New York State Electronic Medicaid System 150003 Billing Guidelines

FREE STANDING OR HOSPITAL BASED ORDERED AMBULATORY

Version 2010 - 01

11/18/2010

TABLE OF CONTENTS

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

1. Purpose Statement

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

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

This document is customized for Hospital-Based/Free Standing Ordered Ambulatory Providers and should be used by the provider as an instructional as well as a reference tool. For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2. Claims Submission

Hospital-Based/Free Standing Ordered Ambulatory Providers can submit their claims to NYS Medicaid in electronic or paper formats.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and a Certification Statement before submitting claims to NYS Medicaid. Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

Providers will be asked to update their Certification Statement on an annual basis. Providers will be provided with renewal information when their Certification Statement is near expiration.

2.1 Electronic Claims

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

Hospital-Based/Free Standing 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. Direct billers should also refer to the sources listed below to comply with the NYS Medicaid requirements.

- HIPAA 837P and 837I Implementation Guides (IG) 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) are subsets of the IGs, which provide specific instructions on the NYS Medicaid requirements for the 837P and 837I transactions. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Companion Guides and Sample Files.
- NYS Medicaid Technical Supplementary Companion Guide provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Companion Guides and Sample Files.

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

2.2 Paper Claims

Hospital-Based/Free Standing Ordered Ambulatory Providers who choose to submit their claims on paper forms must use the New York State eMedNY-150003 claim form.

To view a sample Hospital-Based/Free Standing Ordered Ambulatory eMedNY - 150003 claim form, see Appendix A below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

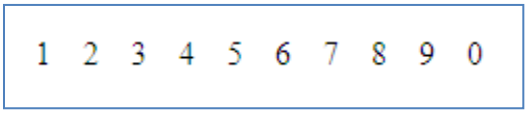
An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: Information for All Providers.

2.2.1 General Instructions for Completing Paper Claims

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

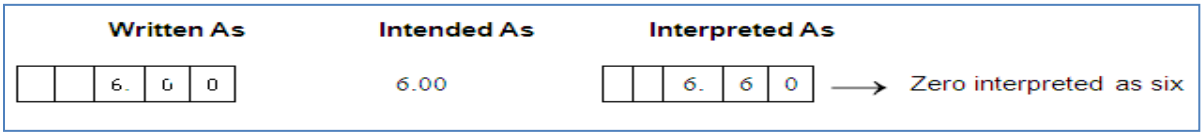
- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1



- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2



- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

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 as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

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.

The address for submitting claim forms is:

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

2.3 eMedNY – 150003 Claim Form

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

To view a sample Hospital-Based/Free Standing Ordered Ambulatory eMedNY - 150003 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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

2.4 Hospital-Based/Free Standing Ordered Ambulatory Services Billing Instructions

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

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

2.4.1 Instructions for the Submission of Medicare Crossover Claims

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

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

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

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

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

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

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

2.4.2 eMedNY - 150003 Claim Form Field Instructions

Header Section: Fields 1 through 23B

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

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

Adjustment/Void Code (Upper Right Corner of Form)

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

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

Original Claim Reference Number (Upper Right Corner of Form)

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

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

2.4.2.1 Adjustment

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

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

Adjustment to Change Information

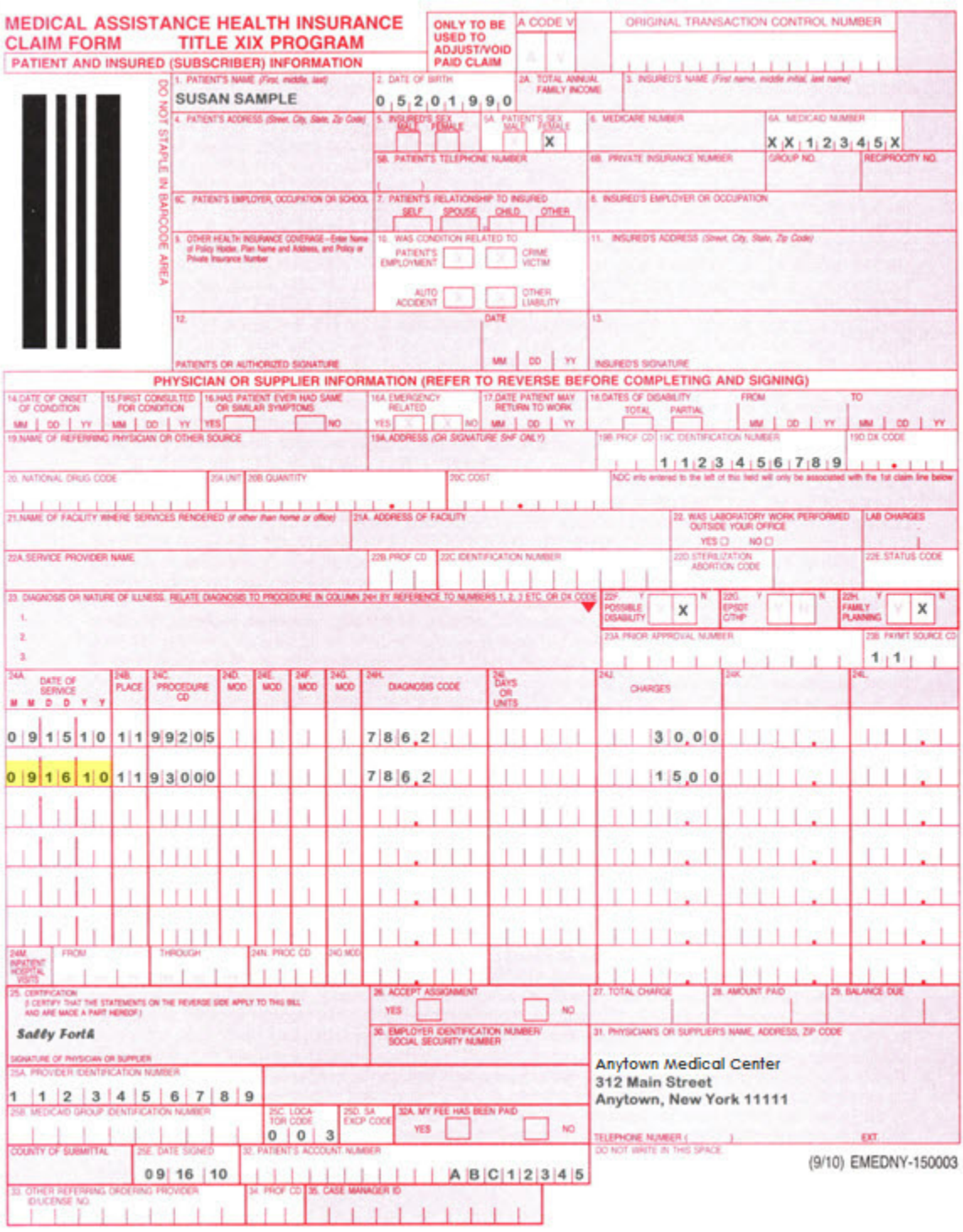
If an adjustment is submitted to correct information on one or more claim lines sharing the same TCN, follow the instructions below:

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

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

Exhibit 2.4.2.1-1 and Exhibit 2.4.2.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 1030119876543200 is shared by two individual claim lines. This TCN was paid on October 27, 2010. After receiving payment, the provider determined that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-1



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 05 20 1990

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX MALE FEMALE

5A. PATIENT'S SEX MALE FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX12345X

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT; CRIME VICTIM; AUTO ACCIDENT; OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

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

14. DATE OF ONSET OF CONDITION 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 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 SNF ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 112345678 9

19D. DX CODE

20. NATIONAL DRUG CODE

20A. UNIT

20B. QUANTITY

20C. COST

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES NO

LAB CHARGES

22A. SERVICE PROVIDER NAME

22B. PROF CD

22C. IDENTIFICATION NUMBER

22D. STERILIZATION ABORTION CODE

22E. STATUS CODE

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

1.

2.

3.

22F. POSSIBLE DISABILITY Y N: X

22G. EPSDT CTHP Y N

22H. FAMILY PLANNING Y N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	99205					7862		3000		
091610	11	93000					7862		1500		

24M. INPATIENT HOSPITAL VISITS FROM THROUGH

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.)

Saddy Forth

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT YES NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

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

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

DO NOT WRITE IN THIS SPACE

25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 16 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

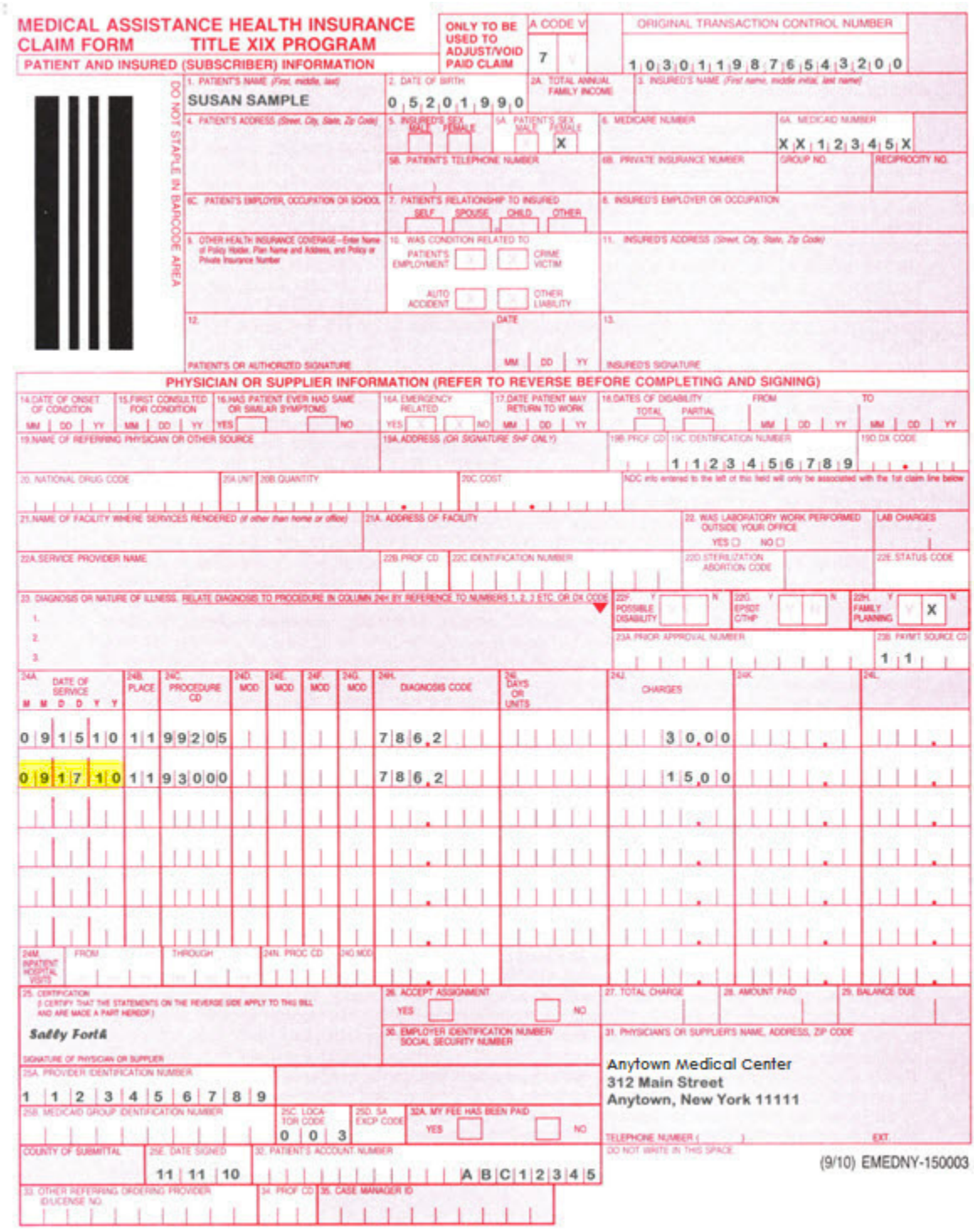
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

Exhibit 2.4.2.1-2



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V: 7 — ORIGINAL TRANSACTION CONTROL NUMBER: 1030119876543200

1. PATIENT'S NAME: SUSAN SAMPLE
2. DATE OF BIRTH: 05201990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME
4. PATIENT'S ADDRESS
5. INSURED'S SEX: MALE / FEMALE
5A. PATIENT'S SEX: MALE / FEMALE: X
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: XX12345X
5B. PATIENT'S TELEPHONE NUMBER
6B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY
11. INSURED'S ADDRESS
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

DO NOT STAPLE IN BARCODE AREA

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 / 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 SNF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: 112345678 9
19D. DX CODE
20. NATIONAL DRUG CODE
20A. UNIT
20B. QUANTITY
20C. COST
NDC info entered to the left of this field will only be associated with the 1st claim line below
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED 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 CTHP Y / N
22H. FAMILY PLANNING Y / N: X
23A. PRIOR APPROVAL NUMBER
23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	99205					7862		3000		
091710	11	93000					7862		1500		

24M. INPATIENT HOSPITAL VISITS — FROM — THROUGH — 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.)
Saddy Forth
SIGNATURE OF PHYSICIAN OR SUPPLIER
26. ACCEPT ASSIGNMENT YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
Anytown Medical Center
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 003
25D. SA EXCP CODE
32A. MY FEE HAS BEEN PAID YES / NO
COUNTY OF SUBMITTAL
25E. DATE SIGNED: 11 11 10
32. PATIENT'S ACCOUNT NUMBER: ABC12345
DO NOT WRITE IN THIS SPACE
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.
34. PROF CD
35. CASE MANAGER ID

(9/10) EMEDNY-150003

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

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

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

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

Exhibit 2.4.2.1-3 and Exhibit 2.4.2.1-4 illustrate an example of a claim with an adjustment being made to cancel a line submitted on the claim. TCN 1030019876543200 contained two individual claim lines, which were paid on October 26, 2010. Later it was determined that one of the claims was billed inadvertently, since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Exhibit 2.4.2.1-3 shows the claim as it was originally submitted and Exhibit 2.4.2.1-4 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-3

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V — ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE
2. DATE OF BIRTH: 05 20 1990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. INSURED'S SEX: MALE / FEMALE
5A. PATIENT'S SEX: MALE / FEMALE: X
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: XX12345X
5B. PATIENT'S TELEPHONE NUMBER
6B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

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

14. DATE OF ONSET OF CONDITION 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 / 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 SNF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: 112345678 9
19D. DX CODE
20. NATIONAL DRUG CODE: 00 1505 02 41 GR
20A. UNIT
20B. QUANTITY: 0.500
20C. COST: 25.00
NDC info entered to the left of this field will only be associated with the 1st claim line below
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED 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 CTHP Y N
22H. FAMILY PLANNING Y N: X
23A. PRIOR APPROVAL NUMBER
23B. PAYMT SOURCE CD: 11

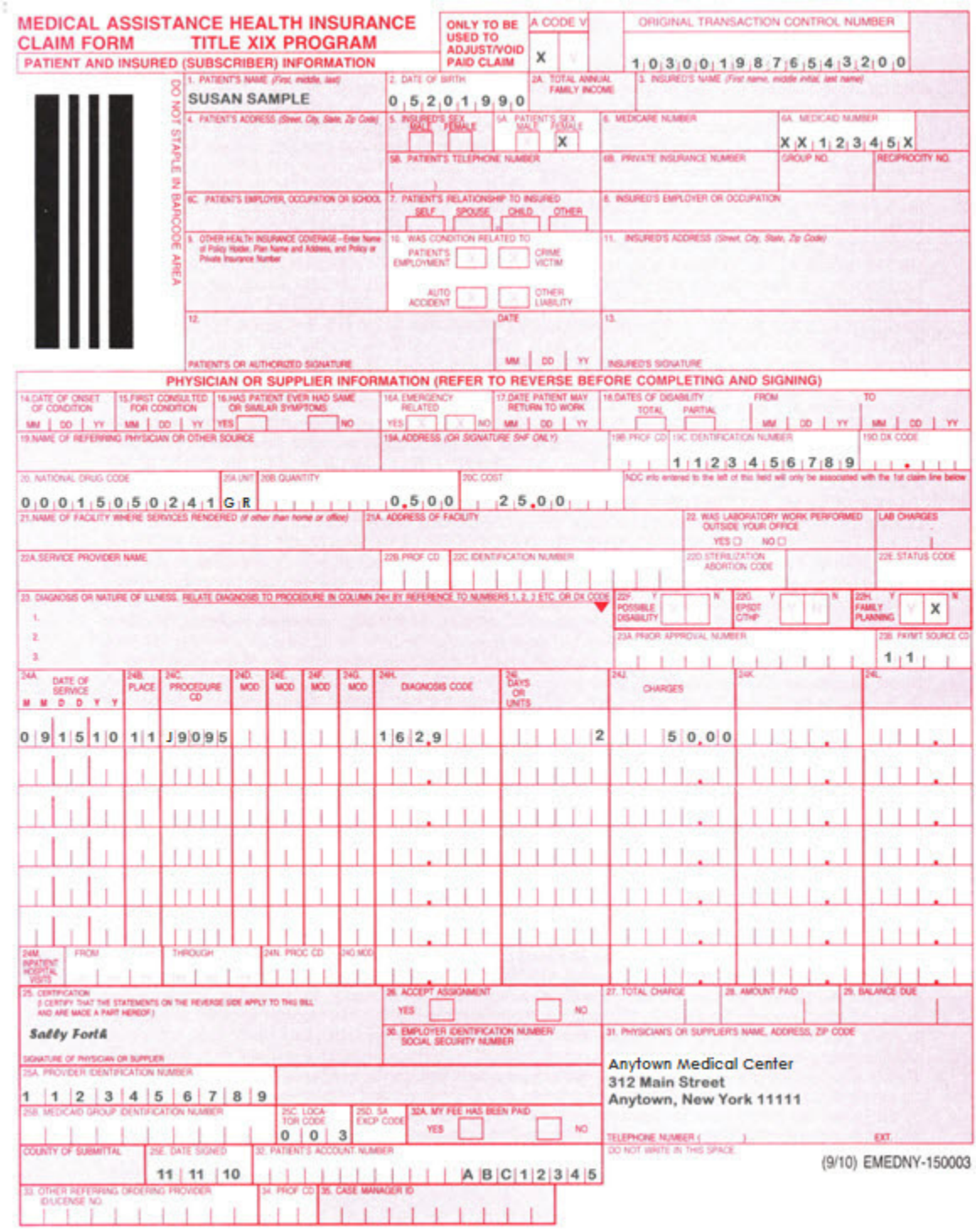
24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J0955					1629	2	50.00		
091610	11	99000					1629		15.00		

24M. INPATIENT HOSPITAL VISITS — FROM — THROUGH — 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.)
Saddy Forth
SIGNATURE OF PHYSICIAN OR SUPPLIER
26. ACCEPT ASSIGNMENT: YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
Anytown Medical Center
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATION CODE: 003
25D. SA EXCP CODE
32A. MY FEE HAS BEEN PAID: YES / NO
COUNTY OF SUBMITTAL
25E. DATE SIGNED: 09 16 10
32. PATIENT'S ACCOUNT NUMBER: ABC12345
DO NOT WRITE IN THIS SPACE
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.
34. PROF CD
35. CASE MANAGER ID

(9/10) EMEDNY-150003

Exhibit 2.4.2.1-4



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

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

ORIGINAL TRANSACTION CONTROL NUMBER: 10300198765432000

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 05201990

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX: MALE / FEMALE

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

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX12345X

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

DO NOT STAPLE IN BARCODE AREA

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 / 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 SNF ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 112345678 9

19D. DX CODE

20. NATIONAL DRUG CODE: 00015050241 GR

20A. UNIT

20B. QUANTITY: 0.500

20C. COST: 25.00

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

22. WAS LABORATORY WORK PERFORMED 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 CTHP Y / N

22H. FAMILY PLANNING Y / N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J0955					1629	2	50.00		

24M. INPATIENT HOSPITAL VISITS FROM THROUGH

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.)

Saddy Forth

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

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

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATION CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 11 11 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

33. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

2.4.2.2 Void

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

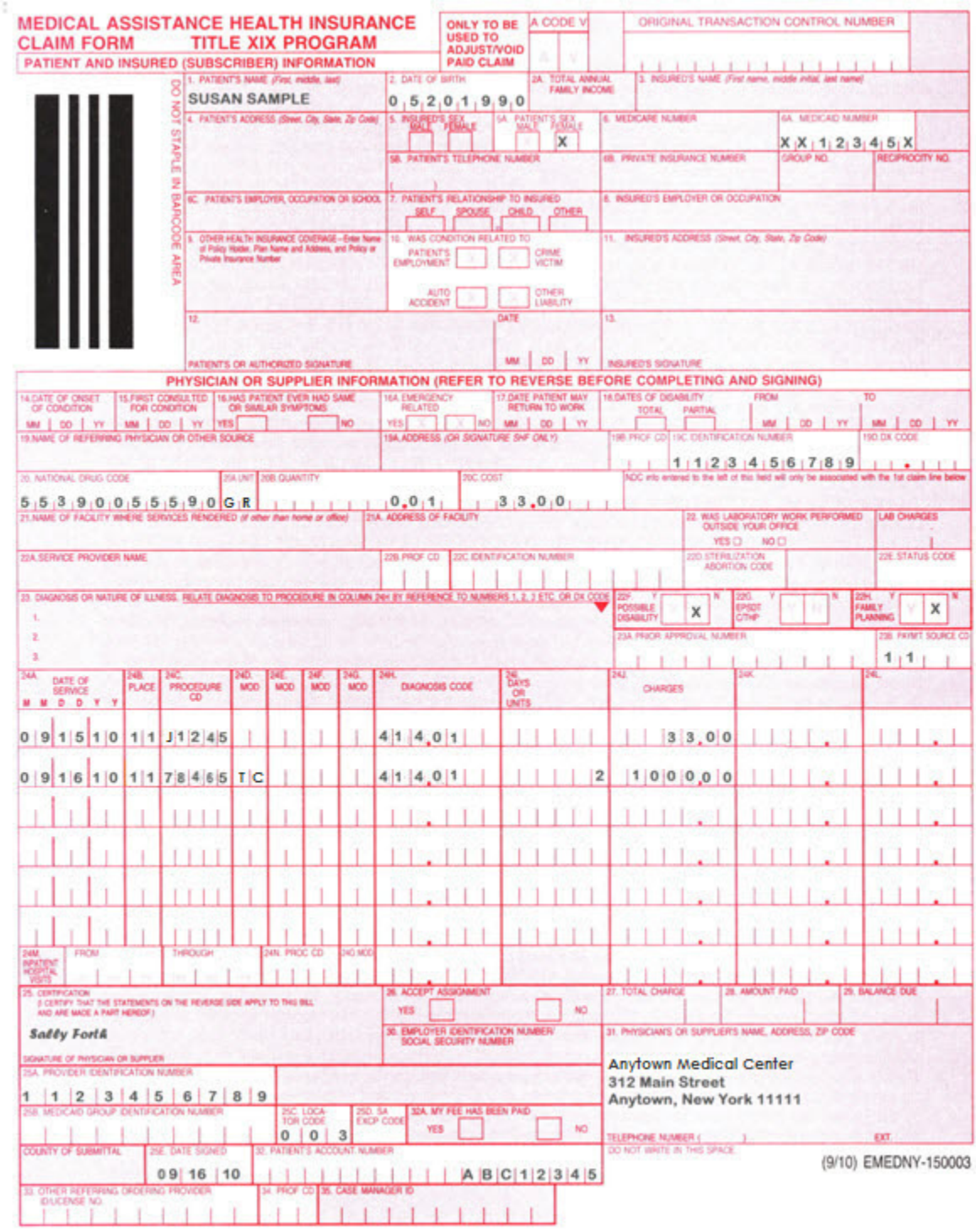
When submitting a void, please follow the instructions below:

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

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

Exhibit 2.4.2.2-1 and Exhibit 2.4.2.2-2 illustrate an example of a claim being voided. TCN 10299123454678900 contained two claim lines, which were paid on October 25, 2010. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and the provider was paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Exhibit 2.4.2.2-1 shows the claim as it was originally submitted and Exhibit 2.4.2.2-2 shows the claim being submitted as voided.

Exhibit 2.4.2.2-1



MEDICAL ASSISTANCE HEALTH INSURANCE
CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 05 20 1990

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX MALE FEMALE

5A. PATIENT'S SEX MALE FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX12345X

6B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT; CRIME VICTIM; AUTO ACCIDENT; OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

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

14. DATE OF ONSET OF CONDITION 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 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 SNF ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 112345678 9

19D. DX CODE

20. NATIONAL DRUG CODE: 55390055590 GR

20A. UNIT

20B. QUANTITY: 0.01

20C. COST: 3300

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

22. WAS LABORATORY WORK PERFORMED 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.

23F. POSSIBLE DISABILITY Y N: X

23G. EPSDT CTHP Y N

23H. FAMILY PLANNING Y N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J1245					4140 1		3300		
091610	11	78465 TC					4140 1	2	10000 0		

24M. INPATIENT HOSPITAL VISITS FROM THROUGH

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.)

Saddy Forth

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT YES NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

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

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

DO NOT WRITE IN THIS SPACE

25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 16 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

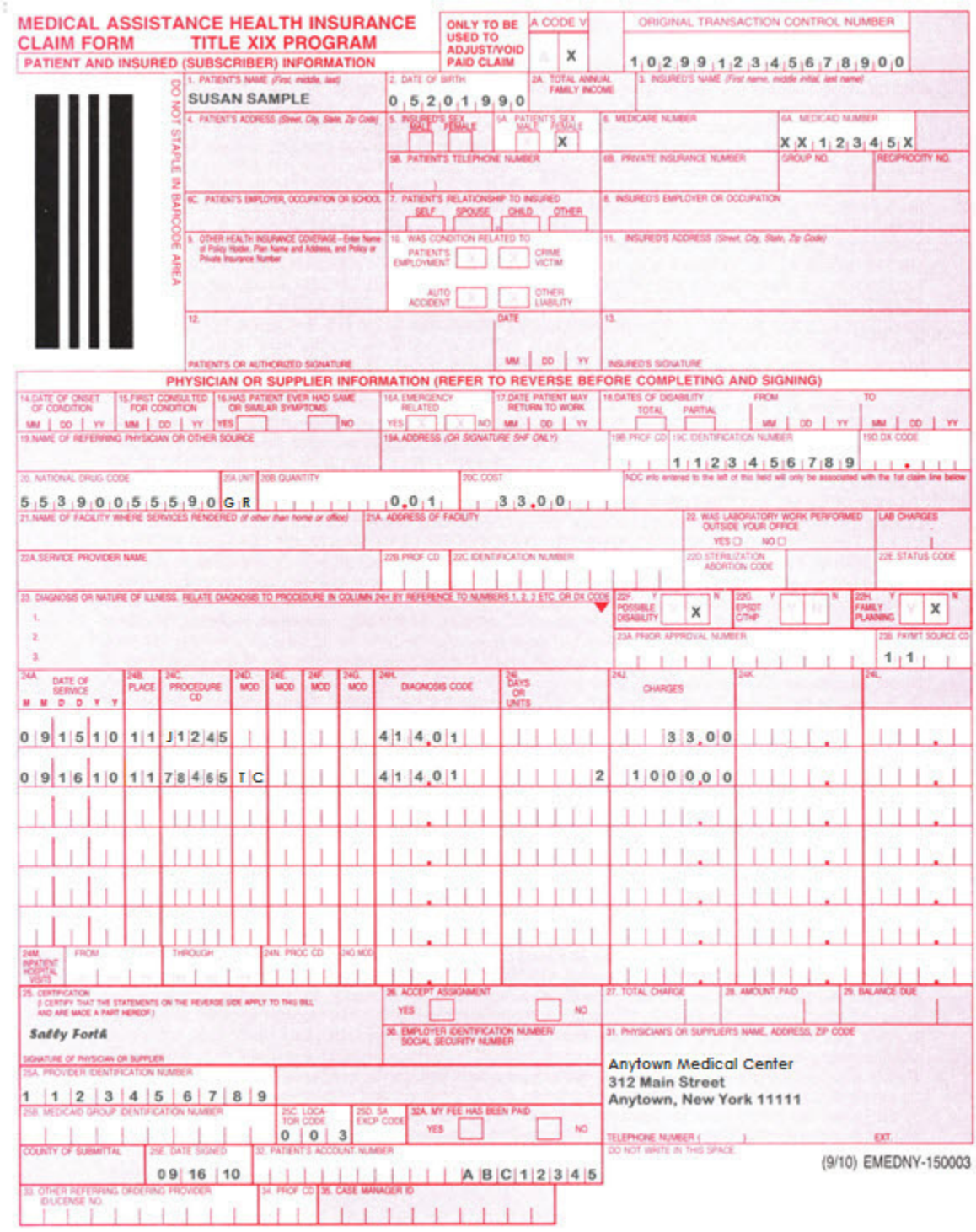
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

Exhibit 2.4.2.2-2



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE V — ORIGINAL TRANSACTION CONTROL NUMBER: 10299123456789000

1. PATIENT'S NAME: SUSAN SAMPLE
2. DATE OF BIRTH: 05201990
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME
4. PATIENT'S ADDRESS
5. INSURED'S SEX: MALE / FEMALE
5A. PATIENT'S SEX: MALE / FEMALE: X
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: XX12345X
5B. PATIENT'S TELEPHONE NUMBER
6B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY
11. INSURED'S ADDRESS
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY
13. INSURED'S SIGNATURE

DO NOT STAPLE IN BARCODE AREA

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 / 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 SNF ONLY)
19B. PROF CD
19C. IDENTIFICATION NUMBER: 112345678 9
19D. DX CODE
20. NATIONAL DRUG CODE: 55390055590GR
20A. UNIT
20B. QUANTITY: 0.01
20C. COST: 33.00
NDC info entered to the left of this field will only be associated with the 1st claim line below
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED 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: X
22G. EPSDT CTHP
22H. FAMILY PLANNING: X
23A. PRIOR APPROVAL NUMBER
23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J1245					4140.1		33.00		
091610	11	78465	TC				4140.1	2	100.00		

24M. INPATIENT HOSPITAL VISITS — FROM — THROUGH — 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.)
Saddy Forth
SIGNATURE OF PHYSICIAN OR SUPPLIER
26. ACCEPT ASSIGNMENT YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
Anytown Medical Center
312 Main Street
Anytown, New York 11111
TELEPHONE NUMBER ( ) EXT.
25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9
25B. MEDICAID GROUP IDENTIFICATION NUMBER
25C. LOCATOR CODE: 003
25D. SA EXCP CODE
32A. MY FEE HAS BEEN PAID YES / NO
COUNTY OF SUBMITTAL
25E. DATE SIGNED: 09 16 10
32. PATIENT'S ACCOUNT NUMBER: ABC12345
DO NOT WRITE IN THIS SPACE
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.
34. PROF CD
35. CASE MANAGER ID

(9/10) EMEDNY-150003

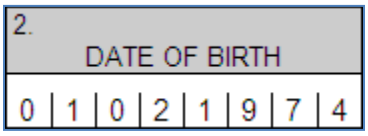
Patient's Name (Field 1)

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

Date of Birth (Field 2)

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

Exhibit 2.4.2-1



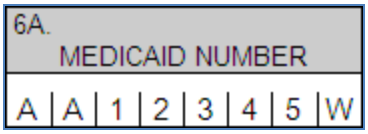
Patient's Sex (Field 5A)

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

Medicaid Number (Field 6A)

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

Exhibit 2.4.2-2



Was Condition Related To (Field 10)

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

- Patient's Employment

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

- Crime Victim

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

- Auto Accident

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

- Other Liability

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

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

Emergency Related (Field 16A)

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

Name of Referring Physician or Other Source (Field 19)

Enter the ordering provider's name in this field.

Address [or Signature – SHF Only] (Field 19A

Leave this field blank.

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

Leave this field blank.

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

For Ordering Provider

Enter the ordering provider's National Provider Identifier (NPI) in this field.

For Referring Provider
Enter the Referring Provider's NPI.

NOTE: A facility ID cannot be used for the Ordering/Referring Provider. In those instances where a service was ordered by a facility, the NPI of a practitioner at the facility ordering the service must be entered in this field.

If no referral was involved, leave this field blank.

DX Code (Field 19D)

Leave this field blank.

Drug Claims Section: Fields 20 to 20C

The following instructions apply to drug code claims ***only***:

- The NDC in field 20 and the associated information in fields 20A through 20C must correspond directly to information on the first line of fields 24A through 24L.
- Only the first line of fields 24A through 24L may be used for drug code billing.
- Only one drug code claim may be submitted per 150002 claim form; however, other procedures may be billed on the same claim.

NDC [National Drug Code] (Field 20)

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

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

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

See Exhibit 2.4.2-3 for examples of the NDC and leading zero placement.

Exhibit 2.4.2-3

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

Unit (Field 20A)

Use one of the following when completing this entry:

UN = Unit

F2 = International Unit

GR = Gram

ML = Milliliter

Quantity (Field 20B)

Enter the numeric quantity administered to the client. Report the quantity in relation to the decimal point as shown in Exhibit 2.4.2-4.

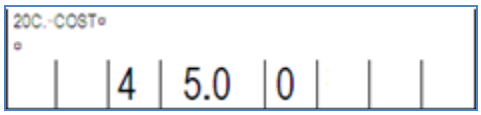
NOTE: The preprinted decimal point must be rewritten in blue or black ink when entering a value in this field. The claim will not process correctly if the decimal is not entered in blue or black ink.

Exhibit 2.4.2-4

Cost (Field 20C)

Enter based on price per unit (e.g. if administering 0.150 grams (GM), enter the cost of only one gram or unit) as shown in Exhibit 2.4.2-5.

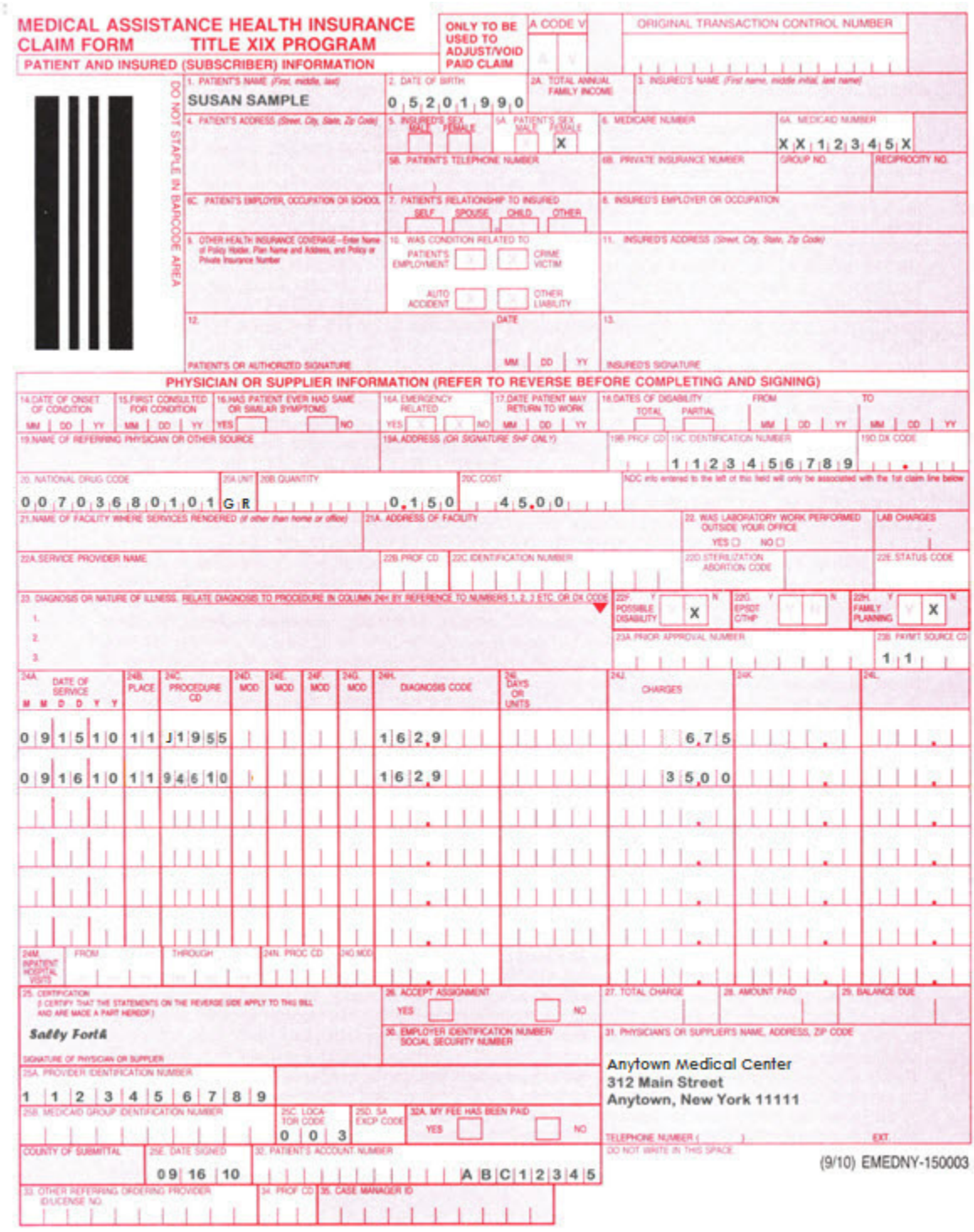
Exhibit 2.4.2-5



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

Exhibit 2.4.2-6 contains a sample of how a drug code would be submitted along with another service provided on the same day.

Exhibit 2.4.2-6



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 05 20 1990

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX: MALE / FEMALE

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

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX123456X

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

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

14. DATE OF ONSET OF CONDITION 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 / 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 SNF ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 1123456789

19D. DX CODE

20. NATIONAL DRUG CODE: 00703680101

20A. UNIT: GR

20B. QUANTITY: 0150

20C. COST: 4500

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

22. WAS LABORATORY WORK PERFORMED 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.

23F. POSSIBLE DISABILITY Y / N: X

23G. EPSDT CTHP Y / N

23H. FAMILY PLANNING Y / N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J1955					1629		675		
091610	11	94610					1629		3500		

24M. INPATIENT HOSPITAL VISITS FROM THROUGH

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.)

Saddy Forth

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

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

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 1123456789

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATION CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 16 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

Name of Facility Where Services Rendered (Field 21)

Leave this field blank.

Address of Facility (Field 21A)

Leave this field blank.

Service Provider Name (Field 22A)

Leave this field blank.

Prof CD [Profession Code – Service Provider] (Field 22B)

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

Leave this field blank.

Sterilization/Abortion Code (Field 22D)

If applicable, enter the appropriate code to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in Appendix B – Code Sets.

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

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

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

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

Leave this field blank.

EPSDT C/THP (Field 22G)

Leave this field blank.

Family Planning (Field 22H)

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

- Physician, clinic or hospital visits during which birth control pills 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)

Leave this field blank.

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

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

Exhibit 2.4.2-7

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

Both boxes need to be filled as follows:

Box M

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

- No Medicare involvement – Source Code Indicator = 1

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

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

  This code indicates that the service is covered by Medicare and that Medicare approved the service and ***either made a payment or paid 0.00 due to a deductible.*** Medicaid is responsible for reimbursing the Medicare deductible and /or (full or partial) coinsurance.

- Patient has Medicare Part B; Medicare denied payment – Source Code Indicator = 3

  This code indicates that Medicare denied payment or did not cover the service billed.

Box O

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

- No Other Insurance involvement – Source Code Indicator = 1

  This code indicates that the patient does not have other insurance coverage.

- Patient has Other Insurance coverage – Source Code Indicator = 2

  This code indicates that the patient has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value ***2*** is entered in Box 'O', the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount. For the appropriate Other Insurance codes, refer to Information for All Providers, Third Party Information, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory Manual.

- Patient Participation – Source Code Indicator = 3

  This code indicates that the patient has incurred a pre-determined amount of medical expenses, which qualify him/her to become eligible for Medicaid.

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

Exhibit 2.4.2-8

	BOX M	BOX O
23B. PAYM'T SOURCE CO 11 / / /	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 12 / * / *	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 13 / * / *	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 21 / / /	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 22 / * / *	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 23 / * / *	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 31 / / /	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 32 / * / *	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 33 / * / *	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.

Encounter Section: Fields 24A to 24O

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

Date of Service (Field 24A)

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

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 B-Code Sets.

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

Procedure Code (Field 24C)

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

NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory Manual.

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

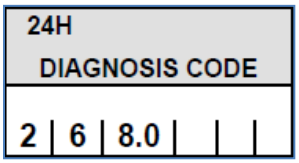
Under certain circumstances, the procedure code must be expanded by a two-digit modifier to further explain or define the nature of the procedure. If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

Note: Modifier values and their definitions are available at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory 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. Proper entry of an IDC-9-CM Diagnosis Code is shown in Exhibit 2.4.2-9.

Exhibit 2.4.2-9



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

Days or Units (Field 24I)

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

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

Box M in field 23B must have an entry value of ***2***. Enter the Medicare Approved Amount in field 24J.

NOTES:

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

Unlabeled (Field 24K)

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

Box M = 2

- 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.

Box M = 3

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

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

Unlabeled (Field 24L)

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

Box O = 2

Enter the other insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid by all other insurance carriers in this field.

Box O = 3

Enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.

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

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

provider should contact the third party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third party resource.

- The patient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the patient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

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

NOTES:

- ***It is the responsibility of the provider to determine whether the patient's Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.***
- ***Leave the last row of Fields 24H, 24J, 24K, and 24L blank.***

Consecutive Billing Section: Fields 24M to 24O

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

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

Leave this field blank.

Proc Code [Procedure Code] (Field 24N)

Leave this field blank.

MOD [Modifier] (Field 24O)

Leave this field blank.

Trailer Section: Fields 25 through 34

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

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

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

Provider Identification Number (Field 25A)

Enter the provider's 10-digit National Provider Identifier (NPI).

Medicaid Group Identification Number (Field 25B)

Leave this field blank.

Locator Code (Field 25C)

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

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

Locator codes 001 and 002 are for administrative use only and are not entered in this field.

If the provider renders services at one location only, enter locator code 003. If the provider renders service to Medicaid patients at more than one location, the entry may be 003 or a higher locator code.

NOTE: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section located at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory Manual.

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

Leave this field blank.

County of Submittal (Unnumbered Field)

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

Date Signed (Field 25E)

Enter the date on which the provider or an authorized representative signed the claim form. The date should be in the format MM/DD/YY.

NOTE: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory Manual.

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

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

- Paper claim submissions: Enter the 5 digit ZIP code or the ZIP plus four.
- Electronic claim submissions: Enter the 9 digit ZIP code. The Locator Code will default to 003 if the nine digit ZIP code does not match information in the provider's Medicaid file.

NOTE: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests please refer to Information for All Providers, Inquiry section which can be found at www.emedny.org by clicking on the link to the webpage as follows: Free Standing or Hospital Based Ordered Ambulatory Manual.

Patient's Account Number (Field 32)

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

Other Referring/Ordering Provider ID/License Number (Field 33)

Leave this field blank.

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

Leave this field blank.

3. Explanation of Paper Remittance Advice Sections

This Section presents samples of each section of the Hospital-Based/Free Standing Ordered Ambulatory provider's remittance advice, followed by an explanation of the elements contained in the section.

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

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

The remittance advice is composed of five sections.

Section One may be one of the following:

- Medicaid Check
- Notice of Electronic Funds Transfer
- Summout (no claims paid)

Section Two: Provider Notification (special messages)

Section Three: Claim Detail

Section Four:

- Financial Transactions (recoupment)
- Accounts Receivable (cumulative financial information)

Section Five: Edit (Error) Description

3.1 Section One – Medicaid Check

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

Exhibit 3.1-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC HOSPITAL

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

00112233/1123456789 2010-05-31
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.
2010-05-31 VOID AFTER 90 DAYS	07080600006	00112233/1123456789

PAY

DOLLARS/CENTS
$*****143.80

TO THE ORDER OF
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

3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

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

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

Table

Date: The date on which the check was issued
Remittance Number
Provider ID No.: This field will contain the Medicaid Provider ID and the NPI

Provider's Name/Address

Right Side

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

3.2 Section One – EFT Notification

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

Exhibit 3.2-1

TO: ABC HOSPITAL

MEDICAID MANAGEMENT INFORMATION SYSTEM

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

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

ABC HOSPITAL $143.80

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

3.2.1 EFT Notification Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

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

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

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

3.3 Section One – Summout (No Payment)

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

Exhibit 3.3-1

TO: ABC HOSPITAL

MEDICAID MANAGEMENT INFORMATION SYSTEM

DATE: 05/31/2010
REMITTANCE NO: 07080600006
PROV ID: 00112233/1123456789

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

ABC HOSPITAL
100 BROADWAY
ANYTOWN NY 11111

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

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

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

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

Center

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

Provider's Name/Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 06/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

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

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

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

3.4.1 Provider Notification Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance Page Number

Date: The date on which the remittance advice was issued

Cycle Number: The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Name of Section: **PROVIDER NOTIFICATION**

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

Remittance Number

Center

Message Text

3.5 Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and denied during the specific cycle.

Exhibit 3.5-1

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 02
DATE 05/31/2107
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
REF AMB
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP333333	DOE	XX12345X	07206-000000227-0-0	05/11/10	90829	1.000	52.80	0.00	DENY	00162 00244
01	CP444444	SAMPLE	XX23456X	07206-000011334-0-0	05/11/10	90804	1.000	17.60	0.00	DENY	00244
01	CP666666	EXAMPLE	XX34567X	07206-000013556-0-0	05/19/10	91105	1.000	14.30	0.00	DENY	00162
01	CP999999	SPECIMEN	XX45678X	07206-000032456-0-0	05/20/10	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

Exhibit 3.5-2

MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
REF AMB
PROV ID: 00112233/1123546789
REMITTANCE NO: 070806000006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP111111	DOE	XX12345X	07206-000033667-0-0	05/11/10	91105	1.000	14.30	14.30	PAID	
02	CP222222	SAMPLE	XX23456X	07206-000033667-0-0	05/12/10	90846	1.000	14.30	14.30	PAID	
01	CP333333	EXAMPLE	XX34567X	07206-000045667-0-0	05/14/10	99221	1.000	52.80	52.80	PAID	
01	CP444444	SPECIMEN	XX45678X	07206-000056767-0-0	05/15/10	99111	1.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	99285	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 05/24/10
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	99281	1.000	14.30	14.30	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	147.00	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PAID	3.60-	NUMBER OF CLAIMS	1
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		3.06-	NUMBER OF CLAIMS	1

Exhibit 3.5-3

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 05/31/2010
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

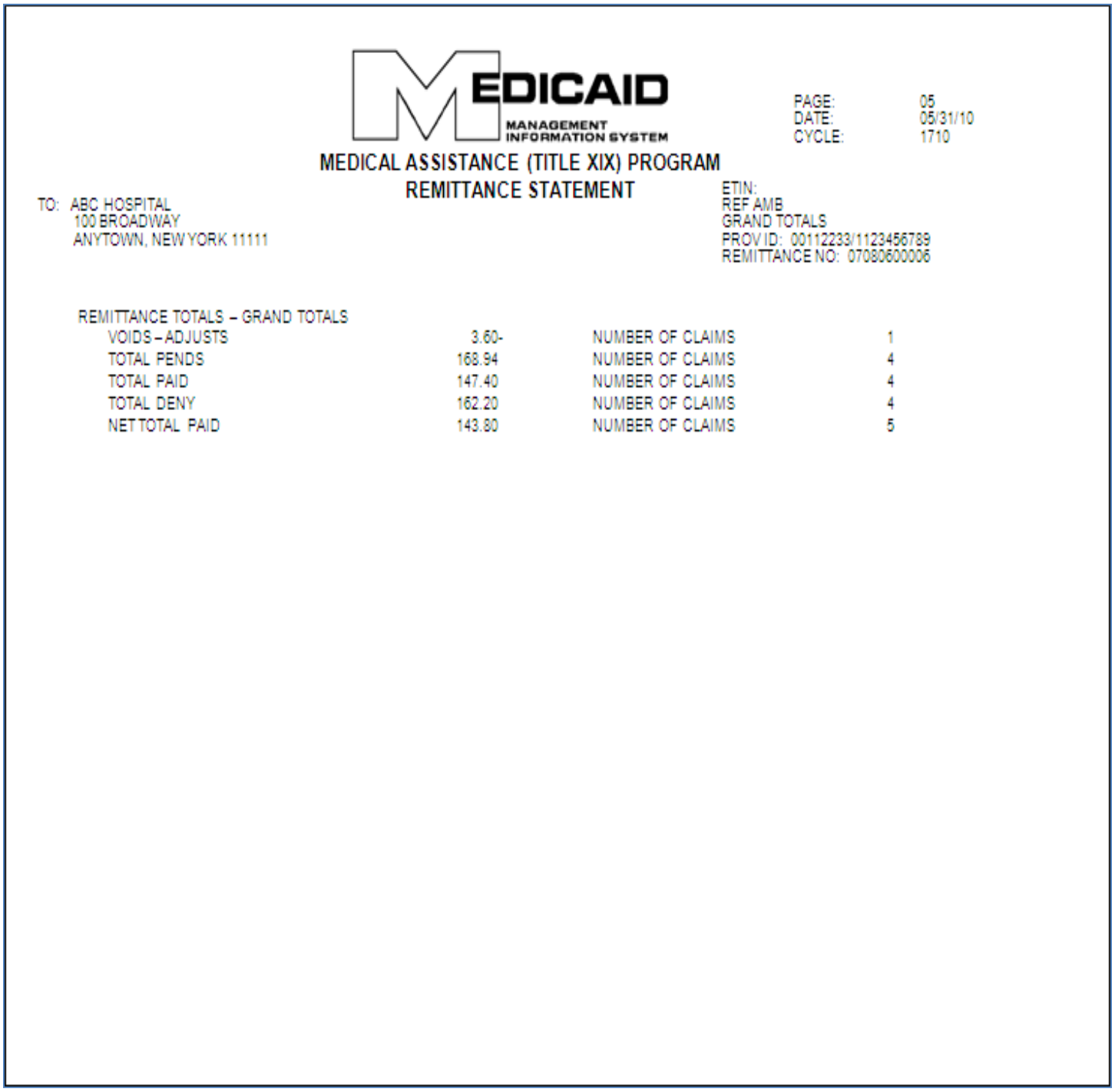
ETIN:
REF AMB
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP333333	DOE	XX12345X	07206-000033467-0-0	05/13/10	90828	1.000	69.30	0.00	**PEND	00162
02	CP444444	SAMPLE	XX23456X	07206-000033468-0-0	05/14/10	90814	1.000	71.04	0.00	**PEND	00162
01	CP666666	EXAMPLE	XX34567X	07206-000035665-0-0	05/14/10	91105	1.000	14.30	0.00	**PEND	00142
01	CP999999	SPECIMEN	XX45678X	07206-000033660-0-0	05/12/10	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

Exhibit 3.5-4



MEDICAID
MANAGEMENT INFORMATION SYSTEM

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
REF AMB
GRAND TOTALS
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

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

3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

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

Upper Right Corner

Remittance Page Number

Date: The date on which the remittance advice was issued

Cycle Number: The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **REF AMB**

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

Remittance Number

3.5.2 Explanation of Claim Detail Columns

LN. NO. (Line Number)

This column indicates the line number of each claim as it appears on the claim form.

Office Account Number

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

Client Name

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

Client ID Number

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

TCN

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

Date of Service

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

Procedure Code

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

Units

The total number of units of service for the specific claim appears under this column. The units are indicated with three (3) decimal positions. Since 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 was approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

Status

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

Denied Claims

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

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

Approved Claims

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

Paid Claims

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

Adjustments

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

Voids

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

Pending Claims

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

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

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

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

Errors

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

3.5.3 Subtotals/Totals/Grand Totals

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

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

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

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

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

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

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

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

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

3.6 Section Four – Financial Transactions and Accounts Receivable

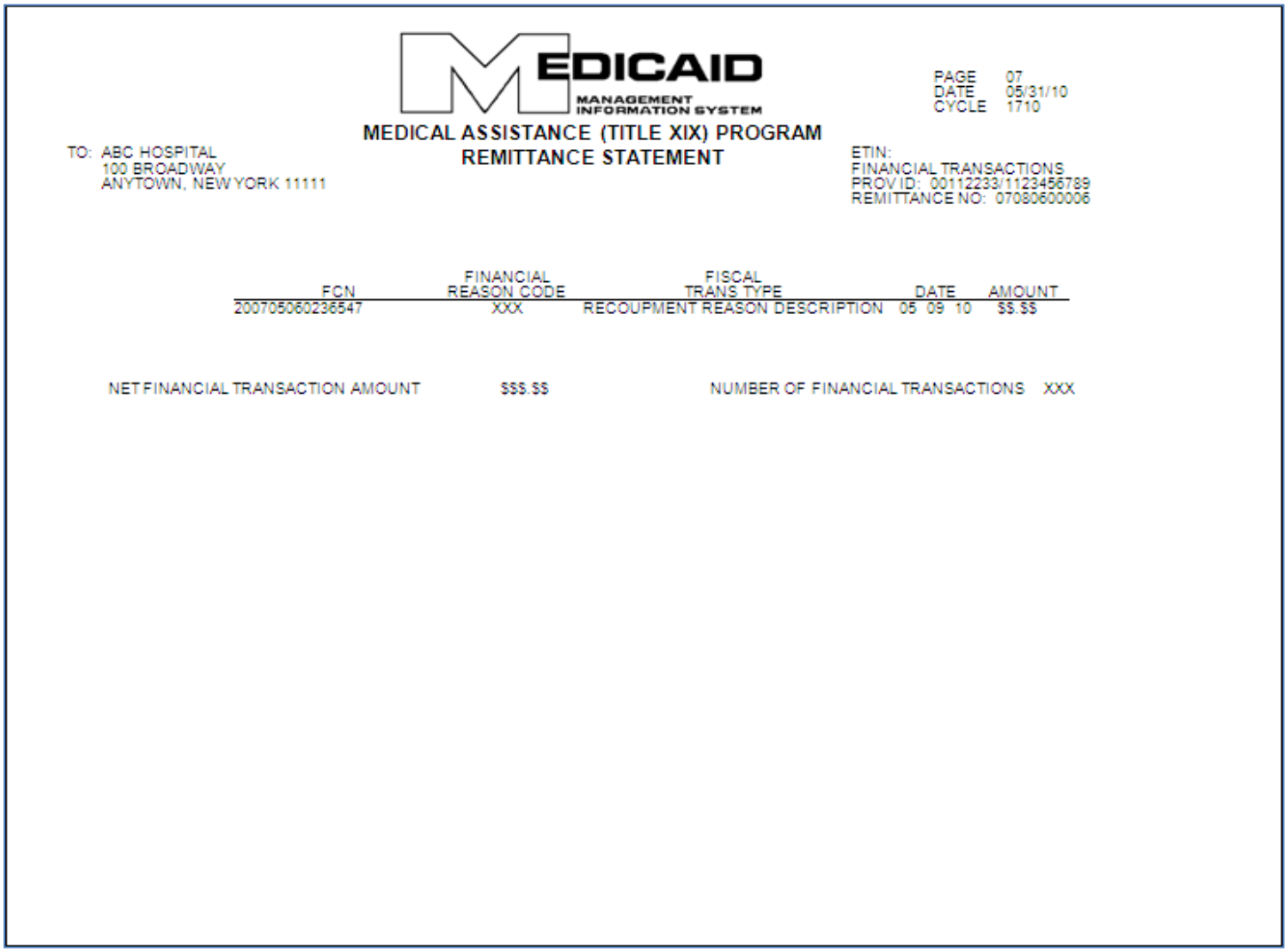
This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 Financial Transactions

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

Exhibit 3.6.1-1



MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 05/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 10	$$.$$

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

3.6.1.1 Explanation of Financial Transactions Columns

FCN

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

Financial Reason Code

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

Financial Transaction Type

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

Date

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

Amount

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

3.6.1.2 Explanation of Totals Section

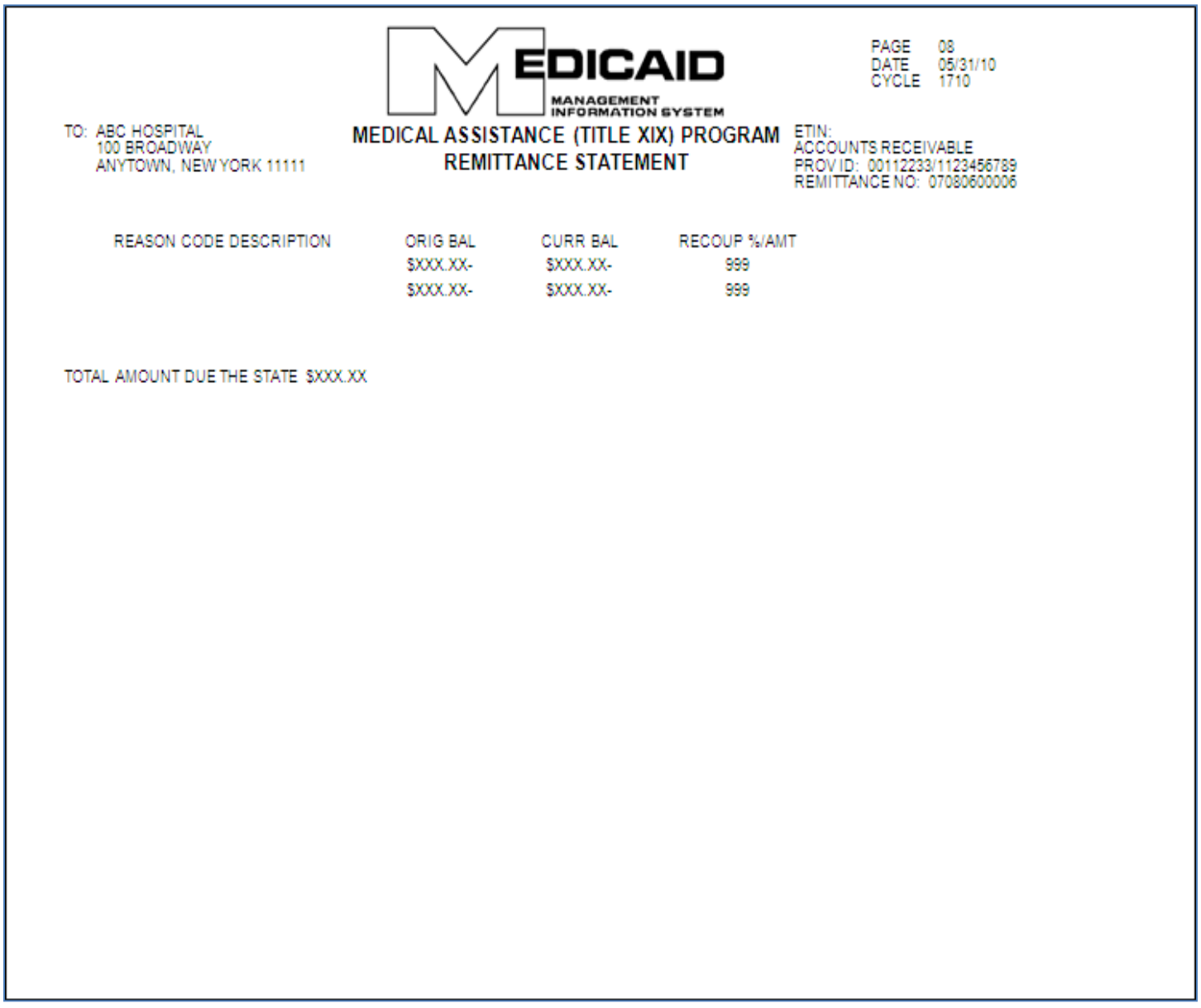
The total dollar amount of the financial transactions (***Net Financial Transaction Amount***) and the total number of transactions (***Number of Financial Transactions***) appear below the last line of the transaction detail list.

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

3.6.2 Accounts Receivable

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

Exhibit 3.6.2-1



MEDICAID
MANAGEMENT INFORMATION SYSTEM

PAGE 08
DATE 05/31/10
CYCLE 1710

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

3.6.2.1 Explanation of Accounts Receivable Columns

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

Reason Code Description

This is the description of the Financial Reason Code. For example, Third Party Recovery.

Original Balance

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

Current Balance

The current amount owed to Medicaid (after the cycle recoupment, 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.

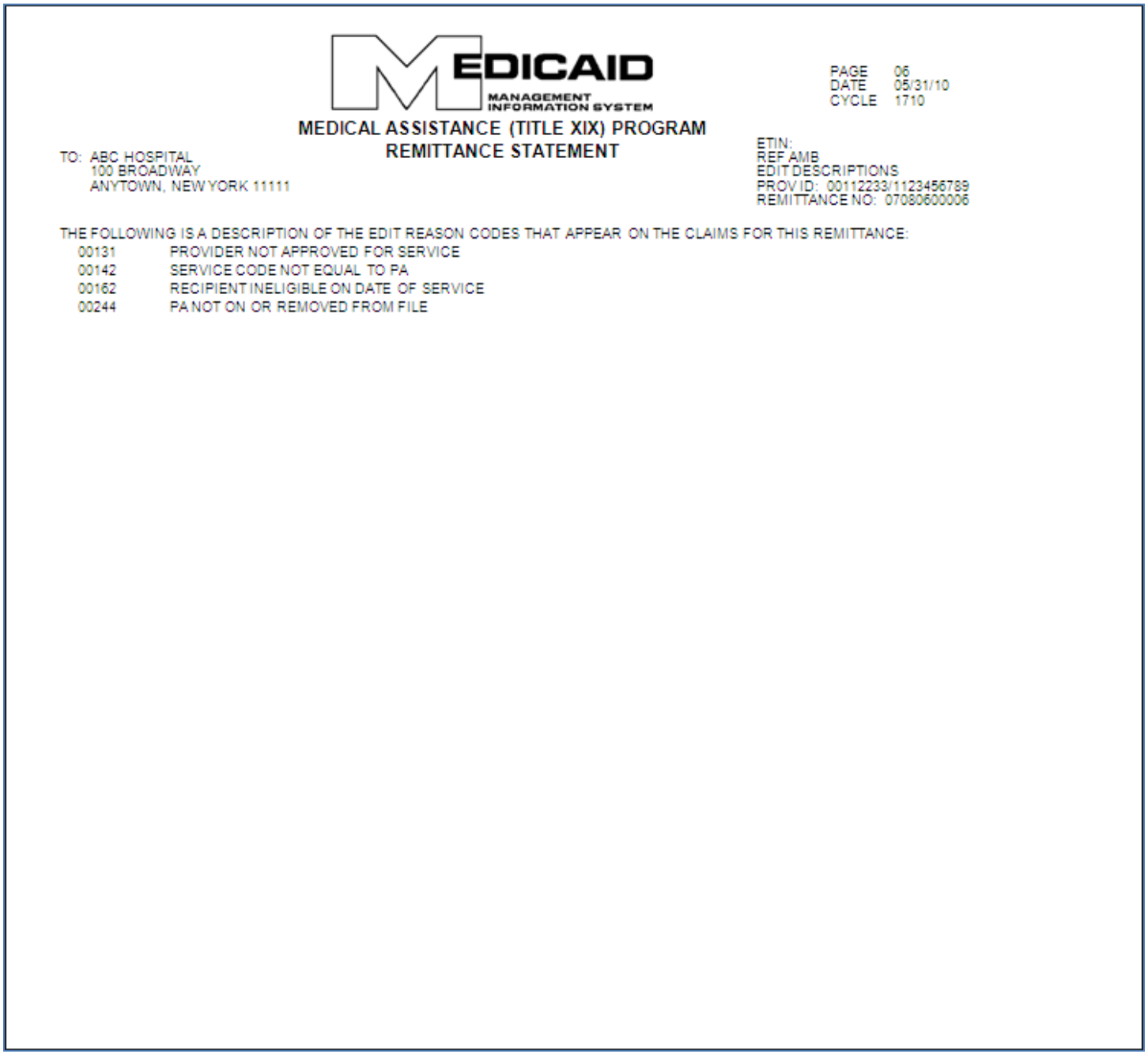
Total Amount Due the State

This amount is the sum of all the ***Current Balances*** listed above.

3.7 Section Five – Edit (Error) Description

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

Exhibit 3.7-1



MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 06
DATE 05/31/10
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC HOSPITAL
100 BROADWAY
ANYTOWN, NEW YORK 11111

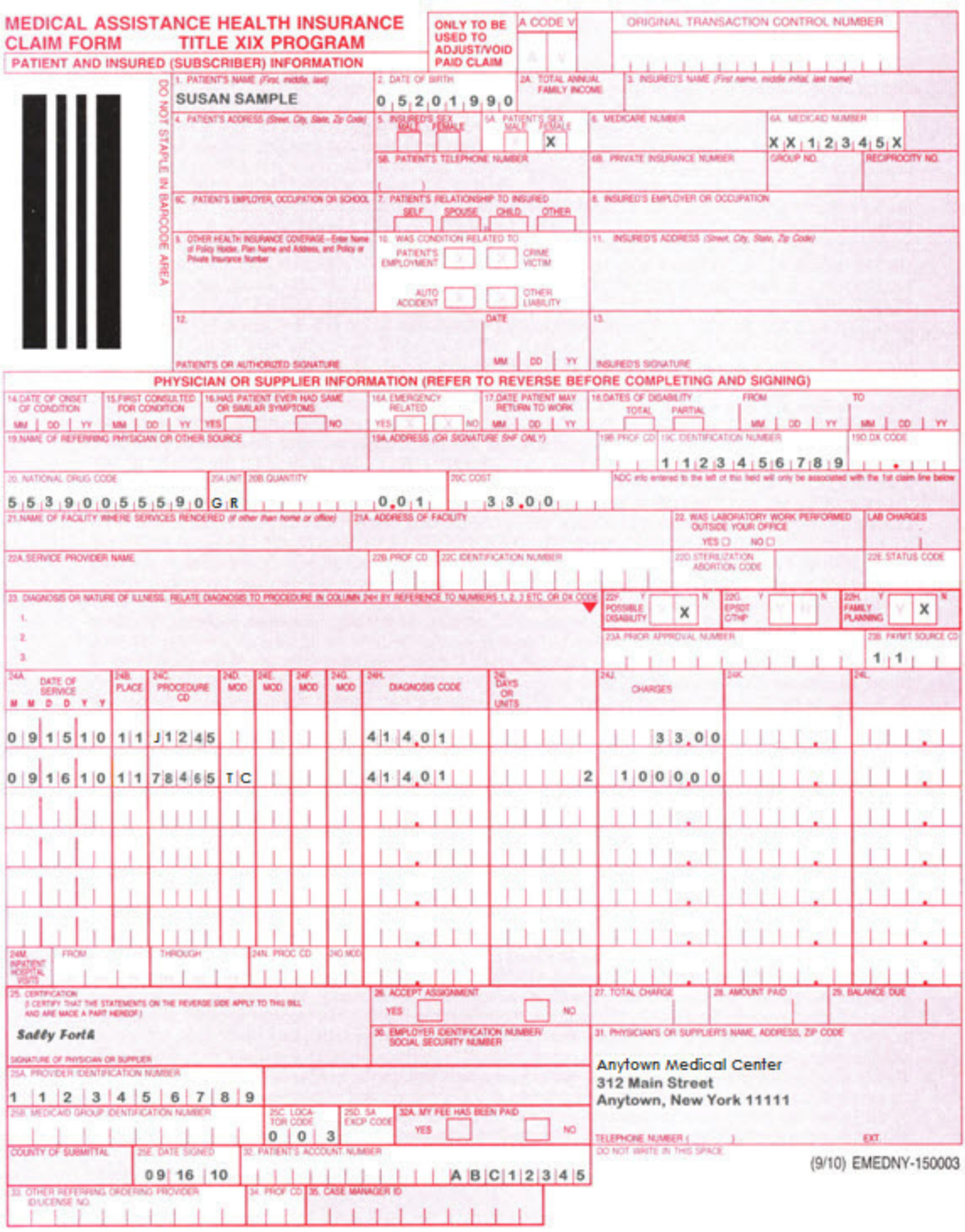
ETIN:
REF AMB
EDIT DESCRIPTIONS
PROV ID: 00112233/1123456789
REMITTANCE NO: 07080600006

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

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

APPENDIX A
CLAIM SAMPLES

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



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): SUSAN SAMPLE

2. DATE OF BIRTH: 05 20 1990

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX: MALE / FEMALE

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

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: XX123455X

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

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

14. DATE OF ONSET OF CONDITION 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 / 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: 112345678 9

19D. DX CODE

20. NATIONAL DRUG CODE: 55390055590GR

20A. UNIT

20B. QUANTITY: 0.01

20C. COST: 33.00

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

22. WAS LABORATORY WORK PERFORMED 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: N: X

22G. EPSDT CTHP: Y / N

22H. FAMILY PLANNING: Y / N: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.
091510	11	J1245					414.01		33.00		
091610	11	78465	TC				414.01	2	100.00		

24M. INPATIENT HOSPITAL VISITS — FROM — THROUGH — 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.)

Sally Forth

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

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

Anytown Medical Center
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 112345678 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 16 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NO.

34. PROF CD

35. CASE MANAGER ID

(9/10) EMEDNY-150003

APPENDIX B
CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of Place of Service codes, Sterilization/Abortion Codes, and a list of accepted Unites States Standard Postal Abbreviations.

Place of Service

Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
24	Birthing center
25	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
58	Mass immunization center
59	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	New Mexico	NM
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Rhode Island	RI
Iowa	IA	South Carolina	SC
Indiana	IN	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI

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

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

APPENDIX C
STERILIZATION CONSENT FORM – LDSS-3134

A Sterilization Consent Form, LDSS-3134, must be completed for each sterilization procedure. No other form can be used in place of the LDSS-3134. A supply of these forms, available in English and in Spanish [LDSS-3134(S)], can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

Claims for sterilization procedures must be submitted on paper, and a copy of the completed and signed Sterilization Consent Form, LDSS-3134 [or LDSS-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 LDSS-3134 [or LDSS-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 LDSS 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.

LDSS-3134 (2/01)

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 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 know 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 that 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)

You are requested to supply the following information, but it is not required: 10.

Race and ethnicity designation (please check)

☐ 1 American Indian or Alaska Native
☐ 2 Asian or Pacific Islander
☐ 3 Black (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 knowlingly 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)

17. (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18. (Name of individual to be sterilized) on 19. (Date of sterilization) 20. (Operation), I explained to him/her the nature of the sterilization operation 21. (Specify type of operation), the fact that it is intended to be a final 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 a 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 procedure.

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 sterilization was performed.

(2) This sterilization was preformed 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 and fill in information requested): 22.

☐ 1. Premature delivery
Individual's expected date of delivery: 23.

☐ 2. Emergency abdominal surgery: 24.
(describe circumstances): 25.

26. (Physician) _____ (Date)

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

I, 27. do certify that on 28. I was present while the counselor read and explained the consent form to 29. (patient's name) and saw the patient sign the consent form in his/her handwriting.

SIGNATURE OF WITNESS	TITLE	DATE
X 30.	31.	32.

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 33.	34.	35. X	36.

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

STERILIZATION CONSENT FORM – LDSS-3134 AND 3134(S) INSTRUCTIONS

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 doctor or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (26) 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 (26).

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 (23), or emergency abdominal surgery (24/25) 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 (26).

Field 16

Enter the name 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.

Field 17

Enter the address of the facility.

Physician's Statement

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

Field 18

Enter the patient's name.

Field 19

Enter the date the sterilization procedure was performed.

Field 20

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 (26) and date 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 21

Specify the type of operation.

Field 22

Select one of the check boxes as necessary.

Field 23

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 (22)and enter the expected date of delivery (23).

Field 24

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 (22) and describe the circumstances(25).

Field 25

Describe the circumstances of the emergency abdominal surgery.

Field 26

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

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 27

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

Field 28

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

Field 29

Enter the patient's name.

Field 30

The witness must sign the form.

Field 31

Enter the title, if any, of the witness.

Field 32

Enter the date of witness's signature.

Reaffirmation

Field 33

The patient must sign the form.

Field 34

Enter the date of the patient's signature. This date should be shortly prior to or same as date of sterilization in field 19.

Field 35

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 30.

Field 36

Enter the date of witness's signature.

APPENDIX D
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113, must be completed for each hysterectomy procedure. ***No other form can be used in place of the LDSS-3113***. A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

Claims for hysterectomy procedures must be submitted on paper forms, and a copy of the completed and signed LDSS-3113 must be attached to the claim.

When completing the LDSS-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)

1. RECIPIENT ID NO.	2. SURGEON'S NAME

EITHER PART I OR PART II MUST BE COMPLETED

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

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, 3. _____ (RECIPIENT NAME), that the hysterectomy to be performed on me will 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. _____ (RECIPIENT NAME) was solely for medical reasons. The 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

ACKNOWLEDGEMENT RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113 INSTRUCTIONS

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 Acknowledgement

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.

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

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

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