

New York State Electronic Medicaid System 150003 Billing Guidelines

LABORATORY

Version 2010 - 01 11/18/2010

TABLE OF CONTENTS

1.	Pur	pose Statement	4
2.	Clai	ms Submission	5
	2.1	Electronic Claims	5
	2.2	Paper Claims	6
	2.2.1	L General Instructions for Completing Paper Claims	6
	2.3	eMedNY – 150003 Claim Form	8
	2.4	Laboratory Services Billing Instructions	8
	2.4.1	Instructions for the Submission of Medicare Crossover Claims	8
	2.4.2	2 eMedNY - 150003 Claim Form Field Instructions	9
3.	Ехр	lanation of Paper Remittance Advice Sections	32
	3.1	Section One – Medicaid Check	33
	3.1.1	L Medicaid Check Stub Field Descriptions	34
	3.1.2	2 Medicaid Check Field Descriptions	34
	3.2	Section One – EFT Notification	35
	3.2.1	L EFT Notification Page Field Descriptions	36
	3.3	Section One – Summout (No Payment)	37
	3.3.1	L Summout (No Payment) Field Descriptions	38
	3.4	Section Two – Provider Notification	39
	3.4.1	Provider Notification Field Descriptions	40
	3.5	Section Three – Claim Detail	41
	3.5.1	L Claim Detail Page Field Descriptions	45
	3.5.2	2 Explanation of Claim Detail Columns	45
	3.5.3	3 Subtotals/Totals/Grand Totals	48
	3.6	Section Four – Financial Transactions and Accounts Receivable	49
	3.6.1	l Financial Transactions	49
	3.6.2	2 Accounts Receivable	51
	3.7	Section Five – Edit (Error) Description	53
Α	ppendi	x A Claim Samples	54

pendix B Code Sets	- 1
Jennia R i Que zeta	۱r

For eMedNY Billing Guideline questions, please contact the eMedNY Call Center 1-800-343-9000.

LABORATORY 11/18/202

1. 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 Laboratory providers and should be used by the provider as an instructional as well as a reference tool. For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

LABORATORY

Version 2010 - 01 11/18/2010

2. Claims Submission

Laboratory providers 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.

Providers will be asked to update their Certification Statement on an annual basis. Providers will be provided with renewal information when their Certification Statement is near expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.1 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.

Laboratories 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. This document is available at www.emedny.org by clicking on the link to the web page as follows: Companion Guides and Sample Files.
- 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. This document is available at www.emedny.org by clicking on the link to the web page as follows: Companion Guides and Sample Files.

Further information about electronic claim pre-requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2 Paper Claims

Laboratory providers who choose to submit their claims on paper forms must use the New York State eMedNY-150003 claim form.

To view a sample eMedNY - 150003 claim form, see Appendix A below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

An Electronic Transmission Identification Number (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 the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2.1 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 entries are 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 in Exhibit 2.1.1-1 as possible:

Exhibit 2.1.1-1



- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.1.1-2.

Exhibit 2.1.1-2

Written As	Intended As	Interpreted As
6. 0 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. See the example in Exhibit 2.1.1-3.

Exhibit 2.1.1-3

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

Characters should not touch each other as seen in Exhibit 2.1.1-4.

Exhibit 2.1.1-4

Written As	Intended As	Interpreted As	
28	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 filling in 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:

P.O. Box 4601 Rensselaer, NY 12144-4601

2.3 **eMedNY - 150003 Claim Form**

The 150003 form is a New York State Medicaid form that can be obtained through the financial contractor (CSC). To order the forms, please contact the eMedNY call center at 1-800-343-9000.

To view a sample Laboratory eMedNY - 150003 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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.

2.4 Laboratory Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Laboratory providers. Although the instructions that follow are based on the eMedNY-150003 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims, in addition to the HIPAA Companion Guides which are available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Companion Guides and Sample Files.

It is important that 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.

2.4.1 Instructions for the Submission of Medicare Crossover Claims

This subsection is intended to familiarize the provider with the submission of crossover claims. Providers can bill claims for Medicare/Medicaid patients to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid.

Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows. Also, *Medicare Part-C* (Medicare Managed Care) and *Medicare Part-D* claims are *not* part of this process.

Providers are urged to review their Medicare remittances for crossovers beginning December 1, 2009, to determine whether their claims have been crossed over to Medicaid for processing. Any claim that was indicated by Medicare as a crossover should not be submitted to Medicaid as a separate claim. If the Medicare remittance does not indicate that the claim has been crossed over to Medicaid, the provider should submit the claim directly to Medicaid.

- Claims that are denied by Medicare will not be crossed over.
- Medicaid will deny claims that are crossed over without a Patient Responsibility.

If a separate claim is submitted directly by the provider to Medicaid for a dual eligible recipient and the claim is paid before the Medicare crossover claim, both claims will be paid. The eMedNY system automatically voids the provider submitted claim in this scenario. Providers may submit adjustments to Medicaid for their crossover claims, because they are processed as a regular adjustment.

Electronic remittances from Medicaid for crossover claims will be sent to the default ETIN when the default is set to electronic. If there is no default ETIN, the crossover claims will be reported on a paper remittance. The ETIN application is available at www.emedny.org by clicking on the link to the webpage as follows: <u>Provider Enrollment Forms</u>.

NOTE: For crossover claims, the Locator Code will default to 003 if the submitted ZIP+4 does not match information in the provider's Medicaid file.

2.4.2 eMedNY - 150003 Claim Form Field Instructions

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 unnumbered fields 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 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.

2.4.2.1 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).

Version 2010 - 01 11/18/2010

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.

Exhibit 2.4.2.1-1 and Exhibit 2.4.2.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 1029119876543200 is shared by three individual claim lines. This TCN was paid on October 18, 2010. 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. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-1

TIENT AND INS	SURED (SUBSCI	RIBE	R) INF	ORMA	TION		PAID CL		AV		1.1.1	1.1.1	1.1	1 1 1 1	1.1.1	
	BO	1. PATIENT	S NAME	(First, m	iddle, last		2. DATE OF	BIRTH	2A	TOTAL ANN	UAL OME	3. INSURED	'S NAME (F	irst name, m	ddle initial, last n	ame)	
	NOT	JANE S			City. State	. Zip Code		0 1 1 9		IT'S SEX FEMALE	6. MEDIC	CARE NUMBE	ER		6A. MEDICAID I	NUMBER	
							MALE	FEMALE	MALE	FEMALE					X X 1 2		
	STAPLE						5B. PATIEN	T'S TELEPHON	E NUMBER		6B. PRIV	ATE INSURA	ANCE NUME	ER	GROUP NO.		OCITY NO.
	Z B	6C. PATIENT	'S EMPLO	OYER, OCC	UPATION	OR SCHOO	OL 7. PATIENT	'S RELATIONS	HIP TO INSU	RED	8. INSUR	RED'S EMPLO	OYER OR O	CCUPATION			
	BARCODE						SELF	SPOUSE	CHILD	OTHER							
		OTHER HE of Policy H Private Inst	older, Plan	Name and	OVERAGE Address, a	-Enter Nan nd Policy or	PATIEN		- C	RIME	11. INS	URED'S ADD	ORESS (Stre	et, City, Stati	e, Zip Code)		
6	AREA	Tivate sist	naros rea	inuci			EMPLOYME			ICTIM							
							ACCIDE	NT X		THER ABILITY			Tip:				
		12.							DATE		13.						
		PATIENT'S	OR AUT	HORIZED	SIGNATU	IRE			мм	DD YY	INSURE	D'S SIGNATI	URE				
TE OF ONSET 15.F	PH IRST CONSU						MATION (RSE BE		COMPLI S OF DISABI		AND SIG	NING)	то	
CONDITION F	OR CONDITI	ON O	R SIMIL	AR SYMP	TOMS	NO	RELATED YES X	NO X NO	RETURN	TO WORK			PARTIAL	MM	DD Y		DD Y
ME OF REFERRING PH								S (OR SIGNATO			19B.PR	OF CD 19C	IDENTIFICA	TION NUMB		19D.DX CC	
ATIONAL DRUG CODE		204	LINIT 2	0B. QUAN	TITY			20C.COS	ST		INDO				6 7 8 ill only be associa		claim line b
1 1 1 1 1	1 1 1	1		I I	1 1	1.1	1 • 1	1 1		T T T							
ME OF FACILITY WHEF	RE SERVICES	RENDERED	(if othe	r than ho	ne or offi	ce) 21	A. ADDRESS O	F FACILITY				1111	22. WAS LA OUTSID	BORATORY E YOUR OF	WORK PERFOR	MED LAB CI	IARGES
ERVICE PROVIDER NA	ME						22B.PROF CI	22C.IDENT	IFICATION 1	UMBER		Philippine I	YES 22D.STERIL	IZATION		22E. ST	ATUS COD
													ABORT	ION CODE			
AGNOSIS OR NATURE C	F ILLNESS. F	RELATE DIAG	NOSIS T	O PROCE	DURE IN	COLUMN	24H BY REFERE	NCE TO NUMBE	ERS 1, 2, 3 E	TC. OR DX C	POSSI	IBLE	N	22G. Y EPSDT C/THP	YN	22H. Y FAMILY PLANNING	YX
											DISAB 23A.P	PRIOR APPR	OVAL NUME				YM'T SOURC
									Tan					Tour .		124	1
SERVICE PI	B. 24C. LACE PRO	CEDURE	24D. MOD	MOD	MOD	MOD	DIAGNOS	SIS CODE	DAYS OR		24J.	CHARGES		24K.		24L.	
	200								UNITS							atti pa inden securitorio	
9 1 4 1 0	85	4 7 5					6 4 8.2	2	Ш		+	1	2.26			+	
9 1 4 1 0	86	7 6 2					6 4 8	2				1	5.9 1				1.
Latina	1 -1:	1-1-1-					212122	1 1 1		1 1 1		1 1 1			1 1	1 1	1
9 1 3 1 0	81	025					6 4 8 2		\vdash		+		2.0 0				•
		Ш					Ш.		Ш						1.		
			1				1.1	LIE	1,,,	111		1.1.1		111	1.1		i.
			_				•				+		•				•
	\perp								\vdash		+						
		111					11.	111	111	111					11.		1.
FROM FROM	THE	ROUGH		24N. PRO	C CD	240.MOD						1 1 1					
ITAL IS ERTIFICATION	YY (3)	TOD:	YY				26. ACCEPT	ASSIGNMENT			27. TOT/	AL CHARGE	28	B. AMOUNT I	PAID	29. BALANCE D	UE
CERTIFY THAT THE STATE ND ARE MADE A PART HER	MENTS ON THI IEOF.)	E REVERSE SIC	DE APPLY	TO THIS E	IILL		YES			NO							
nes Strong							30. EMPLOYI SOCIAL S	ER IDENTIFICA SECURITY NUN	TION NUMB	ER/		sician's on Labora		S NAME, AD	DRESS, ZIP CO	DE	
TURE OF PHYSICIAN OR S PROVIDER IDENTIFICA		R		1840.55							1000000	Main Sti					
1 2 3 4			3 9	000	.001	Lone	CA LOOL:	W EEE 1140 00	EN DATE		Anyto	own, NY	/ 1111	1			
MEDICAID GROUP IDER	NTIFICATION	NOWREK	1	25C. TOR	CODE 0 3		SA 32A. N	Y FEE HAS BE	EN PAID	NO	TELEBRA	ONE NUMBE	B (EXT.	
NTY OF SUBMITTAL		E SIGNED		. PATIENT	'S ACCO		IBER		-			WRITE IN			(9/1	0) EMED!	JY-150
	09	29 10)	1.1	1 1			x x	11213	4 5 >					(5/1	U) LIVILDI	. 100

Exhibit 2.4.2.1-2

MEDICAL ASSISTANCE HEALTH INSURANCE	ONLY TO BE A CODE V	ORIGINAL TRANSACTION CONTROL NUMBER	
CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	USED TO ADJUST/VOID PAID CLAIM 7	1 0 2 9 1 1 9 8 7 6 5 4 3 2 0 0)
1. PATIENT'S NAME (First, middle, last) 2. DATE OF		L 3. INSURED'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, City, State, Zip Code) 5. INSURED	O 1 9 9 0 S SEX 5A. PATIENT'S SEX FEMALE 5A. PATIENT'S SEX 6	5. MEDICARE NUMBER 6A. MEDICAID NUMBER	
	XX	X X 1 2 3 4 5 B. PRIVATE INSURANCE NUMBER GROUP NO. RECIP	ROCITY NO.
	S RELATIONSHIP TO INSURED SPOUSE CHILD OTHER	B. INSURED'S EMPLOYER OR OCCUPATION	
of Policy Holder, Plan Name and Address, and Policy or	rs Color CRIME	11. INSURED'S ADDRESS (Street, City, State, Zip Code)	
Private insurance number EMPLOYME	NT VICTIM		
ACCIDE 12.		13.	
PATIENT'S OR AUTHORIZED SIGNATURE PHYSICIAN OR SUPPLIER INFORMATION (INSURED'S SIGNATURE ORE COMPLETING AND SIGNING)	
14.DATE OF ONSET OF CONDITION 15.FIRST CONSULTED 16.HAS PATIENT EVER HAD SAME 16A. EMERGEI OF CONDITION OR SIMILAR SYMPTOMS RELATED	17.DATE PATIENT MAY RETURN TO WORK	8.DATES OF DISABILITY FROM TO TOTAL PARTIAL	
MM DD YY MM DD YY YES NO YES YES 199.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 194.ADDRESS	OR SIGNATURE SHF ONLY)	19B.PROF CD 19C.IDENTIFICATION NUMBER 19D.DX C	DD YY ODE
20. NATIONAL DRUG CODE 208. QUANTITY	20C.COST	NDC info entered to the left of this field will only be associated with the 1s	t claim line below
	TOWNS -	22. WAS LABORATORY WORK PERFORMED LAB C	CHARGES
21.NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) 21.A. ADDRESS OF	FACILITY	22. WAS LABORATORY WORK PERFORMED CASE OUTSIDE YOUR OFFICE YES \(\text{NO} \) NO \(\text{NO} \)	HARGES
22A.SERVICE PROVIDER NAME 22B.PROF CD	22C.IDENTIFICATION NUMBER	22D.STERILIZATION ABORTION CODE 22E.S	TATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERE	NCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE	POSSIBLE EPSOT FAMILY	Y X N
1. 2.		DISABILITY C/THP PLANNING 23A. PRIOR APPROVAL NUMBER 23B. P	AYM'T SOURCE CD
3. 24A. DATE OF 24B. 24C. 24D. 24E. 24F. 24G. 24H.	241.	24J. 24K. 24L.	1
DATE OF SERVICE PLACE PROCEDURE MOD MOD MOD MOD MOD DIAGNOS	IS CODE DAYS OR UNITS	CHARGES	
0 9 1 4 1 0 8 5 4 7 5		1 2 • 2 6 •	1.1
0 9 1 4 1 0 8 6 7 6 2 6 4 8.2		1 5.9 1 .	
0 9 1 4 1 0 8 1 0 2 5 6 4 8,2	2		1.
			1.1
			1.1
			T. I
24M. FROM THROUGH 24N. PROC CD 240.MCD	way material to		
	ASSIGNMENT	27. TOTAL CHARGE 28. AMOUNT PAID 29. BALANCE	DUE
() CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) 30. EMPLOYE 30. EMPLOYE	R IDENTIFICATION NUMBER/	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE	
SIGNATURE OF PHYSICIAN OR SUPPLIER		ABC Laboratory	
25A PROVIDER IDENTIFICATION NUMBER 1 1 2 3 4 5 6 7 8 9		312 Main Street Anytown, NY 11111	
25B. MEDICAID GROUP IDENTIFICATION NUMBER 25C. LOCATOR CODE 25D. SA EXCP CODE 25D. S	Y FEE HAS BEEN PAID		
COUNTY OF SUBMITTAL 25E, DATE SIGNED 32, PATIENT'S ACCOUNT, NUMBER		TELEPHONE NUMBER () EXT. DO NOT WRITE IN THIS SPACE. (9/10) EMED	NY-150001
09 29 10 34. PROF CD 35. CASE MANAGER ID	X X 1 2 3 4 5 X	(0/10) ENIED	150000
IDLICENSE NO.			

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.

Exhibit 2.4.2.1-3 and Exhibit 2.4.2.1-4 illustrate an example of a claim with an adjustment being made to cancel a line on submitted on the claim. TCN 1029119876543200 contained three individual claim lines, which were paid on October 18, 2010. 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. Exhibit 2.4.2.1-3 shows the claim as it was originally submitted and Exhibit 2.4.2.1-4 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-3

TIENT AND INSUR	TITLI ED (SUBSC						PAID CL		AV	1					
	1. PATIENT	'S NAME	(First, m	iddle, last		2. DATE OF	BIRTH		2A. TOTAL ANN FAMILY INC	UAL OME	3. INSURED'S	NAME (Fi	rst name, middle	initial, last n	ame)
	JANE S			City, State	, Zip Code)	0 5 2 5. INSURED	0 1 9 SEX		ENT'S SEX	6. ME	EDICARE NUMBER	1	6A.	MEDICAID I	NUMBER
	S					MALE	FEMALE	MA	ENT'S SEX FEMALE				X	X1112	3 4 5 X
	APLE					5B. PATIEN	IT'S TELEPHON	IE NUMBI	R	6B. P	PRIVATE INSURAN	ICE NUMB		OUP NO.	RECIPROCITY NO.
	Z	T'S EMPLO	VER OCC	LIPATION	OR SCHOOL	7 PATIENT	S RELATIONS	HIP TO IN	SURED	8 INS	ISURED'S EMPLOY	ER OR O	CUPATION		
	BARCODE 9. OTHER HI	O LIIII CO	121, 000			SELF		CHILE							
	9. OTHER HE of Policy H	lolder, Plan	Name and			10. WAS C	ONDITION REL	ATED TO	CRIME	11.	INSURED'S ADDR	ESS (Stree	t, City, State, Zi	o Code)	
	ARE A	surance Num	tber			EMPLOYM	ENT	Ä	VICTIM						
						ACCIDI	UTO X	X	OTHER LIABILITY						
	12.							DATE		13.					
				010				ММ	DD YY		UDEDIO CIONA				
	PHYSICIAN					MATION	(REFER T	O RE	VERSE BE	FOR	E COMPLE	TING A	ND SIGN	NG)	
TE OF ONSET 15.FIRST CONDITION FOR CO	ONSULTED 16.H		ENT EVE	R HAD S		16A.EMERGE RELATED	NCY	17.DATE	PATIENT MAY RN TO WORK	18.DA	ATES OF DISABILI	TY RTIAL	FROM		то
	D YY YES				NO	YES X	S (OR SIGNATI		DD YY ONLY)	19B	B.PROF CD 19C.II			DD Y	Y MM DD Y
	37. 57.71.57												3 4 5 6	17181	
TONAL DRUG CODE	20/	A.UNIT 20	B. QUAN	TITY			20C.CO	ST			NDC info entered t	the left o	f this field will or	ly be associa	ated with the 1st claim line be
TE OF FACILITY WHERE SEP	VICES RENDERE	D (if other	than ho	me or offi	ne) 21A	ADDRESS O	F FACILITY				122	. WAS LAN	BORATORY WO	RK PERFOR	MED LAB CHARGES
												OUTSIDI	YOUR OFFICE		
RVICE PROVIDER NAME					Q Est	22B. PROF CI	D 22C.IDENT	TIFICATIO	NUMBER		22	D.STERILI ABORTI	ZATION ON CODE		22E.STATUS COD
GNOSIS OR NATURE OF ILLN	ESS. RELATE DIAG	NOSIS TO	O PROCE	DURE IN	COLUMN 24	H BY REFERE	NCE TO NUMBI	ERS 1, 2,	3 ETC. OR DX CO	ODE 22	2F. Y	n I	22G. Y [T N	[22H. Y [
										P	OSSIBLE ISABILITY	y Hill	EPSDT C/THP	N	FAMILY X X
										23	3A. PRIOR APPRO	VAL NUMB	ER		23B. PAYM'T SOURC
DATE OF 24B.	24C.	24D.	24Ë.	24F.		4H.		24I. DAYS		24J	J.		24K.		24L.
SERVICE PLACE	PROCEDURE CD	MOD	MOD	MOD	MOD	DIAGNO	SIS CODE	OR UNITS			CHARGES				
		,				1 1					1 1 1 1		1 1 1		
1 4 1 0	8 5 4 7 5					6 4 8.2	2	+		+	1 2	.2 6			
1 4 1 0	8 6 7 6 2					6 4 8.2	2				1 5	.9 1			<u> </u>
1 1 1 0	8 1 0 2 5					6 4 8.	2	1	1111		2	00	111	1	
	0 1 0 2 3					0 4 0.				_	1 1 1 2	0			
				Ш	Щ			+		+					
						II.								L.	
	1111	y.				7.7	1 1 1		1 1 1 1		1 1 1 1		1 1 1		
								+		+		•			-
TITI															
	THROUGH	24	4N. PRO	C CD	240.MOD	т т	1 1 1					1	1.1.1	r	
FROM	TABLE TOO	DE APPLICA	TO T	W		26. ACCEPT	ASSIGNMENT			27. T	TOTAL CHARGE	28	AMOUNT PAID		29. BALANCE DUE
AT AL STIFICATION	W THE DESERVE	UE APPLY	IO IHIS B	OILL.		YES			NO						
NT AL INTERCATION ERRIFY THAT THE STATEMENTS	ON THE REVERSE SI					SOCIAL:	ER IDENTIFICA SECURITY NUM	MBER NU	MBEH/		PHYSICIAN'S OR S		NAME, ADDRE	:SS, ZIP CO	UE
NT AL. Intercation Part											BC Laborat				
NT ALL STREET, ALL										31	12 Main Str	eet			
NT AS A STATEMENTS THAT THE STATEMENTS RETRIEV THAT THE STATEMENTS ARE MADE A PART HEREOF.) ILLES STRONG URE OF PHYSICIAN OR SUPPLIES ROVIDER IDENTIFICATION IN 1 2 3 4 5 5	I IUMBER 5 6 7	8 9									12 Main Str nytown, NY		1		
NT AS STATEMENTS ARE THAT THE STATEMENTS RETRIEV THAT THE STATEMENTS ARE MADE A PART HEREOF.) THE STORY THE STATEMENT OF SUPPLIES STRONG THE STATEMENT OF SUPPLIES ROVIDER IDENTIFICATION M.	I IUMBER 5 6 7	8 9	25C. TOR	LOCA- CODE	25D. S EXCP	CODE	NY FEE HAS BE	EEN PAID	□ NO	Ar	nytown, NY	1111	1		
TITICATION	I IUMBER 5 6 7	I	25C. TOR	0 3		CODE	MY FEE HAS BE	EEN PAID	NO NO	Ar		1111	1	(0/1	EXT.
TITE AND THE STATEMENTS STATEMENTS AND THE STATEMENTS AND THE STATEMENTS STATEMENTS OF PHYSICIAN OR SUPPLIES FOUNDER IDENTIFICATION IN 1 2 3 4 5 EDUCATO GROUP IDENTIFICATION OF SUBMITTAL 251	NUMBER 5 6 7 ATION NUMBER E. DATE SIGNED 9 29 1	32.	25C. TOR O PATIENT	O 3		CODE YE	ES		NO NO	TELE DO I	nytown, NY	1111	1	(9/1	ехт. 0) EMEDNY-1500

Exhibit 2.4.2.1-4

MEDICAL ASSISTANCE HEALTH INSURAN	ICE ONLY TO BE A CODE V	ORIGINAL TRANSACTION CONTROL NUMBER
CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	USED TO ADJUST/VOID PAID CLAIM	4.0.2.0.4.4.0.0.7.0.5.4.2.2.0.0
	2. DATE OF BIRTH 2A. TOTAL ANNUA FAMILY INCON	1 0 2 9 1 1 1 9 8 7 6 5 4 3 2 0 0
JANE SMITH 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	0 5 2 0 1 9 9 0 5. INSURED'S SEX MALE FEMALE 5A. PATIENT'S SEX MALE FEMALE 6	5. MEDICARE NUMBER 6A. MEDICAID NUMBER
STAPLE	X	X X 1 2 3 4 5 X SB. PRIVATE INSURANCE NUMBER GROUP NO. RECIPROCITY NO.
	()	BE PRIVATE INSURANCE NUMBER SHOULD NO. RESIRROGIT 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 Policy Holder, Flan Name and Address, and Policy or	10. WAS CONDITION RELATED TO 1 PATIENT'S CRIME	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
A Private Insurance Number	EMPLOYMENT VICTIM	
	AUTO X OTHER LIABILITY	
12.	DATE	13.
PATIENT'S OR AUTHORIZED SIGNATURE		INSURED'S SIGNATURE
PHYSICIAN OR SUPPLIER INFORM 14.DATE OF ONSET 15.FIRST CONSULTED 16.HAS PARIENT EVER HAD SAME 17. OF CONDITION 17. OF		ORE COMPLETING AND SIGNING) 18.DATES OF DISABILITY TOTAL PARTIAL TOTAL PARTIAL
MM DD YY MM DD YY YES NO	YES X NO MM DD YY 9A.ADDRESS (OR SIGNATURE SHF ONLY)	190 NM DD YY MM DD YY 198 PROF CD 19C IDENTIFICATION NUMBER 19D DX CODE
		1 1 1 2 3 4 5 6 7 8 9
20. NATIONAL DRUG CODE 20A.UNIT 20B.QUANTITY	20C.COST	NDC into entered to the left of this field will only be associated with the 1st claim line below
21.NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) 21A.	ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES OUTSIDE YOUR OFFICE
22A SERVICE PROVIDER NAME 2	22B.PROF CD 22C.IDENTIFICATION NUMBER	YES NO 2 22D.STERILIZATION 22E.STATUS CODE ABORTION CODE
23. DIAGNOSIS OR NATURE OF ILLNESS, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24	H BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE	E 22F. Y N 22G. Y N 22H. Y N
1.		POSSIBLE DISABILITY EPSDT C/THP FAMILY PLANNING
3.		23A. PRIOR APPROVAL NUMBER 23B. PAYMT SOURCE CD
24B. 24C. 24B. 24C. 24B. 24C. 24B. 24C. 24B. MOD	DIAGNOSIS CODE DAYS OR	24J. CHARGES 24K. 24L.
M M D D Y Y	UNITS	
0 9 1 4 1 0 8 5 4 7 5 6	4 8,2	1 2.2 6
0 9 1 4 1 0 8 6 7 6 2 6	6 4 8.2	1 5.91
24M. FROM THROUGH 24N. PROC CD 240.MOD INSATERIAL WISTS 240. 250 250 250 250 250 250 250 250 250 250		
25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL		27, TOTAL CHARGE 28, AMOUNT PAID 29, BALANCE DUE
AND ARE MADE A PART HEREOF) James Strong		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
SIGNATURE OF PHYSICIAN OR SUPPLIER 25A. PROVIDER IDENTIFICATION NUMBER	通过是最大的时间,然后的自己的时间	ABC Laboratory
1 1 2 3 4 5 6 7 8 9		312 Main Street Anytown, NY 11111
25B. MEDICAID GROUP IDENTIFICATION NUMBER 25C. LOCATOR CODE EXCP C	ODE VES NO	
COUNTY OF SUBMITTAL 25E. DATE SIGNED 32. PATIENT'S ACCOUNT. NUMBE	R	TELEPHONE NUMBER () EXT. DO NOT WRITE IN THIS SPACE. (9/10) EMEDNY-150003
09 29 10		(8/18) EMES (1 100000
IDILICENSE NO.		

2.4.2.2 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.

Exhibit 2.4.2.2-1 and Exhibit 2.4.2.2-2 illustrate an example of a claim being voided. TCN 1029119876543200 contained two claim lines, both of which were paid on October 18, 2010. 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. Exhibit 2.4.2.2-1 shows the claim as it was originally submitted and Exhibit 2.4.2.2-2 shows the claim being submitted as voided.

Exhibit 2.4.2.2-1

AIM FORM TIENT AND INSUR	TITLI ED (SUBSC							ST/VOID CLAIM	AV			111	1.1		1.1	
	8 1. PATIENT	r's name	(First, m	niddle, last)	2. DATE O	F BIRTH	77	2A. TOTAL AND FAMILY INC		3. INSURE	D'S NAME (F			ast name,	
	JANE S			City State	e Zin Codel			9 9 1 0			ARE NUM	RER		6A. MEDICA	AID NI IM	BER
	S	3 AUDITES	so (oueei,	, Ony, Stati	e, zip Godej	5. INSURE	FEMALE] SA. [M	TIENT'S SEX ALE FEMALE	U. MEDIO	ANE NOM	JEN .				14151X
	APLE					5B. PATIEI	VT'S TELEP	HONE NUME		6B. PRIV	ATE INSUF	RANCE NUME	ER	GROUP NO		RECIPROCITY NO.
	Z					()									
	BAR 6C. PATIEN	T'S EMPLO	IYER, OCC	CUPATION	OR SCHOOL	7. PATIENT		ONSHIP TO I		8. INSUR	ED'S EMPI	LOYER OR C	CCUPATION			
	BARCODE 9. OTHER H	EALTH INS	URANCE C	OVERAGE	-Enter Name	10. WAS (CONDITION	RELATED TO		11. INSI	JRED'S AD	DRESS (Stre	et, City, Stat	e, Zip Code)		
		Holder, Plan surance Nurr	Name and nber	1 Address, a	and Policy or	PATIE EMPLOYM	NT'S X	X	CRIME VICTIM	A PART A PO						
4	EA						ито Г		1 OTHER							
	12.					ACCID	ENT	DATE	LIABILITY	13.						
	PATIENT'S	OR AUTH	HORIZED	SIGNATI	JRE			MM	DD YY	INSURE	o's signa"	TURE				
TE OF ONDET LAS FIGURE	PHYSICIAN					MATION 16A.EMERGI			VERSE BE	FORE (OF DISA	ETING A	FROM	NING)		TO
CONDITION FOR C	The State of the S	OR SIMIL	AR SYMP	TOMS	NO NO	RELATE YES X	D	RET	JRN TO WORK			PARTIAL	MM	I on I	YY	MM DD Y
DD YY MM MME OF REFERRING PHYSICI	DD YY YES				140	19A.ADDRES				19B.PR	OF CD 19	C.IDENTIFICA			1 100	19D.DX CODE
											1	11 2	3 4 5	6 7	8 9	11.1
ATIONAL DRUG CODE	20.	DA.UNIT 20	IB. QUAN	ШТҮ			20C	.COST		NDC	into enter	ed to the left	or this field w	iii only be as	sociated	with the 1st claim line be
AME OF FACILITY WHERE SE	VICES RENDERE	D (if other	r than ho	me or offi	ice) 21A	ADDRESS C	F FACILITY		•			22. WAS LA	BORATORY E YOUR OF	WORK PER	FORMED	LAB CHARGES
												YES	□ NO			
SERVICE PROVIDER NAME						22B.PROF C	D 22C.ID	ENTIFICATION	ON NUMBER	1 1	1	22D.STERIL ABORT	IZATION ION CODE			22E.STATUS CODE
IAGNOSIS OR NATURE OF ILL	ESS. RELATE DIAC	GNOSIS TO	O PROCE	DURE IN	COLUMN 2	4H BY REFER	ENCE TO N	UMBERS 1, 2	3 ETC. OR DX C	ODE 22F.	Y	N N	22G. Y		N 2	2H. Y []
										POSSI DISAB		N	EPSDT C/THP	YN	F.	AMILY X
										23A.P	RIOR APP	ROVAL NUME	ER			23B. PAYM'T SOURCE
[24B.	24C.	24D.	24F	24F.	24G.	24H.		241.		[24J.			24K.			1 1 1
DATE OF SERVICE PLACE	PROCEDURE CD	MOD	MOD	MOD	MOD	DIAGNO	SIS CODE	DAY: OR UNIT			CHARGES					
1 1						200 000										
9 1 4 1 0	8 5 4 7 5	Ш	\perp	\vdash	Ш	6 4 8.	2	\Box		+-	1	2.2 6		ш.	Ш	
9 1 4 1 0	8 6 7 6 2			T		6 4 8			1111		1	5.9 1	11	H.		111.
3 1 4 1 1 0	010171012					01410						0.011				
		Ш				Ш.									Ш	111.
	1111	1				1.1	LE		1.1.1.1		1 1		11	1.1		111
1 1 1			-					1				•				
		Ш	\perp			11.		\Box		\perp			Ш	Ш.		111.
	1111	1	1			1.1	1.1		1 1 1 1		1.1		1.1	1.1	1	TIT
				-				+++	1 1			•				•
						ш.								Ш.		111.
FROM PITAL ITS	THROUGH	2	4N. PRO	C CD	240.MOD	1 1	1 1				1 1		1.1	T		TTT
ERTIFICATION	INIT DO	YY			Ш	26. ACCEPT	ASSIGNME	ENT		27. TOTA	L CHARGI	21	. AMOUNT	PAID	29. E	BALANCE DUE
CERTIFY THAT THE STATEMENTS IND ARE MADE A PART HEREOF.)	ON THE REVERSE SI	IDE APPLY	TO THIS E	BILL		YES [NO NO							
mes Strong						30. EMPLOY SOCIAL	ER IDENTII SECURITY	FICATION NUMBER	JMBER/			R SUPPLIER	S NAME, AL	DRESS, ZIP	CODE	
			T								Labor					
ATURE OF PHYSICIAN OR SUPPLIE PROVIDER IDENTIFICATION		8 0									Main S own. N	street IY 111	1			
PROVIDER IDENTIFICATION		5 5		LOCA- CODE	25D. S EXCP	CODE	1995	S BEEN PAI		1	, 1					
				0 3	3	Y	ES		NO NO		ONE NUME	ER ()	No.		EXT.
PROVIDER IDENTIFICATION 1 2 3 4 S MEDICAID GROUP IDENTIFIC		100	DATIENT	TIC ACCO	MINIT AUGUST							- mio araut				
PROVIDER IDENTIFICATION 1 2 3 4 MEDICAID GROUP IDENTIFICATION NTY OF SUBMITTAL 25	E. DATE SIGNED		PATIEN'	T'S ACCO	UNT. NUME	BER 	1 12	l VI al c	lo la Le la					(9/10)	EMEDNY-1500
PROVIDER IDENTIFICATION 1 2 3 4 MEDICAID GROUP IDENTIFICATION NTY OF SUBMITTAL 25	E. DATE SIGNED 9 29 1	10	PATIENT	T'S ACCO	CASE MAN		<u> X</u>	X 1 2	2 3 4 5 2					(:	9/10)	EMEDNY-1500

Exhibit 2.4.2.2-2

ATTENDED AND MOUNTED DURISS CHARGE (Myr. 4000. MS.) ATTENDED AND MOUNTED DURISS CHARGE (Myr. 4000. MS.) ATTENDED AND MOUNTED CHARGE (MYR. 4000. MS.) ATTENDED	MEDICAL A								ONLY TO		A CC	DE V		ORIGIN	AL TRANS	SACTION	CONTR	OL NU	MBER	
DOT OF THE PARTY MAKE PRINCIPLE AND DESCRIPTION OF THE PARTY MAK									ADJUST	VOID	Α	X		1 . 0 . 2 .	0 1 1 1	0.8.7	6.5	1.3.	2.0.0	
A PRINCIPLE AND ADDRESS (Now Cop. Now 25 close) A SUPERING MARKET NOW COp. Now 25 close A SUPERING MARKET	TATILITY AITE	moone	L. DATIELE		,			2. DATE O												
A CASET SERVICE NUMBER STATE SERVICE NUMB											100						at MEDIO		-	
Comment of National Servicing Coloration of Scool 2, 7 Pattern's Relationship To Resided London House Servicing Coloration Servicing Coloration Servicing Servicing Coloration Servicing Servicing Coloration Servicing Servic				S ADDRE	:SS (Street,	. City, Stai	te, Zip Code	5. INSURE	FEMALE	SA. PA			6. ME	EDICAHE NUMI	BEH					
Comment of National Servicing Coloration of Scool 2, 7 Pattern's Relationship To Resided London House Servicing Coloration Servicing Coloration Servicing Servicing Coloration Servicing Servicing Coloration Servicing Servic			APLI					5B. PATIEN	VT'S TELEPHON	IE NUMB		^	6B. F	PRIVATE INSU	RANCE NUME	ER				CITY NO.
PATECH STATE SAMPLE SA			Z					()											
PATECH STATE SAMPLE SA			BAR 6C. PATIEN	T'S EMPLO	OYER, OCC	CUPATION	OR SCHOO						8. IN:	SURED'S EMP	LOYER OR O	CCUPATION				
PATECH STATE SAMPLE SA			9. OTHER H	EALTH INS	SURANCE (OOVERAGE	- Enter Nam	e 10. WAS 0	CONDITION REL	ATED TO			11.	INSURED'S AD	DDRESS (Stre	et, City, State	e, Zip Code)	1		
AUTO COURT SERVICE PROJUCES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES OF FACILITY COURT SERVICES ON HUTTER OF AUTO-COURS SOUTH THE DAMAGES ON HUTTER			A Private Ins	Holder, Plar surance Nu	n Name and imber	1 Address,	and Policy or			X										
NATIONAL OF COLORS 15 PRIST CORRECT DISCRIPTION OF AUTHORIZED SIGNATURE			A					A	ито 🔍	TV.	OTHE	R								
PRYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING) OF COURTS SPRC CORRITOR SPRC CONTINUE SPRC CONTINUE			12.					ACCID	ENT	DATE	LIABIL	LITY	13.							
PRYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING) OF COURTS SPRC CORRITOR SPRC CONTINUE SPRC CONTINUE																				
EATH OF ORDSET S. PRIST COLUMN TO PROCESSOR SALES PARTICULAR PARTICULAR OF COLUMN TO PROCESSOR SALES PARTICU													-							
## CO P CALLIFY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONly 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHERE SERVICES REACHED IF ONLY 18 AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AND AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AND AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AND AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY OF FACULTY WHO AUGUSTS OF FACULTY **AMALE OF FACULTY OF FACULTY W	4.DATE OF ONSET						-		•								aning)		то	
SAL	OF CONDITION	FOR CO	NDITION (OR SIMIL	AR SYMP	PTOMS	•	RELATE	D					TOTAL	PARTIAL	MM	DD	YY	MM D	D YY
AND CODE SALANT								19A. ADDRES	S (OR SIGNAT				19B	PROF CD 19	C.IDENTIFICA	ITION NUMB	BER		19D.DX CODI	
A DATE OF RACILITY WHERE SERVICES RENDERED (if other has none or office) 21A ADDRESS OF FACILITY 22 NUMBERS OF RENDERED (if other has none or office) 21A DAMPGES 22B FROF CD 20C DENTIFICATION NUMBER 22D STERLIZATION CODE 22E STATUS CODE 22B FRONT CODE 22B FR	O NATIONAL DRUG CO	DF	20	A UNIT 2	OB QUAN	ITITY			20C.CO	ST	<u> </u>		Щ							
A SERVICE PROVIDER NAME 228 PROF CD 22C CENTIFICATION NUMBER 228 PROF CD 22C CENTIFICATION NUMBER 228 STATUS CODE 329 TOTAL CHARGES 324 A DATE OF PROCEDURE IN COLUMN 24H ST REFERENCE TO INJUSTES 1, 2, 3 ETC, OR DR COSE 32 APRICH PROVIDER APPROVAL NUMBER 328 FAMALY X X POSSELE 329 FAMALY SUMMER 328 FAMALY SUMMER 328 FAMALY SUMMER 329 FAMALY SUMMER 329 FAMALY SUMMER 320 FAMALY SUMMER 320 FAMALY SUMMER 321 TOTAL CHARGES 321 TOTAL CHARGES 322 TOTAL CHARGES 323 FAMALY SUMMER 324 TOTAL CHARGES 325 FAMALY SUMMER 326 FAMALY SUMMER 327 FORD 328 FAMALY SUMMER 329 FAMALY SUMMER 329 FAMALY SUMMER 329 FAMALY SUMMER 320 FAMALY SUMMER 320 FAMALY SUMMER 320 FAMALY SUMMER 321 TOTAL CHARGES 321 TOTAL CHARGES 322 TOTAL CHARGES 333 FAMALY SUMMER 324 TOTAL CHARGES 334 TOTAL CHARGES 345 FAMALY SUMMER 346 TOTAL CHARGES 346 TOTAL CHARGES 357 FAMALY SUMMER 358 FAMALY SUMMER 359 FAMALY SUMMER 359 FAMALY SUMMER 350 FAMALY SUMMER 360 FAMALY SUMMER 370 FAMALY SUMMER 371 FAMALY SUMMER 371 FAMALY SUMMER 371	1 1 1 1 1	1 1			1 1	1 1	1.1	1 . 1	1 1	LE		1.1	,							
28 PROF CD 22C DENTIFICATION NUMBER 22C STRILLZHON ABORTION COOR 22C STATUS CODE 22C STRILLZHON ABORTION CODE 22C STATUS CODE	1.NAME OF FACILITY	WHERE SER	VICES RENDERE	D (if othe	er than ho	me or off	ice) 21	A. ADDRESS C	F FACILITY	m				1,10	22. WAS LA OUTSID	BORATORY E YOUR OF	WORK PER	RFORMED	LAB CHA	RGES
DIAGNOSS OR NATURE OF ILNESS. RELATE DIAGNOSS TO PROCEDURE IN COLUMN 241 BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR D. COCK 225. 232. PRIOR APPROVAL NUMBER 236. PRIOR APPROVAL NUMBER 237. PRIOR APPROVAL NUMBER 238. PRIOR APPROVAL NUMBER 239. PRIOR APPROVAL NUMBER 241. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ON CEDIFICE BROVIDE	DNAME						Took page o	D Took IDENI	TEICATIO	ONI NILIM	RER							22F STAT	TUS CODE
2.2 23A FRIOR APPROVAL NUMBER 200 PAINT SUMES 200 PAINT TOURS BL. 200 PAINT SUMES 200 PAINT SU	A.SERVICE PROVIDE	1 NAME							220.102.11			1 1	1	11	ABORT	ION CODE			LEC.OIA	100 0002
1. DISABILITY OF THE PROVINCE NUMBER 2. DISABILITY NUMBER 2. DISABILITY OF THE PROVINCE NUMBER 2. DISABILITY OF THE PROVINCE NUMBER 2. DISABILITY OF THE PROVINCE NUMBER 2. DISABILITY NUMBER 2. DISAB	3. DIAGNOSIS OR NATU	RE OF ILLNE	ESS. RELATE DIAG	SNOSIS T	TO PROCE	DURE IN	COLUMN	24H BY REFER	ENCE TO NUMB	ERS 1, 2,	3 ETC.	OR DX C			N		37 BI	N 22	H. Y	Y N
3 A DATE OF SERVICE M D D Y Y PLACE PROCEDURE MOD															DOVAL NUMB	C/THP		PL	ANNING	
A STEE OF SERVICE M D D V Y PLACE PROCEDURE MOD	3.													I I	I I			1 1	**	
No.		24B. PLACE							SIS CODE	24I. DAYS	3		24J			24K.	theoret.			
Market FROM			CD							UNITS	S			Orminal						
AND ARE MADE A PART REPORT DE LEATER FOR AND RESERVE APPLY TO THIS BILL AND REVENSE SIDE APPLY TO THIS BILL AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE A PART REPORT DE LEATER FOR AND ARE MADE AND	0 9 1 4 1 0	0	8 5 4 7 5		L	\perp		6 4 8.	2	1	Ш			1	2.2 6		ш.			
PAIRBIT AND STATE AND	0 9 1 4 1 0		8 6 7 6 2					6 4 8	2					1	5.9 1					
PAIRBIT AND STATE AND						L		ш.												
PAIRBIT AND STATE AND			Ш			L	Ш	ш.		\perp	П		_		L.L	Ш			Ш	
PAIRBIT AND STATE AND	444		Ш		1	L	Ш	ш.		\perp	Ш					Ш			Ш	L
PAIRBIT AND STATE AND	444	11	Ш	L	1			1.		1	Ш									
S. GERIFICATION (URSTRY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MUGE A PART HEREOF.) 10. CERTRY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. BALANCE DUE (1.0 CERTLY THE BILL YES NO. 29. B	4M. FROM	Щ	THROUGH	Ц	24N. PRO	DC CD	240.MOD	ш.												
COUNTY OF SUBMITTAL 25E. DATE SIGNED 30. EMPLOYER IDENTIFICATION NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. EMPLOYER IDENTIFICATION NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. EMPLOYER IDENTIFICATION NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. EMPLOYER IDENTIFICATION NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. MAIN SCIUNTY NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. MAIN SCIUNTY NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. MAIN SCIUNTY NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE 32. MAIN SCIUNTY NUMBER 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC Laboratory 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE ABC La		9 9y	MM 50	199				11.												
lames Strong 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER 31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE ABC Laboratory 312 Main Street Anytown, NY 11111 SB. MEDICAID GROUP IDENTIFICATION NUMBER 25C. LOCA- TOR CODE YES NO OUNTY OF SUBMITTAL 25C. DOCA- YES NO NO TELEPHONE NUMBER 09 29 10 X X 1 2 3 4 5 X	(I CERTIFY THAT THE S	STATEMENTS (ON THE REVERSE S	IDE APPLY	Y TO THIS I	BILL		Г	ASSIGNMENT		Г] NO	27. 1	OTAL CHARG	E 28	B. AMOUNT I	PAID	29. B	ALANCE DUE	
ABC Laboratory Submittal Street Anytown, NY 11111								30. EMPLOY	ER IDENTIFICA	TION NU	JMBER/		31. F	PHYSICIAN'S O	R SUPPLIER	S NAME, AD	DRESS, ZIF	CODE		
1 1 2 3 4 5 6 7 8 9 88 MEDICAID GROUP IDENTIFICATION NUMBER TOR CODE TOR COOL 25D. SA EXCP CODE YES NO TELEPHONE NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE SIGNED 32. PATIENTS ACCOUNT. NUMBER () OUNTY OF SUBMITTAL 25C. DATE S	SIGNATURE OF PHYSICIAN							SUCIAL	GEOURIT NUI	nocn			AE	BC Labor	ratory					
SE. LICOA-		7 7	7 7 7	0 -																
OUNTY OF SUBMITTAL 2SE DATE SIGNED 32. PATIENTS ACCOUNT.NUMBER 00 NOT WRITE IN THIS SPACE (9/10) EMEDNY-1500				8 8		LOCA-	25D.	SA 32A. I	MY FEE HAS BI	EN PAIC	0		Ar	iytown, N	NY 1111					
09 29 10					0	0 3	3	Y	ES			NO)			EXT.	
09 29 10	COUNTY OF SUBMITTA				. PATIEN	TS ACCO	OUNT. NUM	BER	1 1.4		la l	. Let		NOT WRITE IN	THIS SPACE		(9/10)	EMEDN'	Y-15000
2 Office her chilling choching thousen 34, thor or 30, once maintach is	33. OTHER REFERRING				34. PROF	CD 35.	CASE MAN	AGER ID	XX	1 2	2 3 4	1 5 X								
3. OTHER REFERRING ORDERING PROVIDER 34. PROF CD 35. CASE MANAGER ID DILICENSE NO.	ID/LICENSE NO.				1.1		11	11	1 1 1	1										

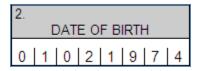
Patient's Name (Field 1)

Enter the patient's first name, followed by the last name. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Date of Birth (Field 2)

Enter the patient's birth date. This information may be obtained from the Client's (Patient's) Common Benefit ID Card. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.2-1.

Exhibit 2.4.2-1



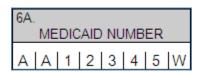
Patient's Sex (Field 5A)

Place an 'X' in the appropriate box to indicate the patient's sex. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Medicaid Number (Field 6A)

Enter the patient's ID number (Client ID number). This information may be obtained from the Client's (Patient's) Common Benefit ID Card. Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of 8 characters in the format AANNNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.2-2.

Exhibit 2.4.2-2



Was Condition Related To (Field 10)

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

Leave this field blank.

Name of Referring Physician or Other Source (Field 19)

Enter the ordering provider's name in this field.

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

If the ordering provider and the laboratory are part of the same Shared Health Facility, the ordering provider muster enter his/her signature in this field.

Prof CD [Professional Code - Ordering/Referring Provider] (Field 19B)

Leave this field blank.

Identification Number [Ordering/Referring Provider (Field 19C)

If the service is ordered by a Physician Assistant or a Nurse Midwife, the supervising licensed practitioner's NPI must be entered in this field.

Independent Laboratories (COS 1000) Only

When providing services to a patient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) who orders laboratory services, enter the NPI of the primary provider in this field. *Do not enter the license number of the primary provider.*

If the restricted patient was referred by his/her primary provider to another provider who orders laboratory services, the laboratory must enter the ordering provider's NPI in this field. *If the provider ordering the laboratory services is not the patient's primary provider*, then the primary's NPI must be entered in field 33.

If a patient is restricted to a facility, the NPI of the practitioner at the facility the patient is restricted to, must be entered in this field, the ID of the facility cannot be used.

DX Code (Field 19D)

Leave this field blank.

Drug Claims Section: Fields 20 to 20C

The following section applies to drug code claims only.

NDC [National Drug Code] (Field 20)

Leave this field blank.

Unit (Field 20A)

Leave this field blank.

Quantity (Field 20B)

Leave this field blank.

Cost (Field 20C)

Leave this field blank.

Name of Facility Where Services Rendered (Field 21)

Leave this field blank.

Address of Facility (Field 21A)

Leave this field blank.

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)

If applicable, enter the appropriate code to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in Appendix B – Code Sets. Information as to whether the ordered laboratory tests are related to an abortion or sterilization must be obtained by the laboratory from the ordering practitioner.

If the service is unrelated or indirectly related (for example: laboratory testing performed in conjunction with a presurgery office visit) to abortion/sterilization, leave this field blank.

If a code is entered in this field, it must be applicable to all procedures listed on the claim. Procedures that are not related to abortion or sterilization must be submitted on separate claim form(s).

Note: The following medical procedures are not induced abortions; therefore when billing for these procedures, leave this field blank.

- Spontaneous abortion (miscarriage)
- Termination of ectopic pregnancy
- Drugs or devices to prevent implantation of the fertilized ovum
- Menstrual extraction

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

Leave this field blank.

EPSDT C/THP (Field 22G)

Leave this field blank.

Family Planning (Field 22H)

Medical family planning services include diagnosis, treatment, drugs, supplies, and related counseling which are furnished or prescribed by, or are under the supervision of a physician or nurse practitioner. The services include, but are not limited to:

- Physician, clinic or hospital visits during which birth control pills, contraceptive devices or other contraceptive methods are either provided during the visit or prescribed
- Periodic examinations associated with a contraceptive method
- Visits during which sterilization or other methods of birth control are discussed
- Sterilization procedures

The ordering provider must indicate whether the ordered services are related to family planning.

This field must always be completed. Place an 'X' in the YES box if *all* services being claimed are family planning services. Place an 'X' in the NO box if *at least one* of the services being claimed is not a family planning service. If some of the services being claimed, but not all, are related to Family Planning, *place the modifier FP* in the two-digit space following the procedure code in Field 24D to designate those specific procedures which are family planning services.

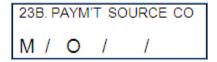
Prior Approval Number (Field 23A)

Leave this field blank.

Payment Source Code [Box M and Box O] (Field 23B)

This field has two components: Box M and Box O as shown in Exhibit 2.4.2-7 below:

Exhibit 2.4.2-7



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

This code indicates that the patient does not have Medicare coverage.

Patient has Medicare Part B; Medicare approved the service – Source Code Indicator = 2

This code indicates that the service is covered by Medicare and that Medicare approved the service and *either made a payment or paid 0.00 due to a deductible*. 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

This code indicates that Medicare denied payment or did not cover 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, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Laboratory 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.

Copay Exception Code

If the patient is exempt from copay, enter the value "Z9" in the two spaces next to Box O. For information on copay exemptions, refer to the Policy Guidelines section on the web page for this manual

Exhibit 2.4.2-8 provides a full illustration of how to complete field 23B and the relationship between this field and fields 24J, 24K, and 24L.

Exhibit 2.4.2-8

	BOX M	вох о
23B. PAYM'T SOURCE CO	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	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.
23B. PAYM'T SOURCE CO	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, enterthe total payments in 24L
23B. PAYM'T SOURCE CO 2/ 01/ /	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 / /	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.
23B. PAYM'T SOURCE CO 2 /3 / /	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, enterthe total payments in 24L.
23B. PAYM'T SOURCE CO	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	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.
23B. PAYM'T SOURCE CO	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, enterthe total payments in 24L.

LABORATORY 11/18/2010

Version 2010 - 01

Encounter Section: Fields 24A to 240

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 final test results were reported *in writing* to the ordering practitioner or forwarding laboratory. Enter the date on which the service was rendered in the format MM/DD/YY.

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

Place [of Service] (Field 24B)

Leave this field blank.

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 to the webpage as follows: Laboratory Manual.

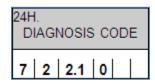
MOD [Modifier] (Fields 24D, 24E, 24F, and 24G)

Leave this field blank.

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. Proper entry of an IDC-9-CM Diagnosis Code is shown in Exhibit 2.4.2-9.

Exhibit 2.4.2-9



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

Days or Units (Field 24I)

If a procedure was performed 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.

Charges (Field 24J)

This field must contain either the Amount Charged or the Medicare Approved Amount.

Amount Charged

When Box M in field 23B has an entry value of 1 or 3, enter the amount charged in this field. The Amount Charged may not exceed the provider's customary charge for the procedure.

Medicare Approved Amount

When Box M in field 23B has an entry value of 2, enter the Medicare Approved Amount in field 24J.

NOTES:

- The entries in field 23B, Payment Source Code, determine the entries in field's 24J, 24K, and 24L.
- Field 24J must never be left blank or contain zeroes.
- It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Unlabeled (Field 24K)

This field is used to indicate the Medicare Paid Amount and must be completed if Box M in field 23B has an entry value of 2 or 3.

Box M = 2

Enter the amount paid by Medicare in this field.

Box M = 3

Enter 0.00 in this field to indicate that Medicare denied payment or did not cover the service.

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

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 carriers 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 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.

If none of the above situations are 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
- Leave the last row of Fields 24H, 24J, 24K, and 24L blank.

Consecutive Billing Section: Fields 24M to 240

This section may be used for block-billing consecutive visits within the *SAME MONTH/YEAR* made to a patient in a hospital inpatient status.

Inpatient Hospital Visit [From/Through Dates] (Field 24M)

Leave this field blank.

Proc Code [Procedure Code] (Field 24N)

Leave this field blank.

MOD [Modifier] (Field 240)

Leave this field 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 claim lines entered in the Encounter Section of the form.

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

The billing provider or authorized representative 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 provider's 10-digit National Provider Identifier (NPI).

Medicaid Group Identification Number (Field 25B)

Leave this field blank.

Locator Code (Field 25C)

For electronic claims, leave this field blank. For paper claims, enter the locator code assigned by NYS Medicaid.

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at any time, afterwards, that a new location is added. Enter the locator code that corresponds to the address where the service was performed.

Locator codes 001 and 002 are for administrative use only and are not 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.

NOTE: 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 located at www.emedny.org by clicking on the link to the webpage as follows: Laboratory Manual.

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

If it was necessary to provide a service covered under the Utilization Threshold (UT) program and service authorization (SA) could not be obtained, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix B-Code Sets.

For more information on the UT Program, please refer to Information for All Providers General Policy, "Utilization Threshold Program" subsection located at www.emedny.org by clicking on the link to the webpage as follows: Laboratory Manual.

If not applicable, 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 provider or an authorized representative 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 at www.emedny.org by clicking on the link to the webpage as follows: Laboratory Manual.

Physician's or Supplier's Name, Address, Zip Code (Field 31)

Enter the provider's name and correspondence 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. The Locator Code will default to 003 if the nine digit ZIP code does not match information in the provider's Medicaid file.

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 at www.emedny.org by clicking on the link to the webpage as follows: Laboratory 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)

If a restricted patient was referred by his/her primary provider to another provider who orders laboratory services, the patient's primary provider's Medicaid ID number must be entered in this field. *Do not enter the license number of the primary provider.*

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

Leave this field blank.

3. Explanation of Paper Remittance Advice Sections

This Section presents samples of each section of the Laboratory provider's remittance advice, 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.

General Remittance Advice Information is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

The remittance advice is composed of five sections.

Section One may be one of the following:

- Medicaid Check
- Notice of Electronic Funds Transfer
- 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

3.1 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).

Exhibit 3.1-1



TO: ABC LABORATORY

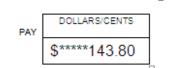
DATE: 2010-05-31

REMITTANCE NO: 07080600006 PROV ID: 00112233/1123456789

00112233/1123456789 2010-05-31 ABC LABORATORY 100 BROADWAY ANYTOWN NY

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

DATE REMITTANCE PROVIDER ID NO NUMBER 2010-05-31 07080600006 00112233/1123456789



Real ABC LABORATORY
100 BROADWAY
ANYTOWN NY

11111



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

John Smith

11111

3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

Table

Date: The date on which the check was issued

Remittance Number

Provider ID No.: This field will contain the Medicaid Provider ID and the NPI

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.

3.2 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.

Exhibit 3.2-1

TO: ABC LABORATORY



DATE: 2010-05-31 REMITTANCE NO: 07080600006 PROVID: 00112233/1123456789

00112233/1123456789 2010-05-31 ABC LABORATORY 100 BROADWAY ANYTOWN NY 11111

ABC LABORATORY

\$143.80

 ${\tt PAYMENT\,IN\,THE\,ABOVE\,AMOUNT\,WILL\,BE\,DEPOSITED\,VIA\,AN\,ELECTRONIC\,FUNDS\,TRANSFER.}$

3.2.1 EFT Notification Page Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/Date

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.

3.3 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.

Exhibit 3.3-1

TO: ABC LABORATORY



DATE: 05/31/2010 REMITTANCE NO:07080600006 PROVID: 00112233/1123456789

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

ABC LABORATORY 100 BROADWAY ANYTOWN

11111

LABORATORY

Version 2010 - 01 11/18/2010

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Notification that no payment was made for the cycle (no claims were approved)

Provider's Name/Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1



TO: ABC LABORATORY 100 BROADWAY ANYTOWN, NEW YORK 11111 PAGE 01 DATE 05/31/10 CYCLE 1710

ETIN: PROVIDER NOTIFICATION PROV ID 00112233/1123456789 REMITTANCE NO 07080600006

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.

NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAWFOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSC.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

3.4.1 Provider Notification Field Descriptions

Upper Left Corner

Provider's Name/Address (as recorded in the Medicaid files)

Upper Right Corner

Remittance Page Number

Date: The 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)

Name of Section: PROVIDER NOTIFICATION

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

Center

Message Text

3.5 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.

Exhibit 3.5-1

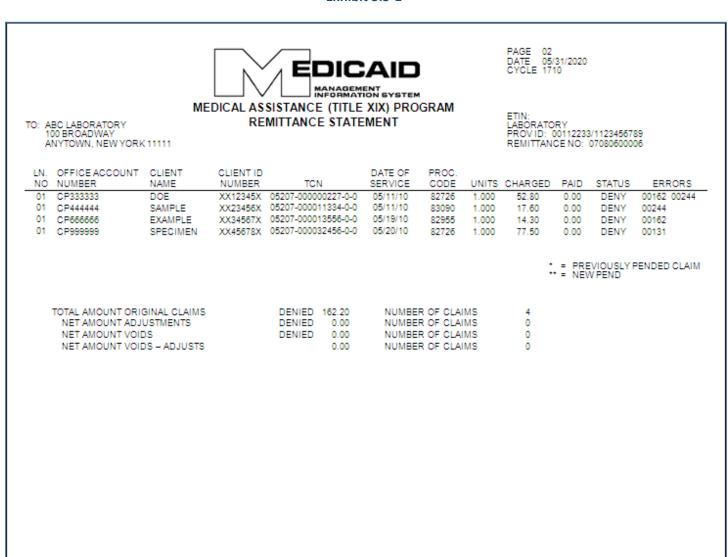


Exhibit 3.5-2



MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT TO: ABC LABORATORY 100 BROADWAY ANYTOWN, NEW YORK 11111

PAGE 03 DATE 05/31/2010 CYCLE 1710

ETIN: LABORATORY PROVID: 00112233/1123546789 REMITTANCE NO: 070806000006

	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC.	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033667-0-0	05/11/10	83593	1.000	14.30	14.30	PAID	
02	CP222222	SAMPLE	XX23456X	07206-000033667-0-0	05/12/10	82955	1.000	14.30	14.30	PAID	
01	CP333333	EXAMPLE	XX34567X	07206-000045667-0-0	05/14/10	83500	1.000	52.80	52.80	PAID	
01	CP444444	SPECIMEN	XX45678X	07206-000056767-0-0	05/15/10	82953	1.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	82943	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	83020	1.000	14.30	14.30	ADJT	05/14/10

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.00	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		3.05-	NUMBER OF CLAIMS	1

Exhibit 3.5-3



PAGE 04 DATE 05/31/2010 CYCLE 1710

TO: ABC LABORATORY 100 BROADWAY ANYTOWN, NEW YORK 11111 MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT

ETIN: LABORATORY PROVID: 00112233/1123456789 REMITTANCE NO: 07080600006

	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER		DATE OF SERVICE		UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP333333	DOE	XX12345X	05207-000033467-0-0	05/13/10	82726	1.000	69.30	0.00	**PEND	00162
02	CP444444	SAMPLE	XX23456X	05207-000033468-0-0	05/14/10	82953	1.000	71.04	0.00	**PEND	00162
01	CP666666	EXAMPLE	XX34567X	05207-000035665-0-0	05/14/10	83020	1.000	14.30	0.00	**PEND	00142
01	CP999999	SPECIMEN	XX45678X	05207-000033660-0-0	05/12/10	83020	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 - LABORATORY					
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	

Exhibit 3.5-4



PAGE: 05 DATE: 05/31/10 CYCLE: 1710

ETIN: LABORATORY GRAND TOTALS PROVID: 00112233/1123456789 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

3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address (as recorded in the Medicaid files)

Upper Right Corner

Remittance Page Number

Date: The 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: LABORATORY

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

3.5.2 Explanation of 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 in this column.

Client ID Number

The patient's Medicaid ID number appears under this column.

TCN

The TCN is a unique identifier assigned to each claim 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

The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

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 Laboratories 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 was 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: Patient 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 and that 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 a separate page of the remittance advice, at the end of the claim detail section.

11/18/2010

3.5.3 Subtotals/Totals/Grand 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
- Deny
- Net total paid (for the specific service classification)

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)

LABORATORY

3.6 Section Four – Financial Transactions and Accounts Receivable

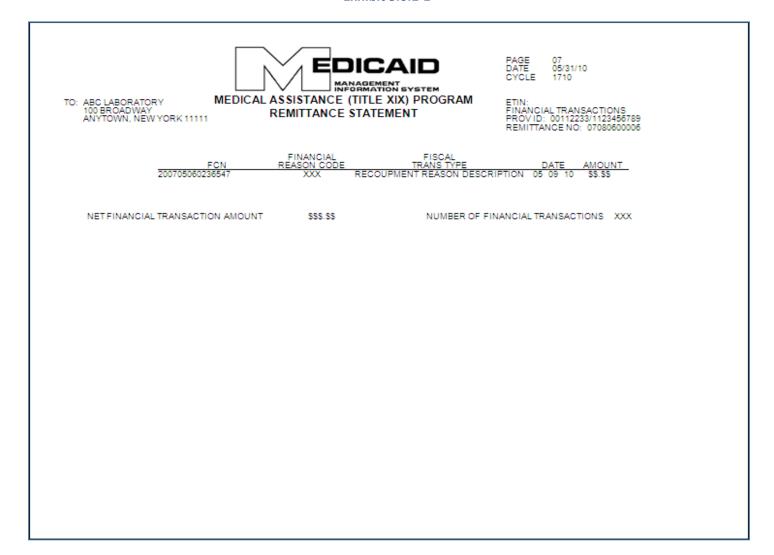
This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 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.

Exhibit 3.6.1-1



3.6.1.1 Explanation of Financial Transactions Columns

FCN

The Financial Control Number (FCN) 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.

Financial 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.

3.6.1.2 Explanation of Totals Section

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 3.6.2

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.

Exhibit 3.6.2-1

ANYTOWN, NEW YORK 11111 MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT

08 05/31/10 1710

ETIN: ACCOUNTS RECEIVABLE PROVID: 00112233/1123456789 REMITTANCE NO: 07080600006

REASON CODE DESCRIPTION

TO: ABC LABORATORY 100 BROADWAY

ORIG BAL SXXX.XX-\$XXX.XX-

CURR BAL SXXX.XX-\$XXX.XX-

RECOUP %/AMT 999 999

TOTAL AMOUNT DUE THE STATE \$XXX.XX

3.6.2.1 Explanation of 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 (Error) Description

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.

Exhibit 3.7-1



LABORATORY EDIT DESCRIPTIONS PROVID: 00112233/1123456789 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

PANOT ON OR REMOVED FROM FILE

APPENDIX A CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains an image of a claim with sample data.

LAIM FORM ATIENT AND INSURE				DGRA RMATIC		USED TO ADJUST/V PAID CLA	OID A V						
	A DATICAL				2. DATE OF		2A. TOTAL AN	NUAL 3	. INSURED'S NAM	E (First name,	middle initial, last ne	me)	
	JANE S	SMITH	ł		0 5 2	2 0 1 1 9 9	FAMILY IN	COME					
		S ADDRESS	S (Street, Cit	ty, State, Zip I	Code) 5. INSURED		A. PATIENT'S SEX	6. MEDICA	ARE NUMBER		6A. MEDICAID N	UMBER	
	STAPLE				ED DATIEN	NT'S TELEPHONE	XX	ep pps//	TE INSURANCE N	IMPED	X ₁ X ₁ 1 ₁ 2		OCITY NO.
					DB. PATIEN	VI S TELEPHONE	NUMBER	Ob. Phive	TE INSURANCE IN	UMBER	GROOF NO.	REGIFA	ociii iio.
	E 6C. PATIEN	I'S EMPLOY	ER, OCCUP	ATION OR SO	HOOL 7. PATIENT) ''S RELATIONSHI	P TO INSURED	8. INSURE	D'S EMPLOYER C	R OCCUPATION	DN .		
	BARCODE 9. OTHER H				SELF	SPOUSE	CHILD OTHER						
		Holder, Plan N	vame and Ad	ERAGE - Enter dress, and Poli	Name 10. WAS C	CONDITION RELA	TED TO CRIME	11. INSU	RED'S ADDRESS	Street, City, St	ate, Zip Code)		
	A Private Ins	surance Numb	ber		EMPLOYM	ENT A	VICTIM	1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A					
	D .				ACCID	UTO X	OTHER LIABILITY						
	12.				ACCID		DATE	13.					
	PATIENT'S						MM DD YY		'S SIGNATURE				
DATE OF ONSET 15.FIRST CO					16A.EMERGE		7.DATE PATIENT MAY		OMPLETIN OF DISABILITY	G AND S		то	
DE CONDITION FOR CON	The state of the s	HAS PATIEI OR SIMILAR	R SYMPTO	MS NO	RELATE	D	RETURN TO WORK		OTAL PARTIAL	M			DD Y
NAME OF REFERRING PHYSICIAN				INO	10000	S (OR SIGNATUR		19B.PRC	F CD 19C.IDENT	FICATION NUM		19D.DX CO	
											5 6 7 8		
NATIONAL DRUG CODE	20.	A.UNIT 20B	B. QUANTIT	Υ		20C.COS1		NDC	info entered to the	left of this field	will only be associa	ed with the 1st	claim line be
IAME OF FACILITY WHERE SERV	CES RENDERE	D (if other	than home	or office)	21A. ADDRESS O	F FACILITY			122. WA	LABORATOR	Y WORK PERFORM	IED TLAB CH	IARGES
A SECTION OF THE SECT		, in cases							OU	SIDE YOUR O	OFFICE		
SERVICE PROVIDER NAME					22B. PROF C	D 22C.IDENTIF	FICATION NUMBER		22D.ST	RILIZATION ORTION CODE		22E.ST.	ATUS CODE
DIAGNOSIS OR NATURE OF ILLNES	S. RELATE DIAG	NOSIS TO	PROCEDU	RE IN COLU	MN 24H BY REFERE	ENCE TO NUMBER	RS 1, 2, 3 ETC. OR DX 0	POSSIE DISABIL	SLE Y	EPSDT C/THP	YN	FAMILY PLANNING	X
									RIOR APPROVAL N			100000000000000000000000000000000000000	YMT SOURCE
3.									1 1 1	1.1		1 41	11 1
	4C. PROCEDURE			4F. 24G. MOD MC	D DIAGNO	SIS CODE	24I. DAYS	24J.	CHARGES	24K.		24L.	
M D D Y Y	CD	1					OR UNITS						
0 1 1 1 1 0 1 0	15 4 7 5				6/4/0		11111		11122	6		111	1
9 1 4 1 0 8	5 4 7 5			+++	6 4 8.	2		+-	1 2.2	0	•	+	•
9 1 4 1 0 8	6 7 6 2				6 4 8.	2			1 5.9	1			
. 1 . 1													
9 1 3 1 0 8	1025	\vdash		+	6 4 8 2	2		+	2.0	0		+	
	1111			1 1	111	TIT	1111					111	1
					1						•		•
				$\perp \downarrow \downarrow$	11.								
	1111	,	, 1	1 .	1.1	111	1111		1 1 1	1	rrr i	1.1	
					-				•		•	+++	
					11.	\perp						11	
A. FROM	THROUGH	24	N. PROC (CD 240.1	00			14					
ATIENT SPITAL SITS CERTIFICATION	MM DO	YY			26 ACCEPT	ASSIGNMENT		127. TOTAL	CHARGE	28. AMOUN	T PAID 12	9. BALANCE DI	JE .
(I CERTIFY THAT THE STATEMENTS ON AND ARE MADE A PART HEREOF.)	THE REVERSE SI	DE APPLY T	O THIS BILL		YES		NO NO						
ames Strong					30. EMPLOY	ER IDENTIFICATI	ION NUMBER/	31. PHYS	ICIAN'S OR SUPPI	IER'S NAME,	ADDRESS, ZIP COE	E	
NATURE OF PHYSICIAN OR SUPPLIER					GUGIAL	SECONITY NOWE		ABC	Laboratory				
A. PROVIDER IDENTIFICATION NU									Main Street				
I 1 2 3 4 5 B. MEDICAID GROUP IDENTIFICAT		8 9	25C. LO	CA- 2	5D. SA 32A N	MY FEE HAS BEE	EN PAID	Anyte	own, NY 1	1111			
		1	25C. LO TOR CO		XCP CODE	ES	NO NO	TEI EDHO	NE NUMBER (,		EXT.	
	DATE SIGNED	32. F	PATIENT'S	ACCOUNT: I	UMBER				WRITE IN THIS SE	ACE.	/0/4		IV 1500
DUNTY OF SUBMITTAL 25E.	DATE GIGINED												
	29 1	0			MANAGER ID	X X	1 2 3 4 5 2	((9/10) EMEDN	11-1500

APPENDIX B CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of Place of Service codes, SA Exception Codes, Specialty Codes exempted from UT, and a list of accepted Unites States Standard Postal Abbreviations.

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 60	Comprehensive inpatient rehabilitation facility Comprehensive outpatient rehabilitation facility
65	
71	End stage renal disease treatment facility State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	
33	Other unlisted facility

SA (Service Authorization) Exception Code

Code	Description
1	Immediate/urgent care
2	Services rendered in retroactive period
3	Emergency care
4	Client has temporary Medicaid
5	Request from county for second opinion to
	determine if recipient can work
6	Request for override pending
7	Special handling

Note: Code 7 must be used when billing for a physician service with a specialty exempted from the Utilization Threshold Program. Exempt specialties are listed below:

Specialty Codes Exempted from Utilization Thresholds

Code	Description
020	Anesthesiology
150	Pediatrics
151	Pediatrics: Cardiology
152	Pediatrics: Hematology-Oncology
153	Pediatrics: Surgery
154	Pediatrics: Nephrology
155	Pediatrics: Neonatal-Perinatal Medicine
156	Pediatrics: Endocrinology
157	Pediatrics: Pulmonology
158	PPAC: Preferred Physicians and Children Program
159	Moms: Medicaid Obstetrical & Maternal Service Program
161	Pediatrics: Pediatric Critical Care
169	Moms: Health Supportive Services
186	T.B. Directly Observed Therapy/Physician
191	Child Psychology
192	Psychiatry
193	Child Neurology
195	Psychiatry and Neurology
196	Clozapine Case Manager
205	Therapeutic Radiology
247	Managed Care – Physician Enhanced Fee
249	HIV Primary Care Services
270	CHAP: Child Health Assurance Program

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
daho	ID	Pennsylvania	PA
llinois	IL	Rhode Island	RI
owa	IA	South Carolina	SC
ndiana	IN	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
_ouisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Iinnesota	MN	Wisconsin	WI
Ame	rican Territories	Abbrev.	
Ame	rican Samoa	AS	
Cana	al Zone	CZ	
Guar	n	GU	
Puer	to Rico	PR	
Trus	t Territories	TT	
Virgi	n Islands	VI	

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



eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.

LABORATORY

Version 2010 - 01 11/18/2010