NEW YORK STATE
MEDICAID PROGRAM

FREE STANDING OR
HOSPITAL BASED ORDERED
AMBULATORY MANUAL

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 Hospital-Based/Free Standing 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 Professional (837P) or 837 Institutional (837I) transactions. In addition to these documents, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

- HIPAA 837P and 837I Implementation Guides (IG) – Documents that explain the proper use of the 837P standards and program specifications. These documents are available at **www.wpc-edi.com/hipaa**.

- NYS Medicaid 837P and 837I Companion Guides (CG) – Subsets of the IGs, which provide instructions for the specific requirements of NYS Medicaid for the 837P and 837I. This document is available at **www.emedny.org**.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Companion Guides and Sample Files**

  ✓ Look for the box labeled “837 Professional Health Care Claim” and click on the link for the **837 Professional Companion Guide** or look for the box labeled “837 Institutional Health Care Claim and click on the link for the ”**837 Institutional Companion Guide**

- NYS Medicaid Technical Supplementary 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 Technical Supplementary CG is available at **www.emedny.org**.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Companion Guides and Sample Files**

✓ Look for the box labeled "Technical Guides" and click on the link for the **Technical Supplementary CG**

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 submitter identifier, issued by the NYS Medicaid Fiscal Agent, Computer Sciences Corporation (CSC), 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**.

✓ Click on **Provider Enrollment Forms** under "Information"

✓ 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**.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **Registration Information Trading Partner Resources**

✓ Click on **Trading Partner Agreement**

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**.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Companion Guides and Sample Files**

✓ Look for the box labeled "Technical Guides" and click on the link for the **eMedNY Provider Testing Users Guide**. Note: Manual Currently Under Construction.

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 www.emedny.org**.

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**.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled "Technical Guides" and click on the link for the **eMedNY Provider Testing Users Guide.** Note: Manual Currently Under Construction.
- ✓ 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 insure 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. For example:

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

- Do not write between lines.

- Do not use arrows or quotation marks to duplicate information.

- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.

- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.

- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

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.

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 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 that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record. For example, a document/record containing a single service date/procedure combination will be assigned a unique, single TCN; a document/record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claim lines submitted under that document/record.

Adjustment

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

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

Adjustment to Change Information

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

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

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

Example:

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

Figure 1A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

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

DO NOT STAPLE IN BARCODE AREA

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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 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 N	22G. EPSDT C/THP Y N	22H. FAMILY PLANNING Y X
1. 2. 3.			

23A. PRIOR APPROVAL NUMBER	23B. PAYM'T SOURCE CODE
	M 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.
04 04 05	11	99205					78.62		300.00		
04 04 05	11	93000					78.62		150.00		
04 11 05	11	99213					78.62		300.00		

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 SIGNATURE OF PHYSICIAN OR SUPPLIER	YES / NO			

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
	James Strong, M.D. 312 Main Street Anytown, New York 11111

25A. PROVIDER IDENTIFICATION NUMBER	
01234567	TELEPHONE NUMBER ( ) EXT.

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 15 05	ABC12345	

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

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: 05 20 1990	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
	5B. PATIENT'S TELEPHONE NUMBER ( )		6B. PRIVATE INSURANCE NUMBER
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

6A. MEDICAID NUMBER: A B 1 2 3 4 5 C	GROUP NO.	RECIPROCITY NO.									

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 N	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	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 4 0 4 0 5	1 1	9 9 2 0 5					7 8 6.2		3 0.0 0		
0 4 0 4 0 5	1 1	9 3 0 0 0					7 8 6.2		1 5.0 0		
0 4 2 1 0 5	1 1	9 9 2 1 3					7 8 6.2		3 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)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE	
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE: James Strong. M.D. 312 Main Street Anytown, New York 11111			
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	TELEPHONE NUMBER ( ) EXT.
COUNTY OF SUBMITTAL	25E. DATE SIGNED: 05 31 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 claim lines that were originally submitted on the same document/record and share the same TCN. The following instructions must be followed:

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

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

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

Example:

TCN 0509612345678901 contained three individual claim lines, 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 line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Refer to Figures 2A and 2B for an illustration of this example.

Figure 2A: Original Claim 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		AB123456C

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 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 N	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 M M D D 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 23 05	11	J9095					162.9	2	16.64		
03 23 05	11	J9000					162.9	6	59.70		
03 23 05	11	96410					162.9		35.00		

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

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

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
	James Strong, M.D. 312 Main Street 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
	03 23 05	ABC12345	

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

EMEDNY – 150001 ((1/04)

Figure 2B: Adjustment

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

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

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

DO NOT STAPLE IN BARCODE AREA

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First, middle, last)*: JANE SMITH	2. DATE OF BIRTH: 05 20 1990	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
	5B. PATIENT'S TELEPHONE NUMBER ( )		6B. PRIVATE INSURANCE NUMBER
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

6A. MEDICAID NUMBER: A B 1 2 3 4 5 C	GROUP NO.	RECIPROCITY NO.							

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 / N	22G. EPSDT C/THP: Y / N	22H. FAMILY PLANNING: Y X
	23A. PRIOR APPROVAL NUMBER		23B. PAYM'T SOURCE CODE: 1 M O

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 23 05	11	J9000					162.9	6	16.64		
03 23 05	11	96410					162.9		350.00		

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

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) **James Strong** SIGNATURE OF PHYSICIAN OR SUPPLIER	26. ACCEPT ASSIGNTMENT: YES / NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
25A. PROVIDER IDENTIFICATION NUMBER: 0 1 2 3 4 5 6 7	30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE James Strong, M.D. 312 Main Street Anytown, New York 11111		

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

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

Void

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

When submitting a void, please follow the instructions below:

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

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

Example:

TCN 0509698765432123 contained two claim lines, 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 the provider was paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

Figure 3A: Original Claim Form

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — 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 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 ☐	
	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 N	22G. EPSDT C/THP Y N	22H. FAMILY PLANNING Y X
1.			
2.			
3.			

23A. PRIOR APPROVAL NUMBER	23B. PAYM'T SOURCE CODE M O
	11

24A. DATE OF SERVICE M M D D 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	11	78478					414.01		90.00		
03 28 05	11	J1240					414.01		150.00		

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		
		James Strong, M.D. 312 Main Street 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	TELEPHONE NUMBER ( ) EXT.
01234567		003		YES ☐ NO ☐	

COUNTY OF SUBMITTAL	25E. DATE SIGNED	32. PATIENT'S ACCOUNT NUMBER	DO NOT WRITE IN THIS SPACE
	03 28 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 V

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)*: ROBERT JOHNSON
2. DATE OF BIRTH: 0 6 0 3 1 9 5 6
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 ( )
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 ( ) 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 ( )
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 N
22G. EPSDT C/THP: Y N
22H. FAMILY PLANNING: Y X
23A. PRIOR APPROVAL NUMBER:
23B. PAYM'T SOURCE CODE: 1 1 M O

24A. DATE OF SERVICE M M D D 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	1 1	7 8 4 7 8					4 1 4.0 1		9 0.0 0		
0 3 2 8 0 5	1 1	J 1 2 4 0					4 1 4.0 1		1 5 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)
James Strong
SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES ( ) NO ( )
27. TOTAL CHARGE:
28. AMOUNT PAID:
29. BALANCE DUE:
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER:
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
James Strong, M.D.
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

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

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

DATE OF BIRTH (Field 2)

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

Example: Mary Brandon was born on 01/01/1974. Enter the birth date as 01011974.

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

PATIENT'S SEX (Field 5A)

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

MEDICAID NUMBER (Field 6A)

Enter the recipient'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 whether the service rendered to the recipient was for a condition resulting from an accident or a crime. Use the boxes as follows:

Patient's Employment

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

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

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

Other Liability
Use this box to indicate that the condition was related to another type of accident-related injury.

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

EMERGENCY RELATED (Field 16A)

If applicable, 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)

Please 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.emedny.org**.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **Crosswalks**
- ✓ Look for the table labeled "eMedNY Crosswalks" and click on **Provider License Type to Profession Code Mapping** (to the right of "Using License Number")

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

Enter the ordering provider's Medicaid ID number in this field. If a license number (or State Certification 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. If the out-of-state license is less than 6 digits, enter zero(s) after the state code to make the license a 6 digit number. Please refer to Appendix A – Codes for the Post Office state abbreviations.

DX CODE (Field 19D)

Please leave this field blank.

NAME OF FACILITY WHERE SERVICES RENDERED (Field 21)

Please leave this field blank.

ADDRESS OF FACILITY (Field 21A)

Please leave this field blank.

SERVICE PROVIDER NAME (Field 22A)

Please leave this field blank.

PROF CD [Service Provider] (Field 22B)

Please leave this field blank.

IDENTIFICATION NUMBER [Service Provider] (Field 22C)

Please 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). This type of claim **must be submitted on paper** with the DSS-3134 form attached to it.

Notes: 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)

Please leave this field blank.

POSSIBLE DISABILITY (Field 22F)

Please leave this field blank.

EPSDT C/THP (Field 22G)

Please 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 are prescribed.
- Periodic examinations associated with a contraceptive method.
- Visits during which sterilization or other methods of birth control are discussed.
- Sterilization procedures.
- Procedures to promote fertility.

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)

Please leave this field blank.

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

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

** - Other Insurance Code

Claim Form eMedNY-150001: Encounter Section (Fields 24A–24O)

The claim form can accommodate up to eight encounters with a single recipient, 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: January 15, 2006 = 01/15/06

Note: A service date must be entered for each Procedure Code listed.

PLACE [OF SERVICE] (Field 24B)

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

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

PROCEDURE CODE (Field 24C)

This code identifies the type of service that was rendered to the recipient. Enter the appropriate five-character Procedure Code.

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.

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

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 zero.**

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

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

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 the provider to zero-fill other insurance payment for same type of service. This communication should be documented in the patient's billing record.
- The provider bills the insurance company and receives a rejection because:
  - ► The service is not covered; or
  - ► The deductible has not been met.
- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to, or uncooperative in submitting claims to the insurance company. In these cases the LDSS must be notified prior to zero-filling. 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)

Please leave this field blank.

PROC CD [PROCEDURE CODE] (Field 24N)

Please leave this field blank.

MOD [MODIFIER] (Field 24O)

Please leave this field blank.

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

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

PROVIDER IDENTIFICATION NUMBER (Field 25A)

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

This field is pre-printed for all providers except for practitioner groups.

MEDICAID GROUP IDENTIFICATION NUMBER (Field 25B)

Please 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 any time afterwards that a new location is added.

Locator Codes 001 and 002 are for administrative use only and are **not to be entered in this field**.

Enter the Locator Code (003 or higher) 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 of this web page.

SA EXCP CODE (Field 25D)

Please 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 upper left 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, which can be found 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.

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 INFORMATION (Fields 33–35)

Please leave these fields blank.

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

Please 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 must complete the Electronic remittance Request Form, which is available at **www.emedny.org**.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Under “Provider Maintenance Forms”, click on **Electronic Remittance Request Form**

For additional information, providers may also call CSC-Provider Enrollment Support at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at **www.emedny.org**.

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Companion Guides and Sample Files**

✓ Look for the box labeled "835 Health Care Claim Payment Advice"

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 may elect to receive the status of paper claim submissions in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.eMedNY.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. 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, providers must complete the

Remittance Sort Request form, available at **www.emedny.org**.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Under "Provider Maintenance Forms", click on **Paper Remittance Sort Request Form**

For additional information, providers may also call CSC-Provider Enrollment Support at 800-343-9000.

Remittance Advice Format

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

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

Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Physicians 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 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
AUTHORIZED SIGNATURE

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

Check Stub Information

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
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/date
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 that 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 denied during the specific cycle. This section may also contain pending claims from previous cycles that remain in a pend status.

MEDICAID MANAGEMENT INFORMATION SYSTEM

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:
REF AMB
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	90829	1.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	05206-000011334-0-0	07/11/05	90804	1.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	05206-000013556-0-0	07/19/05	91105	1.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	05206-000032456-0-0	07/20/05	90945	1.000	77.50	0.00	DENY	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

PAGE 03
DATE 08/01/2005
CYCLE 458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
REF AMB
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	91105	1.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	05206-000033667-0-0	07/12/05	90846	1.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	05206-000045667-0-0	07/14/05	99221	1.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	05206-000056767-0-0	07/15/05	99111	1.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	05206-000067767-0-0	06/05/05	99285	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/05
01	CP744495	PARKER	VZ45678P	05206-000088767-0-0	06/05/05	99281	1.000	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

PAGE 04
DATE 08/01/2005
CYCLE 458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
REF AMB
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	90828	1.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	05206-000033468-0-0	07/14/05	90814	1.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	05206-000035665-0-0	07/14/05	91105	1.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	05206-000033660-0-0	07/12/05	91105	1.000	14.30	0.00	**PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

REMITTANCE TOTALS – REF AMB			
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

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:
REF AMB
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: **REF AMB**
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 NUMBER
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 Physicians must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000

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

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

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

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

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

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

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

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

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

Pending Claims

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

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: 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 TRANSACTION AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

Explanation of the Financial Transactions Columns

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

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

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

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

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

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

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

Accounts Receivable

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

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

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

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

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

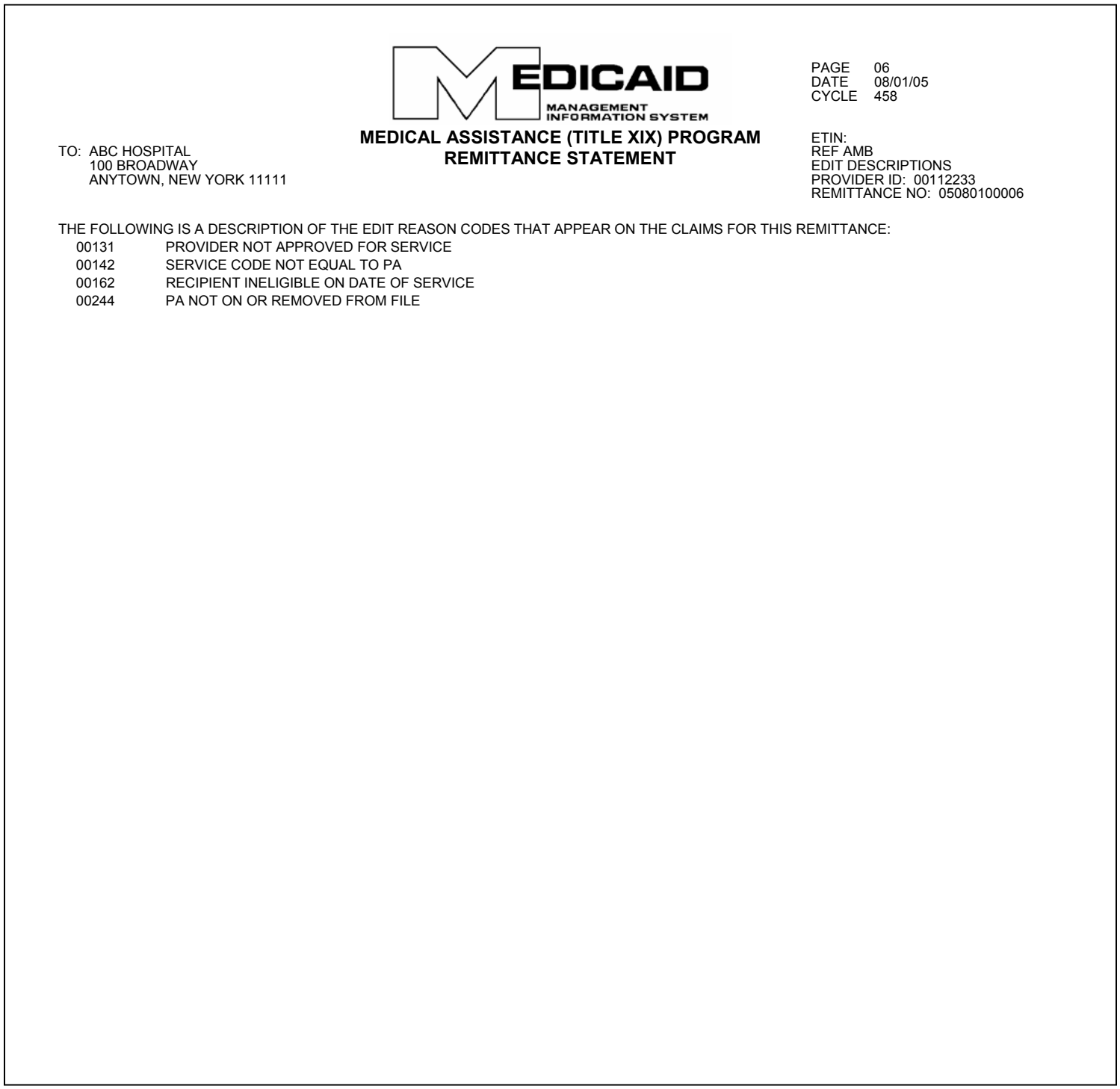
CURRENT BALANCE
The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

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

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

Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three. 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:
REF AMB
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
00244	PA NOT ON OR REMOVED FROM FILE

Appendix A – Code Sets

Place of Service

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

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

Claims for sterilization procedures **must be submitted on paper**, and 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. (*Name of individual to be sterilized*) on 18. (*Date of sterilization*)

18. (Con't), I explained to him/her the nature of the *operation* sterilization operation 19. (*specify type of operation*). 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 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 no 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

Claims for hysterectomy procedures must be submitted on paper forms, and 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.