# NEW YORK STATE
# MEDICAID PROGRAM

# HOSPITAL-BASED/FREE STANDING
# ORDERED AMBULATORY

# BILLING GUIDELINES

# TABLE OF CONTENTS

# Section I - Purpose Statement

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

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

This document is customized for Ordered Ambulatory Providers and should be used by the provider's billing staff as an instructional as well as a reference tool.

# Section II – Claims Submission

Ordered Ambulatory providers can submit their claims to NYS Medicaid in electronic or paper formats.

## 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.

Ordered Ambulatory providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Practitioner (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) – A document that explains the proper use of the 837P standards and program specifications. This document is available at http://www.wpc-edi.com/hipaa.

- NYS Medicaid 837P Companion Guide (CG) – A subset of the IG, which provides instructions for the specific requirements of NYS Medicaid for the 837P. This document is available at www.nyhipaadesk.com.

  Under the **News and Resources** tab:

  ✓ Select eMedNY Phase II HIPAA Transactions from the menu. (Click on the +box)

  ✓ Click on 837 Professional Health Care Claim Transaction

  ✓ Click on Companion Guide-837 Professional

- NYS Medicaid Supplemental Companion Guide – This document 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. The Supplemental CG is available at www.nyhipaadesk.com.

  Under the **News and Resources** tab:

  ✓ Select eMedNY Phase II HIPAA Transactions from the menu (Click on the +box)

- ✓ Click on 837 Professional Health Care Claim Transaction
- ✓ Click on Supplemental Companion Guide

## Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and password
- A Trading Partner Agreement
- Testing

**ETIN**
This is a four-character submitter identifier, issued by the NYS Medicaid Fiscal Agent upon application and must be used in every electronic transaction submitted to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org.

Under **Information**:

- ✓ Click on Provider Enrollment Forms
- ✓ Click on Electronic Transmitter Identification Number

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

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

The Certification Statement is available at www.emedny.org together with the ETIN application.

**User ID and Password**
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods.

**Trading Partner Agreement**
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org.

From the **Menu**:

✓ Select HIPAA

✓ Click on NYS Medicaid Trading Partner Information and Forms

✓ Click on Trading Partner Agreement Form

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

Under **Information**:

✓ Click on eMedNY Phase II

✓ Click on eMedNY Provider Testing Users Guide

## Communication Methods

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

- eMedNY eXchange
- FTP
- CPU to CPU

- eMedNY Gateway

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

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. Procedures and instructions regarding how to enroll in the eMedNY eXchange are available at www.emedny.org.

Under **Information**:

✓ Click on eMedNY Phase II

✓ Click on eMedNY Provider Testing User Guide

✓ On the Table of Contents, click on Overview

✓ Scroll down to Access Methods

**FTP**
FTP allows for direct or dial-up connection.

**CPU to CPU (FTP)**
This method consists of an established direct connection between the submitter and the processor and it is most suitable for high volume submitters.

**eMedNY Gateway**
This is a dial-up access method. It requires the use of the User ID assigned at the time of enrollment and a password.

**Note: For questions regarding FTP, CPU to CPU or eMedNY Gateway connections, call CSC-Provider Enrollment Support at 800-343-9000.**

## ePACES

Additionally, NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837P. ePACES,

which is provided free of charge, is ideal for providers with small-to-medium claim volume.

To take advantage of ePACES, providers need to follow an enrollment process, which is available at www.emedny.org. Providers who enroll in ePACES will be automatically enrolled in eMedNY eXchange.

The requirements for using ePACES include:

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

The following transactions can be submitted via ePACES:

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

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

# Paper Claims

Ordered Ambulatory providers who choose to submit their claims on paper forms must use the New York State eMedNY-150001 claim form. A link to this form appears at the end of this subsection.

## General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in

the required fields. The following guidelines will help ensure the accuracy of the imaging output.

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

1 2 3 4 5 6 7 8 9 0

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

| Written As | Intended As | Interpreted As |
|---|---|---|
| 6.00 | 6.00 | 6.60 → Zero interpreted as six |

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

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

- Characters should not touch each other. Example:

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

- Do not write in 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 (i.e. information written over white out, 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.

If submitting multiple claim forms, they may be batched up to 100 forms per batch. Use paper clips or rubber bands to hold the claim forms in each batch together. Do not use staples.

For mailing completed claim forms, use the self-addressed envelopes provided by CSC for this purpose. For information on how to order envelopes please refer to Information for All Providers, Inquiry section on this web page. The address for submitting claim forms is:

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

# Claim Form eMedNY-150001

To view the eMedNY-150001 claim form please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Claim Sample-HCFA-Ordered Ambulatory

## General Information About the eMedNY-150001

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

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

| | | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|

# Billing Instructions for Ordered Ambulatory Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Ordered Ambulatory Services. Although the instructions that follow are based on the eMedNY-150001 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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

## Field by Field Instructions for Claim Form eMedNY-150001

**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 of the claim lines entered in the Encounter Section of the form.***

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

**ADJUSTMENT/VOID CODE (Upper Right Corner of Form)**

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

- If submitting a **void** to a previously paid claim, enter 'X' or the value **8** in the 'V' box.

**ORIGINAL CLAIM REFERENCE NUMBER (Upper Right Corner Of The Form)**

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier which is assigned to each claim document or electronic record regardless of the number of individual claims

(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 claims submitted under that document/record.

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

- To change information contained in one or more claims submitted on a previously paid TCN

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

***Adjustment to Change Information:***
If an adjustment is submitted to correct information on one or more claims 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 claims originally submitted in the same document/record (all claims with the same TCN) and all applicable fields must be completed with the necessary changes.

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

**Example:**

TCN 0509567890123456 is shared by three individual claims. This TCN was paid on April 18, 2005. After receiving payment, the provider determines that the service date of one of the claim records is incorrect. An adjustment must be submitted to correct the records. Refer to Figures 1A and 1B for an illustration of this example.

# Figure 1A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

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

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

| 1. PATIENT'S NAME (First, middle, last) | 2. DATE OF BIRTH | 2A. TOTAL ANNUAL FAMILY INCOME | 4. INSURED'S NAME (First name, middle initial, last name) |
|---|---|---|---|
| JANE SMITH | 05/20/1990 | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX | 5A. PATIENT'S SEX | 6. MEDICARE NUMBER | 6A. MEDICAID NUMBER |
|---|---|---|---|---|
| | MALE / FEMALE | MALE: X / FEMALE: X | | AB12345C |

| 5B. PATIENT'S TELEPHONE NUMBER | 6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO. |
|---|---|---|---|
| ( ) | | | |

| 6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL | 7. PATIENT'S RELATIONSHIP TO INSURED | 8. INSURED'S EMPLOYER OR OCCUPATION |
|---|---|---|
| | SELF / SPOUSE / CHILD / OTHER | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number | 10. WAS CONDITION RELATED TO | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | PATIENT'S EMPLOYMENT: X / CRIME VICTIM: X<br>AUTO ACCIDENT: X / OTHER LIABILITY: X | |

| 12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY | 13. INSURED'S SIGNATURE |
|---|---|---|
| | | |

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

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

| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE |
|---|---|---|---|---|
| | | | 00619416 | |

| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES | ADMITTED MM DD YY | DISCHARGED MM DD YY | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE MM DD YY | 20C. TYPE OF SURGERY |
|---|---|---|---|---|---|
| | | | | | |

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

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

| 23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE ▼ | 22F. POSSIBLE DISABILITY Y X | 22G. EPSDT C/THP Y N | 22H. FAMILY PLANNING Y X |
|---|---|---|---|
| 1.<br>2.<br>3. | | | |

| 23A. PRIOR APPROVAL NUMBER | 23B. PAYM'T SOURCE CODE |
|---|---|
| | 11 |

| 24A. DATE OF SERVICE M M D D Y Y | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 03 28 05 | | 71010 | TC | | | | 783.9 | | 100.00 | | |
| 03 28 05 | | 72010 | TC | | | | 783.9 | | 40.00 | | |
| 03 28 05 | | 73500 | TC | | | | 783.9 | | 125.00 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) | 26. ACCEPT ASSIGNMENT | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| James Strong<br>SIGNATURE OF PHYSICIAN OR SUPPLIER | YES / NO | | | |

| 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE |
|---|---|
| | Anytown Medical Center<br>312 Main Street<br>Anytown, New York 11111 |

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

| 25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID | TELEPHONE NUMBER ( ) EXT. |
|---|---|---|---|---|
| | 003 | | YES / NO | |

| COUNTY OF SUBMITTAL | 25E. DATE SIGNED | 32. PATIENT'S ACCOUNT NUMBER | DO NOT WRITE IN THIS SPACE |
|---|---|---|---|
| | 04 04 05 | ABC12345 | |

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

EMEDNY – 150001 ((1/04)

# Figure 1B: Adjustment

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | CODE: 7 A V | ORIGINAL CLAIM REFERENCE NUMBER: 0 5 0 9 5 6 7 8 9 0 1 2 3 4 5 6

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

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

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

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. DATE OF ONSET OF CONDITION MM DD YY | 15. FIRST CONSULTED FOR CONDITION MM DD YY | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES ☐ NO ☐ | 16A. EMERGENCY RELATED: YES X NO X | 17. DATE PATIENT MAY RETURN TO WORK MM DD YY | 18. DATES OF DISABILITY: TOTAL ☐ PARTIAL ☐ | FROM MM DD YY / TO MM DD YY |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS *(OR SIGNATURE SHF ONLY)* | | 19B. PROF CD | 19C. IDENTIFICATION NUMBER: 0 0 6 1 9 4 1 6 | | 19D. DX CODE |
| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES | ADMITTED MM DD YY | DISCHARGED MM DD YY | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE MM DD YY | 20C. TYPE OF SURGERY | |
| 21. NAME OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)* | 21A. ADDRESS OF FACILITY | | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES ☐ NO ☐ | LAB CHARGES | | |
| 22A. SERVICE PROVIDER NAME | 22B. PROF CD | 22C. IDENTIFICATION NUMBER | 22D. STERILIZATION ABORTION CODE | 22E. STATUS CODE | | |

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

1.
2.
3.

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

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

| 24A. DATE OF SERVICE M M D D Y Y | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 3 2 8 0 5 | | 7 1 0 1 0 | T C | | | | 7 3 7.9 | | 1 0.0 0 | | |
| 0 3 2 8 0 5 | | 7 2 0 1 0 | T C | | | | 7 3 7.9 | | 4 0.0 0 | | |
| 0 3 2 9 0 5 | | 7 3 5 0 0 | T C | | | | 7 3 7.9 | | 1 2.5 0 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

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

**James Strong**

SIGNATURE OF PHYSICIAN OR SUPPLIER

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

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

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

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

COUNTY OF SUBMITTAL | 25E. DATE SIGNED: 05 28 05 | 32. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5

DO NOT WRITE IN THIS SPACE

EMEDNY – 150001 ((1/04)

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

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

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

**Example:**

TCN 0509612345678901 contained three individual claims, which were paid on April 18, 2005. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim for that service must be cancelled to reimburse Medicaid for the overpayment; an adjustment should be submitted. Refer to figures 2A and 2B for an illustration of this example.

# Figure 2A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

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

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

| 1. PATIENT'S NAME (First, middle, last) | 2. DATE OF BIRTH | 2A. TOTAL ANNUAL FAMILY INCOME | 4. INSURED'S NAME (First name, middle initial, last name) |
|---|---|---|---|
| JANE SMITH | 05/20/1990 | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX | 5A. PATIENT'S SEX | 6. MEDICARE NUMBER | 6A. MEDICAID NUMBER |
|---|---|---|---|---|
| | MALE / FEMALE | MALE: X / FEMALE: X | | AB12345C |

| 5B. PATIENT'S TELEPHONE NUMBER | 6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO. |
|---|---|---|---|
| ( ) | | | |

| 6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL | 7. PATIENT'S RELATIONSHIP TO INSURED | 8. INSURED'S EMPLOYER OR OCCUPATION |
|---|---|---|
| | SELF / SPOUSE / CHILD / OTHER | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number | 10. WAS CONDITION RELATED TO | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | PATIENT'S EMPLOYMENT: X / CRIME VICTIM: X<br>AUTO ACCIDENT: X / OTHER LIABILITY: X | |

| 12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE (MM DD YY) | 13. INSURED'S SIGNATURE |
|---|---|---|
| | | |

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

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

| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE |
|---|---|---|---|---|
| | | | 00619416 | |

| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES | ADMITTED (MM DD YY) | DISCHARGED (MM DD YY) | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE (MM DD YY) | 20C. TYPE OF SURGERY |
|---|---|---|---|---|---|
| | | | | | |

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

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

| 23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE ▼ | 22F. POSSIBLE DISABILITY: Y / X | 22G. EPSDT C/THP: Y / N | 22H. FAMILY PLANNING: Y / X |
|---|---|---|---|
| 1.<br>2.<br>3. | | | |

| 23A. PRIOR APPROVAL NUMBER | 23B. PAYM'T SOURCE CODE |
|---|---|
| | 11 |

| 24A. DATE OF SERVICE (M M D D Y Y) | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 03 28 05 | | 71010 | TC | | | | 737.9 | | 100.00 | | |
| 03 28 05 | | 72010 | TC | | | | 737.9 | | 40.00 | | |
| 03 28 05 | | 73500 | TC | | | | 737.9 | | 125.00 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) | 26. ACCEPT ASSIGNMENT | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| James Strong<br>SIGNATURE OF PHYSICIAN OR SUPPLIER | YES / NO | | | |

| 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE |
|---|---|
| | Anytown Medical Center<br>312 Main Street<br>Anytown, New York 11111 |

| 25A. PROVIDER IDENTIFICATION NUMBER | | | | | | | | | TELEPHONE NUMBER ( ) EXT. |
|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

| 25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID | DO NOT WRITE IN THIS SPACE |
|---|---|---|---|---|
| | 003 | | YES / NO | |

| COUNTY OF SUBMITTAL | 25E. DATE SIGNED | 32. PATIENT'S ACCOUNT NUMBER | EMEDNY – 150001 ((1/04) |
|---|---|---|---|
| | 04 04 05 | ABC12345 | |

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

# Figure 2B: Adjustment

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | CODE: X | ORIGINAL CLAIM REFERENCE NUMBER: 05096123456789 01

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

| 1. PATIENT'S NAME (First, middle, last) | 2. DATE OF BIRTH | 2A. TOTAL ANNUAL FAMILY INCOME | 4. INSURED'S NAME (First name, middle initial, last name) |
|---|---|---|---|
| JANE SMITH | 05/20/1990 | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX | 5A. PATIENT'S SEX | 6. MEDICARE NUMBER | 6A. MEDICAID NUMBER |
|---|---|---|---|---|
| | MALE / FEMALE | MALE: X / FEMALE: X | | AB12345C |

| 5B. PATIENT'S TELEPHONE NUMBER | 6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO. |
|---|---|---|---|
| ( ) | | | |

| 6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL | 7. PATIENT'S RELATIONSHIP TO INSURED | 8. INSURED'S EMPLOYER OR OCCUPATION |
|---|---|---|
| | SELF / SPOUSE / CHILD / OTHER | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number | 10. WAS CONDITION RELATED TO | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | PATIENT'S EMPLOYMENT: X / CRIME VICTIM: X<br>AUTO ACCIDENT: X / OTHER LIABILITY: X | |

| 12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY | 13. INSURED'S SIGNATURE |
|---|---|---|
| | | |

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

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

| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE |
|---|---|---|---|---|
| | | | 00619416 | |

| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED MM DD YY | DISCHARGED MM DD YY | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE MM DD YY | 20C. TYPE OF SURGERY |
|---|---|---|---|---|
| | | | | |

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

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

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

1.
2.
3.

| 22F. POSSIBLE DISABILITY | 22G. EPSDT C/THP | 22H. FAMILY PLANNING |
|---|---|---|
| Y / X | Y / N | Y / X |

| 23A. PRIOR APPROVAL NUMBER | 23B. PAYM'T SOURCE CODE |
|---|---|
| | 11 |

| 24A. DATE OF SERVICE MM DD YY | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 03 28 05 | | 72010 | TC | | | | 737.9 | | 40.00 | | |
| 03 29 05 | | 73500 | TC | | | | 737.9 | | 12.50 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) | 26. ACCEPT ASSIGNMENT YES / NO | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| James Strong<br>SIGNATURE OF PHYSICIAN OR SUPPLIER | 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE | | |
| | | Anytown Medical Center<br>312 Main Street<br>Anytown, New York 11111 | | |

| 25A. PROVIDER IDENTIFICATION NUMBER | 25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID YES / NO | TELEPHONE NUMBER ( ) EXT. |
|---|---|---|---|---|---|
| 01234567 | | 003 | | | |

| COUNTY OF SUBMITTAL | 25E. DATE SIGNED | 32. PATIENT'S ACCOUNT NUMBER | DO NOT WRITE IN THIS SPACE |
|---|---|---|---|
| | 05 28 05 | ABC12345 | |

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

EMEDNY – 150001 ((1/04)

## Void

A void is submitted to nullify **all** individual claims 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 claims to be cancelled and all applicable fields must be completed.

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

**Example:**

TCN 0509698765432123 contained two claims, which were paid on April 18, 2005. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claims paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

# Figure 3A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

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

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

| 1. PATIENT'S NAME (First, middle, last) | 2. DATE OF BIRTH | 2A. TOTAL ANNUAL FAMILY INCOME | 4. INSURED'S NAME (First name, middle initial, last name) |
|---|---|---|---|
| ROBERT JOHNSON | 06/03/1956 | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX | 5A. PATIENT'S SEX | 6. MEDICARE NUMBER | 6A. MEDICAID NUMBER |
|---|---|---|---|---|
| | MALE ☐ FEMALE ☐ | MALE X FEMALE ☐ | | AB12345C |

| 5B. PATIENT'S TELEPHONE NUMBER | 6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO. |
|---|---|---|---|
| ( ) | | | |

| 6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL | 7. PATIENT'S RELATIONSHIP TO INSURED | 8. INSURED'S EMPLOYER OR OCCUPATION |
|---|---|---|
| | SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number | 10. WAS CONDITION RELATED TO | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | PATIENT'S EMPLOYMENT ☐ CRIME VICTIM ☐ AUTO ACCIDENT ☐ OTHER LIABILITY ☐ | |

| 12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY | 13. INSURED'S SIGNATURE |
|---|---|---|
| | | |

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

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

| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE |
|---|---|---|---|---|
| | | | 00619416 | |

| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES | ADMITTED MM DD YY | DISCHARGED MM DD YY | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE MM DD YY | 20C. TYPE OF SURGERY |
|---|---|---|---|---|---|
| | | | | | |

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

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

| 23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE ▼ | 22F. POSSIBLE DISABILITY Y X | 22G. EPSDT C/THP Y N | 22H. FAMILY PLANNING Y X |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

| 23A. PRIOR APPROVAL NUMBER | 23B. PAYM'T SOURCE CODE |
|---|---|
| | 11 |

| 24A. DATE OF SERVICE MM DD YY | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 03 28 05 | | 71010 | TC | | | | 737.9 | | 100.00 | | |
| 03 28 05 | | 72010 | TC | | | | 737.9 | | 40.00 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) | 26. ACCEPT ASSIGNMENT | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| James Strong | YES ☐ NO ☐ | | | |
| SIGNATURE OF PHYSICIAN OR SUPPLIER | 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE | | |
| | | Anytown Medical Center<br>312 Main Street<br>Anytown, New York 11111 | | |

| 25A. PROVIDER IDENTIFICATION NUMBER | | | |
|---|---|---|---|
| 01234567 | | | |

| 25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID | TELEPHONE NUMBER ( ) EXT. |
|---|---|---|---|---|
| | 003 | | YES ☐ NO ☐ | |

| COUNTY OF SUBMITTAL | 25E. DATE SIGNED | 32. PATIENT'S ACCOUNT NUMBER | DO NOT WRITE IN THIS SPACE |
|---|---|---|---|
| | 04 04 05 | ABC12345 | |

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

EMEDNY – 150001 ((1/04)

# Figure 3B: Void

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | CODE: A X | ORIGINAL CLAIM REFERENCE NUMBER: 0 5 0 9 6 9 8 7 6 5 4 3 2 1 2 3

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

DO NOT STAPLE IN BARCODE AREA

| 1. PATIENT'S NAME (First, middle, last) | 2. DATE OF BIRTH | 2A. TOTAL ANNUAL FAMILY INCOME | 4. INSURED'S NAME (First name, middle initial, last name) |
|---|---|---|---|
| ROBERT JOHNSON | 0 6 0 3 1 9 5 6 | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX MALE / FEMALE | 5A. PATIENT'S SEX MALE / FEMALE | 6. MEDICARE NUMBER | 6A. MEDICAID NUMBER |
|---|---|---|---|---|
| | | X / X | | A B 1 2 3 4 5 C |

| 5B. PATIENT'S TELEPHONE NUMBER | 6B. PRIVATE INSURANCE NUMBER | GROUP NO. | RECIPROCITY NO. |
|---|---|---|---|
| ( ) | | | |

| 6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL | 7. PATIENT'S RELATIONSHIP TO INSURED SELF / SPOUSE / CHILD / OTHER | 8. INSURED'S EMPLOYER OR OCCUPATION |
|---|---|---|
| | | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number | 10. WAS CONDITION RELATED TO | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | PATIENT'S EMPLOYMENT X / CRIME VICTIM X<br>AUTO ACCIDENT X / OTHER LIABILITY X | |

| 12. PATIENT'S OR AUTHORIZED SIGNATURE | DATE MM DD YY | 13. INSURED'S SIGNATURE |
|---|---|---|
| | | |

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

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

| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 19A. ADDRESS (OR SIGNATURE SHF ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | 19D. DX CODE |
|---|---|---|---|---|
| | | | 0 0 6 1 9 4 1 6 | |

| 20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES | ADMITTED MM DD YY | DISCHARGED MM DD YY | 20A. NAME OF HOSPITAL | 20B. SURGERY DATE MM DD YY | 20C. TYPE OF SURGERY |
|---|---|---|---|---|---|
| | | | | | |

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

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

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

1.
2.
3.

| 22F. POSSIBLE DISABILITY Y X | 22G. EPSDT C/THP Y N | 22H. FAMILY PLANNING Y X |
|---|---|---|
| | | |

| 23A. PRIOR APPROVAL NUMBER | 23B. PAYM'T SOURCE CODE |
|---|---|
| | 1 1 |

| 24A. DATE OF SERVICE M M D D Y Y | 24B. PLACE | 24C. PROCEDURE CD | 24D. MOD | 24E. MOD | 24F. MOD | 24G. MOD | 24H. DIAGNOSIS CODE | 24I. DAYS OR UNITS | 24J. CHARGES | 24K. | 24L. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 3 2 8 0 5 | | 7 1 0 1 0 | T C | | | | 7 3 7.9 | | 1 0.0 0 | | |
| 0 3 2 8 0 5 | | 7 2 0 1 0 | T C | | | | 7 3 7.9 | | 4 0.0 0 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) | 26. ACCEPT ASSIGNMENT YES / NO | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
|---|---|---|---|---|
| James Strong<br>SIGNATURE OF PHYSICIAN OR SUPPLIER | 30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE | | |
| | | Anytown Medical Center<br>312 Main Street<br>Anytown, New York 11111 | | |

| 25A. PROVIDER IDENTIFICATION NUMBER | 25B. MEDICAID GROUP IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID YES / NO | TELEPHONE NUMBER ( ) EXT. |
|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | 0 0 3 | | | |

| COUNTY OF SUBMITTAL | 25E. DATE SIGNED | 32. PATIENT'S ACCOUNT NUMBER | DO NOT WRITE IN THIS SPACE |
|---|---|---|---|
| | 05 28 05 | A B C 1 2 3 4 5 | |

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

EMEDNY – 150001 ((1/04)

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

## PATIENT'S NAME (Field 1)

Enter the patient's first name, followed by the last name, as they appear on the Common Benefit Identification Card.

## DATE OF BIRTH (Field 2)

Enter the patient's birth date indicated on the Common Benefit ID Card. The birth date must be in the format MMDDYYYY.

**Example**: Mary Brandon was born on January 2nd, 2004.

| 2. DATE OF BIRTH | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 1 | 0 | 2 | 2 | 0 | 0 | 4 |

## PATIENT'S SEX (Field 5A)

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

## MEDICAID NUMBER (Field 6A)

Enter the patient's ID number (Client ID number) as it appears on the Common Benefit Identification Card. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

**Example:**

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

## WAS CONDITION RELATED TO (Field 10)

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

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

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

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

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

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

## EMERGENCY RELATED (Field 16A)

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

## NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (Field 19)

Enter the ordering provider's name in this field.

## ADDRESS [Or Signature SHF Only] (Field 19A)

Leave this field blank.

## PROF CD (PROFESSION CODE) [Ordering/Referring Provider] (Field 19B)

If a license number is indicated in Field 19C, the Profession Code that identifies the ordering/referring provider's profession must be entered in this field. Profession Codes are listed at www.nyhipaadesk.com.

Under the **News and Resources** tab:

✓ Select eMedNY Phase II News from the menu

✓ Click on Using License Number in Phase II

✓ Click on License Type to Profession Code Crosswalk.

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

Enter the ordering provider's Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her license number. If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A – Codes for the Post Office state abbreviations.

**DX CODE (Field 19D)**

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 A – Codes.

If the procedure is unrelated 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).

When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, **DSS-3134**, is required and must be attached to the

paper claim form (see Appendix B).

**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.

## PAYM'T SOURCE CODE [Box M and Box O] (Field 23B)

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

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

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

- **Patient has Medicare Part B; Medicare paid for the service – Source Code Indicator = 2**
  This code indicates that the service is covered by Medicare and that Medicare approved the service and made a payment. Medicaid is responsible for reimbursing the Medicare deductible and/or (full or partial) coinsurance.

- **Patient has Medicare Part B; Medicare denied payment – Source Code Indicator = 3**
  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 recipient 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. Refer to Information for All Providers, Third Party Information on this web page, for the appropriate Other Insurance codes.

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

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

23B. PAYM'T SOURCE CO

M / O / /

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

## Encounter Section: Fields 24A Through 24O

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

### DATE OF SERVICE (Field 24A)

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

**Example**: July 1, 2003 = 07/01/03

**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. can be found on this web page under Procedure Codes and Fee Schedule for this manual.**

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

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

**Note: Modifier values and their definitions can be found on this web page under Procedure Codes and Fee Schedule for this manual.**

### DIAGNOSIS CODE (Field 24H)

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

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

**Example:**

267. Ascorbic Acid Deficiency - Acceptable to Medicaid (no subcategories)

268. Vitamin D Deficiency - Not Acceptable to Medicaid (Subcategories exist)

Acceptable Diagnosis Codes:
267.
268.0
268.1

The following example illustrates the correct entry of an ICD-9-CM Diagnosis Code.

**Example:**

| 24H. DIAGNOSIS CODE | | | | | |
|---|---|---|---|---|---|
| 2 | 6 | 8 . 0 | | | |

**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.

**The entries in Fields 24J, 24K, and 24L are determined by the entries in Field 23B, Payment Source Code.**

**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**:

- **Field 24J must never be left blank or contain $0.00**

- **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.**

**The value in Box 'M' is 2**
Enter the amount paid by Medicare in this field.

**The value in Box 'M' is 3**
When Box 'M' in field 23B contains the value **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 payers in this field.

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

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

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

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

- Prior to billing the insurance company, the provider knows that the service will not be covered because:

  - ► The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.

  - ► In very limited situations the Local Department of Social Services (LDSS) has advised providers 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. Since June 1, 1992 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 recipient 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 recipient or absent parent.

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

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

**FROM AND THROUGH DATES (Field 24M)**

Leave this field blank.

**PROC CD [Procedure Code] (Field 24N)**

Leave this field blank.

**MOD [Modifier] (Field 24O)**

Leave this field blank.

**Trailer Section: Fields 25 Through 34**

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

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

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

**PROVIDER IDENTIFICATION NUMBER (Field 25A)**

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

The Provider ID number is pre-printed by CSC on this field for all providers except for practitioner groups.

**MEDICAID GROUP IDENTIFICATION NUMBER (Field 25B)**

Leave this field blank.

**LOCATOR CODE (Field 25C)**

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

Currently Locator codes are issued as two-digit codes. However, any entry in this field must have three digits. Therefore, providers need to enter an additional zero to the left of these two-digit codes to comply with eMedNY billing requirements. For example, locator code 03 must be entered as 003, etc.

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

**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 on this web page.**

## SA EXCP CODE (SERVICE AUTHORIZATION EXCEPTION CODE) (Field 25D)

Leave this field blank.

## COUNTY OF SUBMITTAL (Unnumbered Field)

Enter the name of the county wherein the claim form is signed. The County may be left blank **only** when the provider's address, as preprinted in the lower right corner of the claim form, 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 on this web page.**

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

The provider's name and correspondence address are preprinted in this field except for practitioner groups.

**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 that can be found on this web page.**

## PATIENT'S ACCOUNT NUMBER (Field 32)

For record-keeping purposes, the provider may choose to identify a recipient 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 recipient identification.

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

Leave this field blank.

## PROF CD (PROFESSION CODE) [Other Referring/Ordering Provider] (Field 34)

Leave this field blank.

# Section III – Remittance Advice

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

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

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

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

Remittance advices are available in electronic and paper formats.

## Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835) providers may call CSC-Provider Enrollment Support at 800-343-9000 or complete the HIPAA 835 Transaction Request form, which is available at www.emedny.org.

Under **Information**:

✓ Click on Provider Enrollment Forms

✓ Click on HIPAA 835 Transaction Request Form

The NYS Medicaid Companion Guides for the 835 transaction are available at www.nhipaadesk.com.

Under the **News and Resources** tab:

✓ Select eMedNY Phase II HIPAA Transactions from the menu

✓ Click on 835 Health Care Claim Payment Advice Transaction

✓ Click on Companion Guide-835 Health Care Transaction

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

Providers who choose to receive the 835 electronic remittance advice will receive adjudicated claims (paid/denied) detail for their electronic and paper claim submissions on this format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produce pends.

# Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices. Providers who bill all of their claims on paper forms can only receive paper remittance advices.

## Remittance Sorts

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

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

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

To request a sort pattern other than the default, please call CSC-Provider Enrollment Support at 800-343-9000 or complete the Remittance Sort Request form, available at www.emedny.org.

Under **Information**:

✓ Click on Provider Enrollment Forms

✓ Click on HIPAA 835 Transaction Request Form

## Remittance Advice Format

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

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

## Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Ordered Ambulatory providers followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only.

The following information applies to a remittance advice with the default sort pattern.

## Section One – Medicaid Check

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC HOSPITAL

DATE: 2005-08-01
REMITTANCE NO: 05080100006
PROVIDER ID: 00112233

05080100006 2005-08-01
ABC HOSPITAL
100 BROADWAY
ANYTOWN NY 11111

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

29/2

| DATE | REMITTANCE NUMBER | PROVIDER ID NO. |
|---|---|---|
| 2005-08-01<br>VOID AFTER 90 DAYS | 05080100006 | 00112233 |

| PAY | DOLLARS/CENTS |
|---|---|
| | $*****143.80 |

TO THE ORDER OF
05080100006 2005-08-01
ABC HOSPITAL
100 BROADWAY
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John
Smith

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

### *Check Stub Information*

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

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
Provider ID number

**CENTER**
Remittance number/date
Provider's name/address

### *Medicaid Check*

**LEFT SIDE**
Table
Date on which the check was issued
Remittance number
Provider ID number

Remittance number
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.

## Section One – EFT Notification

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

TO: ABC HOSPITAL

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 2005-08-01
REMITTANCE NO: 05080100006
PROVIDER ID: 00112233

05080100006 2005-08-01
ABC HOSPITAL
100 BROADWAY
ANYTOWN NY 11111

ABC HOSPITAL $143.80

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

### *Information on the EFT Notification Page*

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

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
Provider ID number

**CENTER**
Remittance number/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.

## Section One – Summout (No Payment)

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

TO: ABC HOSPITAL


DATE: 08/01/2005
REMITTANCE NO: 05080100006
PROVIDER ID: 00112233

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

ABC HOSPITAL
100 BROADWAY
ANYTOWN NY 11111

***Information on the Summout Page***

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

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
Provider ID number

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

## Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 08/01/05
CYCLE 458

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00112233
REMITTANCE NO 05080100006

REMITTANCE ADVICE MESSAGE TEXT

EMEDNY WILL BE CLOSED MONDAY, SEPTEMBER 5, 2005 IN OBSERVANCE OF LABOR DAY.

***Information on the Provider Notification Page***

**UPPER LEFT CORNER**
Provider's name and address

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

ETIN (not applicable)
Name of section: **Provider Notification**
Provider ID number
Remittance number

**CENTER**
Message text

## Section Three – Claim Detail

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 02
DATE 08/01/2005
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP343444 | DAVIS | UU44444R | 05206-000000227-0-0 | 07/11/05 | 70010 | 1.000 | 52.80 | 0.00 | DENY | 00162 00131 |
| 01 | CP443544 | BROWN | PP88888M | 05206-000011334-0-0 | 07/11/05 | 71130 | 1.000 | 17.60 | 0.00 | DENY | 00170 |
| 01 | CP766578 | MALONE | SS99999L | 05206-000013556-0-0 | 07/19/05 | 72040 | 1.000 | 14.30 | 0.00 | DENY | 00162 |
| 01 | CP999890 | SMITH | ZZ22222T | 05206-000032456-0-0 | 07/20/05 | 76070 | 1.000 | 77.50 | 0.00 | DENY | 00131 |

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 03
DATE 08/01/2005
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP112346 | DAVIS | UU44444R | 05206-000033667-0-0 | 07/11/05 | 73550 | 1.000 | 14.30 | 14.30 | PAID | |
| 02 | CP112345 | DAVIS | UU44444R | 05206-000033667-0-0 | 07/12/05 | 73592 | 1.000 | 14.30 | 14.30 | PAID | |
| 01 | CP113433 | CRUZ | LL11111B | 05206-000045667-0-0 | 07/14/05 | 74247 | 1.000 | 52.80 | 52.80 | PAID | |
| 01 | CP445677 | JONES | YY33333S | 05206-000056767-0-0 | 07/15/05 | 74249 | 1.000 | 66.00 | 66.00 | PAID | |
| 01 | CP113487 | WAGER | ZZ98765R | 05206-000067767-0-0 | 06/05/05 | 74020 | 1.000 | 17.60 | 17.60- | ADJT | ORIGINAL CLAIM PAID 06/24/05 |
| 01 | CP744495 | PARKER | VZ45678P | 05206-000088767-0-0 | 06/05/05 | 74010 | 1.000 | 14.30 | 14.00 | ADJT | |

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 04
DATE 08/01/2005
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP8765432 | CRUZ | LL11111B | 05206-000033467-0-0 | 07/13/05 | 75822 | 1.000 | 69.30 | 0.00 | **PEND | 00162 |
| 02 | CP4555557 | CRUZ | LL11111B | 05206-000033468-0-0 | 07/14/05 | 75665 | 1.000 | 71.04 | 0.00 | **PEND | 00162 |
| 01 | CP8876543 | TAYLOR | GG43210D | 05206-000035665-0-0 | 07/14/05 | 73592 | 1.000 | 14.30 | 0.00 | **PEND | 00142 |
| 01 | CP0009765 | ESPOSITO | FF98765C | 05206-000033660-0-0 | 07/12/05 | 73592 | 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 AMOUT ADJUSTMENTS | PEND | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS | PEND | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS – ADJUSTS | | 0.00 | NUMBER OF CLAIMS | 0 |

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

| | | | |
|---|---|---|---|
| MEMBER ID: 00112233 | | | |
| VOIDS – ADJUSTS | 3.60- | NUMBER OF CLAIMS | 1 |
| TOTAL PENDS | 168.94 | NUMBER OF CLAIMS | 4 |
| TOTAL PAID | 147.40 | NUMBER OF CLAIMS | 4 |
| TOTAL DENIED | 162.20 | NUMBER OF CLAIMS | 4 |
| NET TOTAL PAID | 143.80 | NUMBER OF CLAIMS | 5 |

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE: 05
DATE: 08/01/05
CYCLE: 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
GRAND TOTALS
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

REMITTANCE TOTALS – GRAND TOTALS

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

### *General Information on the Claim Detail Pages*

**UPPER LEFT CORNER**
Provider's name and address

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

ETIN (not applicable)
Provider Service Classification: **Practitioner**
Provider ID number
Remittance number

### *Explanation of the Claim Detail Columns*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Adjustments***
The status ADJT refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the debit transaction (adjusted claim) and the credit transaction (previously paid 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: Recipient ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

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

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

### ERRORS

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

### *Subtotals/Totals*

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

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

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

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

- Adjustments/voids (combined)

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

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

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

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

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

## Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

### *Financial Transactions*

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 08/01/05
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

| FCN | FINANCIAL REASON CODE | FISCAL TRANS TYPE | | DATE | | AMOUNT |
|---|---|---|---|---|---|---|
| 200505060236547 | XXX | RECOUPMENT REASON DESCRIPTION | 05 | 09 | 05 | $$.$$ |

NET FINANCIAL AMOUNT $$$.$$

NUMBER OF FINANCIAL TRANSACTIONS XXX

### *Explanation of the Financial Transactions Columns*

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

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

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

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

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

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

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

### *Accounts Receivable*

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

PAGE 08
DATE 08/01/05
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

### *Explanation of the Accounts Receivable Columns*

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

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

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

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

**PERCENTAGE OR AMOUNT**
The deduction (recoupment) scheduled for each cycle.

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

## Section Five – Edit Descriptions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 06
DATE 08/01/05
CYCLE 458

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PRACTITIONER
EDIT DESCRIPTIONS
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

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 |
| 00170 | PROCEDURE CODE NOT ON FILE |

# Appendix A – Code Sets

## Place of Service

| Code | Description |
|---|---|
| 03 | School |
| 04 | Homeless shelter |
| 05 | Indian health service free-standing facility |
| 06 | Indian health service provider-based facility |
| 07 | Tribal 638 free-standing facility |
| 08 | Tribal 638 provider-based facility |
| 11 | Doctor's office |
| 12 | Home |
| 13 | Assisted living facility |
| 14 | Group home |
| 15 | Mobile unit |
| 20 | Urgent care facility |
| 21 | Inpatient hospital |
| 22 | Outpatient hospital |
| 23 | Emergency room-hospital |
| 24 | Ambulatory surgical center |
| 25 | Birthing center |
| 26 | 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 |
| 60 | Mass immunization center |
| 61 | Comprehensive inpatient rehabilitation facility |
| 62 | Comprehensive outpatient rehabilitation facility |
| 65 | End stage renal disease treatment facility |
| 71 | State or local public health clinic |
| 72 | Rural health clinic |
| 81 | Independent laboratory |
| 99 | Other unlisted facility |

## Sterilization/Abortion Codes

| Code | Description |
|---|---|
| A | Induced Abortion – Danger to the woman's life. |
| B | Induced Abortion – Physical health damage to the woman. |
| C | Induced Abortion – Victim of rape or incest. |
| D | Induced Abortion – Medically necessary. |
| E | Induced Abortion – Elective – i.e., not considered medically necessary by the attending physician – provision of elective abortions is restricted to New York City recipients. |
| F | Procedure performed for the purpose of sterilization. |

## United States Standard Postal Abbreviations

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

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

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

# Appendix B – Sterilization Consent Form – DSS-3134

A Sterilization Consent Form, DSS-3134, must be completed for each sterilization procedure. **No other form can be used in place of the DSS-3134.** A supply of these forms, available in English and in Spanish [DSS-3134(S)], can be obtained from:

**New York State Department of Health**
**Corning Tower - Room 2029**
**Empire State Plaza**
**Albany, New York 12237**

For electronic claim submissions, the completed and signed DSS-3134 [or DSS-31234(S)] must be kept in the patient's file. If upon audit and examination, it is found that the consent form is not present or is defective, the Department will recoup any and all payments associated with the sterilization procedure. For paper claim submissions, a copy of the completed and signed **Sterilization Consent Form**, DSS-3134 [or DSS-3134(S)] must be attached to the claim.

When completing the DSS-3134, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable (will cause a paper claim to deny). Also, the persons completing the form should check to see that all five copies are legible.

- Each required field or blank must be completed in order to ensure payment.

- If a woman is not currently Medicaid eligible at the time she signs the DSS-3134 [or 3134(S)] form but becomes eligible prior to the procedure and if she is 21 years of age when the form was signed, the 30 day waiting period starts from the date the DSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

DSS-3134 **(Rev.5/82)**

**STERILIZATION**
CONSENT FORM

| PATIENT NAME | CHART NO. | RECIPIENT ID NO. |
|---|---|---|
| 1. | | |
| HOSPITAL/CLINIC | | |

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from 2. (*doctor or clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a 3. . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 4. (*Month Day Year*)

I, 5. , hereby consent of my own free will to be sterilized by 6. (*doctor*)

by a method called 7. . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.
I have received a copy of this form.

8. (*Signature*) *Date:* 9. (*Month Day Year*)

10. You are requested to supply the following information, but it is not required:
*Race and ethnicity designation (please check)*

☐1 American Indian or Alaska Native
☐2 Asian or Pacific Islander
☐3 Blank (not of Hispanic origin)
☐4 Hispanic
☐5 White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent.
I have also read him/her the consent form in 11. language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

12.
*Interpreter* *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 13. (*name of individual*) signed the consent form, I explained to him/her the nature of the sterilization operation 14. , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15.
*Signature of person obtaining consent* *Date*

16.
*Facility*

16.
*Address*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 17. on 18.
*Name of individual to be sterilized* *Date of sterilization*

18. (Con't) , I explained to him/her the nature of the *operation* sterilization operation 19. , The fact that *specify type of operation* it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the pro- cedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ 1 Premature delivery 20.
22. Individual's expected date of delivery: 21.
☐ 2 Emergency abdominal surgery: 23.
(describe circumstances): 23.(Con't)

24.
*Physician*
*Date* 25.

**THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY**
**WITNESS CERTIFICATION**

I, 26. do certify that on 27. , 19 I was present while the counselor read and explained the consent form to 28. (patient's name) and saw the patient sign the consent form in his/her own handwriting.

| SIGNATURE OF WITNESS | TITLE | DATE |
|---|---|---|
| X 29. | 30. | 31. |

**REAFFIRMATION** (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form.
I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

| SIGNATURE OF PATIENT | DATE | SIGNATURE OF WITNESS | DATE |
|---|---|---|---|
| X 32. | 33. | X 34. | 35. |

**DISTRIBUTION**: 1 - Medical Record File 2 - Hospital Claim 3 - Surgeon Claim 4 - Anesthesiologist Claim 5 - Patient

## *Field-by-Field Instructions for Completing the Sterilization Consent Form – DSS-3134 and 3134(S)*

### Patient Identification

**Field 1**

Enter the patient's name, Medicaid ID number, and chart number; name of hospital or clinic is optional.

### Consent To Sterilization

**Field 2**

Enter the name of the individual or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (24) cannot obtain the consent.

**Field 3**

Enter the name of sterilization procedure to be performed.

**Field 4**

Enter the patient's date of birth. Check to see that the patient is at least 21 years old. If the patient is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

**Field 5**

Enter the patient's name.

**Field 6**

Enter the name of doctor who will probably perform the sterilization. It is understood that this might not be the doctor who eventually performs the sterilization (24).

**Field 7**

Enter the name of sterilization procedure.

**Field 8**

The patient must sign the form.

**Field 9**

Enter the date of patient's signature. This is the date on which the consent was obtained. The sterilization procedure must be performed less than 30 days nor more than 180 days from this date, except in instances of premature delivery (20, 21), or emergency abdominal surgery (22, 23) when at least 72 hours (three days) must have elapsed.

**Field 10**

Completion of the race and ethnicity designation is optional.

**Interpreter's Statement**

**Field 11**

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

**Field 12**

The interpreter must sign and date the form.

**Statement of Person Obtaining Consent.**

**Field 13**

Enter the patient's name.

**Field 14**

Enter the name of the sterilization operation.

**Field 15**

The person who obtained consent from the patient must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (24).

**Field 16**

Enter the name and address of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

## Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

**Field 17**

Enter the patient's name.

**Field 18**

Enter the date the sterilization procedure was performed.

**Field 19**

Enter the name of the sterilization procedure.

## Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (24) and date (25) the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, proceed as follows:

**Field 20**

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one and (21) enter the expected date of delivery.

**Field 21**

If the patient was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two and (23) describe the circumstances.

**Field 24**

The physician who performed the sterilization must sign and date the form.

**Field 25**

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to

the sterilization.

**For Sterilizations Performed In New York City**

New York City local law requires the presence of a witness chosen by the patient when the patient consents to sterilization. In addition, upon admission for sterilization, in New York City, the patient is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

**Witness Certification**

**Field 26**

Enter the name of the witness to the consent to sterilization.

**Field 27**

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

**Field 28**

Enter the patient's name.

**Field 29**

The witness must sign the form.

**Field 30**

Enter the title, if any, of the witness.

**Field 31**

Enter the date of witness's signature.

**Reaffirmation**

**Field 32**

The patient must sign the form.

**Field 33**

Enter the date of the patient's signature. This date should be shortly prior to or same as date of sterilization in field 18.

**Field 34**

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 29.

**Field 35**

Enter the date of witness's signature.

# Appendix C – Acknowledgment of Receipt of Hysterectomy Information Form – DSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, DSS-3113, must be completed for each hysterectomy procedure. **No other form can be used in place of the DSS-3113.** A supply of these forms, available in English and in Spanish, can be obtained from:

**New York State Department of Health**
**Corning Tower - Room 2029**
**Empire State Plaza**
**Albany, New York 12237**

For electronic claim submissions, the completed and signed DSS-3113 must be kept in the patient's file. If upon audit and examination, it is found that the acknowledgment of hysterectomy form is not present or is defective, the Department will recoup any and all payments associated with the hysterectomy procedure. For paper claim submissions, a copy of the completed and signed DSS-3113 must be attached to the claim.

When completing the DSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable (will cause a paper claim to deny).

- Each required field or blank must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

**DSS-3113** **(Rev. 4/84)**

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
(NYS MEDICAID PROGRAM)

| *EITHER PART I OR PART II MUST BE COMPLETED* | 1. RECIPIENT ID NO. | 2. SURGEON'S NAME |
|---|---|---|
| | | |

**Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION**

**RECIPIENT'S ACKNOWLEDGEMENT STATEMENT**

It has been explained to me, 3._____, that the hysterectomy to be performed on me will
(RECIPIENT NAME)
make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

| 4. RECIPIENT OR REPRESENTATIVE SIGNATURE | 5. DATE | 6. INTERPRETER'S SIGNATURE (If required) | 7. DATE |
|---|---|---|---|
| X | | X | |

**SURGEON'S CERTIFICATION**

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

| 8. SURGEON'S SIGNATURE | 9. DATE |
|---|---|
| X | |

**Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION**

The hysterectomy performed on 10._____ was solely for medical reasons. The
(RECIPIENT NAME)
hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

11 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility)_____

_____

12 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

_____

_____

13 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

| 14. SURGEON'S SIGNATURE | 15. DATE |
|---|---|
| X | |

**DISTRIBUTION:** File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

### *Field-by-Field Instructions for Completing Acknowledgement Receipt of Hysterectomy Information Form – DSS-3113*

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

**Field 1**

Enter the recipient's Medicaid ID number.

**Field 2**

Enter the surgeon's name.

**Part I: Recipient's Acknowledgement Statement and Surgeon's Certification**
This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The patient was not a Medicaid recipient on the day the hysterectomy was performed.

**Field 3**

Enter the recipient's name.

**Field 4**

The recipient or her representative must sign the form.

**Field 5**

Enter the date of signature.

**Field 6**

If applicable, the interpreter must sign the form.

**Field 7**

If applicable, enter the date of interpreter's signature.

**Field 8**

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

**Field 9**

Enter the date of the surgeon's signature.

**Part II: Waiver of Acknowledgment**
The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the recipient's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

**Field 10**

Enter the recipient's name.

**Field 11**

If the recipient's acknowledgment was **not** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

**Field 12**

If the recipient's Acknowledgment was **not** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

**Field 13**

If the patient's Acknowledgment was **not** obtained because she was not a Medicaid recipient at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

**Field 14**

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

**Field 15**

Enter the date of the surgeon's signature.