare paid for the service – Source Code Indicator = 2**
  This code indicates that the service is covered by Medicare and that Medicare approved the service and made a payment. Medicaid is responsible for reimbursing the Medicare deductible and/or (full or partial) coinsurance.
- **Patient has Medicare Part B; Medicare denied payment – Source Code Indicator = 3**
  Clinical Social Workers should not submit claims to Medicaid if Medicare has denied approval of the service billed.

Box O

Box O is used to indicate whether the patient has insurance coverage other than Medicare or Medicaid or whether the patient is responsible for a pre-determined amount of his/her medical expenses. The values entered in this box define the nature of the amount entered in field 24L. Enter the appropriate indicator from the following list.

- **No Other Insurance involvement – Source Code Indicator = 1**
  This code indicates that the patient does not have other insurance coverage.

- **Patient has Other Insurance coverage – Source Code Indicator = 2**
  This code indicates that the patient has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value 2 is entered in box O, the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount. For the appropriate Other Insurance codes, refer to Information for All Providers, Third Party Information on the web page for this manual.

- **Patient Participation – Source Code Indicator = 3**
  This code indicates that the patient has incurred a pre-determined amount of medical expenses, which qualify him/her to become eligible for Medicaid.

The following chart provides a full illustration of how to complete field 23B and the relationship between this field and fields 24J, 24K and 24L.

23B. PAYM'T SOURCE CO
M / O / /

	BOX M	BOX O
23B. PAYM'T SOURCE CO **1 1** M / O / /	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 1 – **No Other Insurance involvement.** Field 24L must be left blank.
23B. PAYM'T SOURCE CO **1 2** M / O / * / *	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO **1 3** M / O / * / *	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO **2 1** M / O / /	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 1 – **No Other Insurance involvement**. Field 24L must be left blank.
23B. PAYM'T SOURCE CO **2 2** M / O / * / *	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO **2 3** M / O / * / *	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO **3 1** M / O / /	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 1 – **No Other Insurance involvement**. Field 24L must be left blank.
23B. PAYM'T SOURCE CO **3 2** M / O / * / *	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO **3 3** M / O / * / *	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.

Encounter Section: Fields 24A through 24O
The claim form can accommodate up to seven encounters with a single patient, plus a block of encounters in a hospital setting, if all the information in the Header Section of the claim (Fields 1–23B) applies to all the encounters.

DATE OF SERVICE (Field 24A)

Enter the date on which the service was rendered in the format MM/DD/YY.

> **Example:** April 1, 2007 = 04/01/07

Note: A service date must be entered for each procedure code listed.

PLACE [of Service] (Field 24B)

This two-digit code indicates the type of location where the service was rendered. Please note that place of service code is different from locator code. Select the appropriate codes from Appendix A-Code Sets.

Note: If code 99 (Other Unlisted Facility) is entered in this field for any claim line, the exact address where the procedure was performed must be entered in fields 21 and 21A.

PROCEDURE CODE (Field 24C)

This code identifies the type of service that was rendered to the patient. Enter the appropriate five-character procedure code in this field.

Note: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:

Clinical Social Worker Manual

MOD [Modifier] (Fields 24D, 24E, 24F and 24G)

Under certain circumstances, the procedure code must be expanded by a two-digit modifier to further explain or define the nature of the procedure. If the procedure code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

Special Instructions for Claiming Medicare Deductible
When billing for the Medicare **deductible**, modifier **"U2"** must be used in conjunction with the Procedure Code for which the deductible is applicable. **Do not enter** the **"U2"** modifier if billing for Medicare coinsurance.

Note: Modifier values and their definitions are available at www.emedny.org by clicking on the link to the web page below under Procedure Codes and Fee Schedule:

[Clinical Social Worker Manual]

DIAGNOSIS CODE (Field 24H)

Using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) coding system, enter the appropriate code which describes the main condition or symptom of the patient. The ICD-9-CM code must be entered exactly as it is listed in the manual in the correct spaces of this field and in relation to the decimal point.

Note: A three-digit Diagnosis Code (no entry following the decimal point) will only be accepted when the Diagnosis Code has no subcategories. Diagnosis Codes with subcategories MUST be entered with the subcategories indicated after the decimal point.

The following is an example of an ICD-9-CM Diagnosis Code properly entered in Field 24H:

Example:

24H. DIAGNOSIS CODE					
3	**0**	**0.0**	**1**		

DAYS OR UNITS (Field 24I)

If a procedure was performed and approved by Medicare more than one time on the same date of service, enter the number of times in this field. If the procedure was performed only one time, this field may be left blank.

The entries in Field 23B, Payment Source Code, determine the entries in Fields 24J, 24K, and 24L.

CHARGES (Field 24J)

This field must contain the Medicare Approved Amount when billing for CSW diagnostic services. When billing for therapeutic services, enter the Medicare reasonable charge amount.

Medicare Approved Amount
When Box M in field 23B has an entry value of **2**, enter the Medicare Approved Amount in field 24J. The Medicare Approved amount is determined as follows:

- If billing for the Medicare **deductible**, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the established amount for the year in which the service was rendered.

- If billing for the Medicare **coinsurance**, the Medicare Approved amount should equal the sum of the amount paid by Medicare plus the Medicare co-insurance amount plus the Medicare deductible amount, if any.

Medicare Reasonable Charge Amount
Although this amount does not appear on the Medicare Explanation of Benefits (EOMB), it can be calculated by increasing the Medicare Allowed amount by 60%. It may also be calculated by adding together the Medicare Paid amount and the Amount Due from the Patient, both found on the EOMB.

Note: Field 24J must never contain zero. If the Medicare approved amount from the EOMB equals zero, then Medicaid should not be billed.

UNLABELED (Field 24K)

This field must contain the Medicare Paid amount.

- When billing for the Medicare **deductible**, enter 0.00 in this field.

- When billing for the Medicare **coinsurance**, enter the Medicare Paid amount as the sum of the actual Medicare paid amount and the Medicare deductible, if any.

UNLABELED (Field 24L)

This field must be completed when Box O in field 23B has an entry value of **2** or **3**.

- When Box O has an entry value of **2**, enter the other insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid by all other insurance payers in this field.

- When Box O has an entry value of **3**, enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.

If none of the above situations is applicable, leave this field blank.

Note: It is the responsibility of the provider to determine whether the patient's Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.

If the other insurance carrier denied payment enter 0.00 in field 24L. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ► The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - ► In very limited situations the Local Department of Social Services (LDSS) has advised the provider to zero-fill other insurance payment for same type of service. This communication should be documented in the patient's billing record.
- The provider bills the insurance company and receives a rejection because:
  - ► The service is not covered; or
  - ► The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to, or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling. LDSS has subrogation rights enabling them to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third party resource.

- The patient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the patient or absent parent.

- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

Fields 24M through 24O (INPATIENT HOSPITAL VISITS) may be used for block-billing consecutive visits within the SAME MONTH/YEAR made to a patient in a hospital inpatient status.

INPATIENT HOSPITAL VISITS [From/Through Dates] (Field 24M)

Leave this field blank.

PROC CD [Procedure Code] (Field 24N)

Leave this field blank.

MOD [Modifier] (Field 24O)

Leave this field blank.

Note: Leave the last row of Fields 24H, 24J, 24K, and 24L blank.

Trailer Section: Fields 25 through 34
The information entered in the Trailer Section of the claim form (fields 25 through 34) must apply to all of the claim lines entered in the Encounter Section of the form.

CERTIFICATION [Signature of Physician or Supplier] (Field 25)

The billing provider must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

PROVIDER IDENTIFICATION NUMBER (Field 25A)

Enter the Medicaid Provider ID number, which is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Note: The planned National Provider Identifier (NPI) implementation date is September 1, 2008. Until NYS Medicaid accepts and processes claims using the National Provider ID/NPI, providers must continue to report their assigned NYS Medicaid Provider ID number. Providers can check www.emedny.org for up-to-date information as the implementation date approaches.

MEDICAID GROUP IDENTIFICATION NUMBER (Field 25B)

The Medicaid Group ID number is the eight-digit identification number assigned to the Group at the time of enrollment in the Medicaid program.

For a **Group Practice**, enter the Group ID number in this field. A claim should be submitted under the Group ID **only** if payment for the service(s) being claimed is to be made to the group. In such case, the Medicaid Provider ID number of the group member that rendered the service must be entered in field 25A.

For a **Shared Health Facility**, enter the 8-digit identification number assigned to the facility by the New York State Department of Health at the time of enrollment in the Medicaid program.

If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, leave this field blank.

Note: The planned National Provider Identifier (NPI) implementation date is September 1, 2008. Until NYS Medicaid accepts and processes claims using the National Provider ID/NPI, providers must continue to report their assigned NYS Medicaid Provider ID number. Providers can check www.emedny.org for up-to-date information as the implementation date approaches.

LOCATOR CODE (Field 25C)

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. If the provider renders services at one location only, enter locator code 003. If the provider renders service to Medicaid patients at more than one location, the entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.

Notes:

- **Until NPI implementation by NYS Medicaid, the Locator Code field must be completed on both 837P electronic transactions and on paper claim submissions. After NPI implementation, the Locator Code field is only required for paper claim submissions.**

- **The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section on the web page for this manual.**

SA EXCP CODE [Service Authorization Exception Code] (Field 25D)

Leave this field blank.

COUNTY OF SUBMITTAL (Unnumbered Field)

Enter the name of the county wherein the claim form is signed. The County may be left blank **only** when the provider's address is within the county wherein the claim form is signed.

DATE SIGNED (Field 25E)

Enter the date on which the Clinical Social Worker signed the claim form. The date should be in the format MM/DD/YY.

Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, which can be found on the web page for this manual.

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE (Field 31)

Enter the provider's name and address, using the following rules for submitting the ZIP code:

- **Paper claim submissions:** Enter the 5 digit ZIP code or the ZIP plus four.
- **Electronic claim submissions:** Enter the 9 digit ZIP code.

Note: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to Information for All Providers, Inquiry section which can be found on the web page for this manual.

PATIENT'S ACCOUNT NUMBER (Field 32)

For record-keeping purposes, the provider may choose to identify a patient by using an office account number. This field can accommodate up to 20 alphanumeric characters. If an office account number is indicated on the claim form, it will be returned on the Remittance Advice. Using an Office Account Number can be helpful for locating accounts when there is a question on patient identification.

OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 33)

Leave this field blank.

PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 34)

Leave this field blank.

Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- **Subtotals** (by category, status, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers **must** complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available on www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Providers who submit claims under multiple ETINs receive a separate 835 for each ETIN and a separate check for each 835. Also, any 835 transaction can contain a maximum of ten thousand (10,000) claim lines; any overflow will generate a separate 835 and a separate check.

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Note: Providers with only one ETIN, who elect to receive an electronic remittance, will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

Remittance Sorts

The default sort for the paper remittance advice is:
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers **must** complete the Paper Remittance Sort Request Form which is available on www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - Medicaid Check
  - Notice of Electronic Funds Transfer (EFT)
  - Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four:
  - Financial Transactions (recoupments)
  - Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Clinical Social Workers followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID
MANAGEMENT INFORMATION SYSTEM

TO: JAMES STRONG

DATE: 2007-08-06
REMITTANCE NO: 070806000006
PROV ID: 00112233/0123456789

00112233/0123456789 2007-08-06
JAMES STRONG
100 BROADWAY
ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2007-08-06 VOID AFTER 90 DAYS	070806000006	0123456789

PAY

DOLLARS/CENTS
$*****143.80

TO THE ORDER OF

JAMES STRONG
100 BROADWAY
ANYTOWN NY 11111

MEDICAID
MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
CHECKS DRAWN ON
KEY BANK N.A.
60 STATE STREET, ALBANY, NEW YORK 12207

Check Stub Information

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date
Provider's name/Address

Medicaid Check

LEFT SIDE
Table

Date on which the check was issued
Remittance number
* Provider ID No.: This field will contain the NPI **or** the Medicaid Provider ID (if applicable)

Provider's name/Address

RIGHT SIDE
Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

*** Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: JAMES STRONG

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2007-08-06
REMITTANCE NO: 070806000006
PROV ID: 00112233/0123456879

00112233/0123456879 2007-08-06
JAMES STRONG
100 BROADWAY
ANYTOWN NY 11111

JAMES STRONG $143.80

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

Information on the EFT Notification Page

UPPER LEFT CORNER
Provider's name (as recorded in the Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Provider's name/Address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: JAMES STRONG

MEDICAID
MANAGEMENT INFORMATION SYSTEM

DATE: 08/06/2007
REMITTANCE NO: 070806000006
PROV ID: 00112233/0123456789

NO PAYMENT WILL BE RECEIVED THIS CYCLE. SEE REMITTANCE FOR DETAILS.

JAMES STRONG
100 BROADWAY
ANYTOWN NY 11111

Information on the Summout Page

UPPER LEFT CORNER
Provider Name (as recorded in Medicaid files)

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
Notification that no payment was made for the cycle (no claims were approved)
Provider name and address

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 08/06/07
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROV ID: 00112233/0123456789
REMITTANCE NO 070806000006

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF $0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Remittance number

CENTER
Message text

Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle. This section may also contain pending claims from previous cycles that remain in a pend status.

MEDICAID MANAGEMENT INFORMATION SYSTEM

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DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP343444	DAVIS	UU44444R	07206-000000227-0-0	07/11/07	96100	1.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	07206-000011334-0-0	07/11/07	90818	1.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	07206-000013556-0-0	07/19/07	90812	1.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	07206-000032456-0-0	07/20/07	90806	1.000	77.50	0.00	DENY	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	162.20	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	DENIED	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

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DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP112346	DAVIS	UU44444R	07206-000033667-0-0	07/11/07	90806	1.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	07206-000033667-0-0	07/12/07	90812	1.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	07206-000045667-0-0	07/14/07	90826	1.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	07206-000056767-0-0	07/15/07	96100	1.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	07206-000067767-0-0	06/05/07	96100	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/07
01	CP744495	PARKER	VZ45678P	07206-000088767-0-0	06/05/07	90818	13.000	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.40	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PAID	3.60-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		3.60-	NUMBER OF CLAIMS	1

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MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP8765432	CRUZ	LL11111B	07206-000033467-0-0	07/13/07	90826	1.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	07206-000033468-0-0	07/14/07	90853	1.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	07206-000035665-0-0	07/14/07	96100	1.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	07206-000033660-0-0	07/12/07	90812	1.000	14.30	0.00	**PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

REMITTANCE TOTALS – PRACTITIONER

VOIDS – ADJUSTS	3.60-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

MEMBER ID: 00112233

VOIDS – ADJUSTS	3.60-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENIED	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE: 05
DATE: 08/06/07
CYCLE: 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
GRAND TOTALS
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	3.60-	NUMBER OF CLAIMS	1
TOTAL PENDS	168.94	NUMBER OF CLAIMS	4
TOTAL PAID	147.40	NUMBER OF CLAIMS	4
TOTAL DENY	162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID	143.80	NUMBER OF CLAIMS	5

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

UPPER RIGHT CORNER
Remittance page number
Date on which the remittance advice was issued
Cycle number. The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **PRACTITIONER**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Remittance number

Explanation of the Claim Detail Columns

LN. NO. (LINE NUMBER)
This column indicates the line number of each claim as it appears on the claim form.

OFFICE ACCOUNT NUMBER
If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

CLIENT NAME
This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear under this column.

CLIENT ID NUMBER
The client's Medicaid ID number appears under this column.

TCN
The TCN is a unique identifier assigned to each document (claim form) that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

DATE OF SERVICE
This column lists the service date as entered in the claim form.

PROCEDURE CODE
The five-digit procedure code that was entered in the claim form appears under this column.

UNITS

The total number of units of service for the specific claim appears under this column. The units are indicated with three (3) decimal positions. Since Clinical Social Workers must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

CHARGED

This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

PAID

If the claim is approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

STATUS

This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

Denied Claims

Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

Approved Claims

Approved claims will be identified by the statuses **PAID, ADJT** (adjustment), or **VOID**.

Paid Claims

The status PAID refers to **original** claims that have been approved.

Adjustments

The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim) and the debit transaction (adjusted claim).

Voids

The status VOID refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

Pending Claims

Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Client ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

ERRORS

For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are “approved” edits, which identify certain “errors” found in the claim, which do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits may be listed for each claim. Edit code definitions will be listed on the last page(s) of the remittance advice.

Subtotals/Totals

Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by claim **status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by **provider type** are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by **member ID** are provided next to the subtotals for provider type. For individual practitioners these totals are exactly the same as the subtotals by provider type. For practitioner groups, this subtotal category refers to the specific member of the group who provided the services. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

Grand Totals for the entire provider remittance advice appear on a separate page following the page containing the **totals** by **provider type and member ID**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

The Financial Transactions subsection lists all the recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

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DATE 08/06/07
CYCLE 1563

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00112233/0123456879
REMITTANCE NO: 07080600006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	$$.$$

NET FINANCIAL TRANSACTION AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

FCN (Financial Control Number)
This is a unique identifier assigned to each financial transaction.

FINANCIAL REASON CODE
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

FISCAL TRANSACTION TYPE
This is the description of the Financial Reason Code. For example: Third Party Recovery.

DATE
The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

AMOUNT
The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

Totals
The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

Accounts Receivable

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

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DATE 08/06/07
CYCLE 1563

EDICAID
MANAGEMENT INFORMATION SYSTEM

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

REASON CODE DESCRIPTION	ORIG BAL	CURR BAL	RECOUP %/AMT
	$XXX.XX-	$XXX.XX-	999
	$XXX.XX-	$XXX.XX-	999

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

REASON CODE DESCRIPTION
This is the description of the Financial Reason Code. For example: Third Party Recovery.

ORIGINAL BALANCE
The original amount (or starting balance) for any particular financial reason.

CURRENT BALANCE
The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

RECOUPMENT % AMOUNT
The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State
This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/06/07
CYCLE 1563

TO: JAMES STRONG
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
EDIT DESCRIPTIONS
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:

00131	PROVIDER NOT APPROVED FOR SERVICE
00142	SERVICE CODE NOT EQUAL TO PA
00162	RECIPIENT INELIGIBLE ON DATE OF SERVICE
00244	PA NOT ON OR REMOVED FROM FILE

Appendix A – Code Sets

Place of Service

Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
24	Birthing center
25	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
58	Mass immunization center
59	Comprehensive inpatient rehabilitation facility
60	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

United States Standard Postal Abbreviations

State	Abbrev.	State	Abbrev.
Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	New Mexico	NM
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Rhode Island	RI
Iowa	IA	South Carolina	SC
Indiana	IN	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI

American Territories	Abbrev.
American Samoa	AS
Canal Zone	CZ
Guam	GU
Puerto Rico	PR
Trust Territories	TT
Virgin Islands	VI

Note: Required only when reporting out-of-state license numbers.