



**New York State  
Electronic Medicaid System  
150002 Billing Guidelines**

**PHYSICIAN**

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

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# 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 Physicians 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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Information for All Providers](#).

## 2. Claims Submission

Physicians can submit their claims to NYS Medicaid in electronic or paper formats.

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

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

### 2.1 Electronic Claims

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

Physicians who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction. Direct billers should refer to the sources listed below to comply with the NYS Medicaid requirements.

- HIPAA 837P Implementation Guide (IG) explains the proper use of the 837P standards and program specifications. This document is available at [www.wpc-edi.com/hipaa](http://www.wpc-edi.com/hipaa).
- NYS Medicaid 837P Companion Guide (CG) is a subset of the IG, which provides specific instructions on the NYS Medicaid requirements for the 837P transaction. This document is available at [www.emedny.org](http://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](http://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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Information for All Providers](#).

## 2.2 Paper Claims

Physicians who choose to submit their claims on paper forms must use the New York State eMedNY-150002 claim form.

To view a sample eMedNY - 150002 claim form, see Appendix A below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

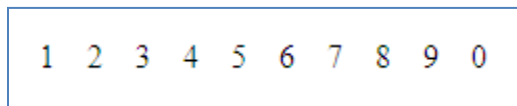
An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the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

| Written As   | Intended As | Interpreted As |    |   |   |      |  |  |  |    |   |   |
|--|-------------|----------------|----|---|---|------|--|--|--|----|---|---|
| <table border="1"> <tr> <td></td> <td></td> <td>6.</td> <td>0</td> <td>0</td> </tr> </table> |             |                | 6. | 0 | 0 | 6.00 | <table border="1"> <tr> <td></td> <td></td> <td>6.</td> <td>6</td> <td>0</td> </tr> </table> → Zero interpreted as six |  |  | 6. | 6 | 0 |
|  |             | 6.             | 0  | 0 |   |      |  |  |  |    |   |   |
|  |             | 6.             | 6  | 0 |   |      |  |  |  |    |   |   |


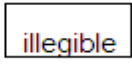
- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

| Written As  | Intended As | Interpreted As   |
|---|-------------|--|
|  | 2           |  → Two interpreted as seven |
|  | 3           |  → 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          |  → 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 – 150002 Claim Form

The 150002 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 Physician eMedNY - 150002 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 Physician Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Physicians. Although the instructions that follow are based on the eMedNY-150002 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](http://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, pending, 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](http://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 - 150002 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.

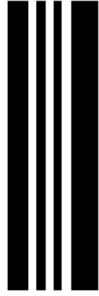
Exhibit 2.4.2.1-1 and Exhibit 2.4.2.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 0904101234567890 is shared by three individual claim lines. This TCN was paid on February 10, 2009. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-1

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM  |  |  |   | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM   |  | A CODE V<br>A V  |  | ORIGINAL CLAIM REFERENCE NUMBER  |   |  |  |   |  |   |  |                                     |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
|--|--|--|---|---|--|--|--|--|---|--|--|---|--|---|--|-------------------------------------|--|---|--|---|--|--|-----------------------|---|--|--|--------------|--|--|------|--|--|------|--|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION   |  |  |   |   |  |  |  |  |   |  |  |   |  |   |  |                                     |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 1. PATIENT'S NAME (Prt, middle, and last)<br><b>JANE SMITH</b>   |  |  |   | 2. DATE OF BIRTH<br><b>05201990</b>   |  | 2A. TOTAL ANNUAL FAMILY INCOME   |  | 3. INSURED'S NAME (Prt, middle initial, last name)   |   |  |  |   |  | 4. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b>              |  | 5A. MEDICATION NUMBER               |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)   |  |  |   | 5. INSURED'S SEX<br>MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>  |  | 5A. PATIENT'S SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>                            |  | 6. PRIVATE INSURANCE NUMBER  |   | GROUP NO.  |  | REG/PROCTY NO.  |  | 6B. PATIENT'S TELEPHONE NUMBER                            |  | 7. INSURED'S EMPLOYER OR OCCUPATION |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 8. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL  |  |  |   | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> |  | 8. INSURED'S EMPLOYER OR OCCUPATION  |  | 9. OTHER HEALTH INSURANCE CO/GRACE - State name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number |   | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |  | 11. INSURED'S ADDRESS (Street, City, State, Zip Code)                         |  | 12. PATIENT'S OR AUTHORIZED SIGNATURE                     |  | 13. INSURED'S SIGNATURE             |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)   |  |  |   |   |  |  |  |  |   |  |  |   |  |   |  |                                     |  |   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 14. DATE OF ONSET OF CONDITION<br>MM DD YY   |  |  | 15. FIRST CONSULTED FOR CONDITION<br>MM DD YY |   |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 17. DATE PATIENT MAY RETURN TO WORK<br>MM DD YY                                       |  |  | 18. DATES OF DISABILITY<br>TOTAL PARTIAL<br>MM DD YY                          |  |   | 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  |                                     |  | 19A. ADDRESS (OR SIGNATURE SHIP ONLY)   |  |   | 19B. PROF CO   |  |                       | 19C. IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b>  |  |  | 19D. DX CODE |  |  |      |  |  |      |  |  |
| 20. NATIONAL DRUG CODE   |  |  | 20A. UNIT                                     |   |  | 20B. QUANTITY  |  |  | 20C. COST   |  |  | 21. NAME OF FACILITY (WHERE SERVICES RENDERED) (If other than home or office) |  |   | 21A. ADDRESS OF FACILITY   |                                     |  | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   | LAB CHARGES  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 23A. SERVICE PROVIDER NAME   |  |  | 23B. PROF CO                                  |   |  | 23C. IDENTIFICATION NUMBER   |  |  | 23D. STERILIZATION/ABORTION CODE  |  |  | 23E. STATUS CODE  |  |   | 24. DIAGNOSIS OR NATURE OF ILLNESS - SELECTED ICD9CM TO PRODUCE IN COLUMN 24 BY REFERENCE TO NUMBERS 1, 2 & 3, ICD9CM CODE |                                     |  | 24F. POSSIBLE DISABILITY<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/> |  |   | 24G. EP/OT/OTHP<br>Y <input type="checkbox"/> N <input type="checkbox"/> |  |                       | 24H. FAMILY PLANNING<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/> |  |  |              |  |  |      |  |  |      |  |  |
| 25. DATE OF SERVICE<br>M M D D Y Y   |  |  | 25B. PLACE                                    |   |  | 25C. PROCEDURE CD  |  |  | 25D. MOD  |  |  | 25E. MOD  |  |   | 25F. MOD   |                                     |  | 25G. MOD  |  |   | 25H. DIAGNOSIS CODE  |  |                       | 25I. DAYS OR UNITS  |  |  | 25J. CHARGES |  |  | 25K. |  |  | 25L. |  |  |
| 0 1 2 9 0 9  |  |  | 1 1   |   |  | 9 9 2 0 5  |  |  |   |  |  |   |  |   |  |                                     |  | 7 8 6 2   |  |   |  |  |                       | 3 0 0 0   |  |  |              |  |  |      |  |  |      |  |  |
| 0 1 2 9 0 9  |  |  | 1 1   |   |  | 9 3 0 0 0  |  |  |   |  |  |   |  |   |  |                                     |  | 7 8 6 2   |  |   |  |  |                       | 1 5 0 0   |  |  |              |  |  |      |  |  |      |  |  |
| 0 2 0 8 0 9  |  |  | 1 1   |   |  | 9 9 2 1 3  |  |  |   |  |  |   |  |   |  |                                     |  | 7 8 6 2   |  |   |  |  |                       | 3 0 0 0   |  |  |              |  |  |      |  |  |      |  |  |
| 24M. HOSPITAL UNITS  |  |  | FROM  |   |  | THROUGH  |  |  | 24N. PROC CD  |  |  | 24O. MOD  |  |   | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |  | 27. TOTAL CHARGE  |  |   | 28. AMOUNT PAID  |  |                       | 29. BALANCE DUE   |  |  |              |  |  |      |  |  |      |  |  |
| 30. CERTIFICATION<br>(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)<br><b>James Strong</b><br>SIGNATURE OF PHYSICIAN OR SUPPLIER<br>30A. PROVIDER IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b> |  |  |   |   |  |  |  |  |   |  |  |   |  | 30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER |  |                                     | 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE<br><b>James Strong<br/>312 Main Street<br/>Anytown, New York 11111</b> |   |  | TELEPHONE NUMBER ( ) EXT.<br>DO NOT WRITE IN THIS SPACE |  |  | (1008) 8182111-110003 |   |  |  |              |  |  |      |  |  |      |  |  |
| 25E. MEDICARD GROUP IDENTIFICATION NUMBER  |  |  | 25C. LOCATOR CODE<br><b>0 0 3</b>             |   |  | 25D. SA ENCP CODE  |  |  | 32A. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 32. DATE SIGNED<br><b>02 10 09</b>  |  |   | 32. PATIENT'S ACCOUNT NUMBER   |                                     |  | A B C 1 2 3 4 5   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |
| 33. OTHER REFERRING ORDERING PROVIDER LICENSE NUMBER   |  |  | 34. PROF CO                                   |   |  | 35. CASE MANAGER ID  |  |  | COUNTY OF SUBMITTAL   |  |  | 36. DATE SIGNED   |  |   | 37. PATIENT'S ACCOUNT NUMBER   |                                     |  | A B C 1 2 3 4 5   |  |   |  |  |                       |   |  |  |              |  |  |      |  |  |      |  |  |

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Exhibit 2.4.2.1-2

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM  |                            |   |   | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM |                 | A CODE V<br>7 V |   | ORIGINAL CLAIM REFERENCE NUMBER<br>0 9 0 4 1 0 1 2 3 4 5 6 7 8 9 0 |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
|--|----------------------------|---|---|---|-----------------|-----------------|---|--|---|------------------|---|-------------------------------------|--|--|-------------------------|---|---|---|-----------------|---|---|---|---|------------------|---|-----------------|----------------------------|-----------------|--|--|--|--|--|--|--|--|--|----|-------------------------|--|--|--|--|--|--|--|--|--|--|
|  <p style="writing-mode: vertical-rl; transform: rotate(180deg);">DO NOT STAPLE IN BARCODE AREA</p>   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 1. PATIENT'S NAME (First, middle, last)<br><b>JANE SMITH</b>   |                         |   |   | 2. DATE OF BIRTH<br><b>05/20/1990</b>   |                 |   |   | 3. INSURED'S NAME (First, middle, initial, last name) |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
|  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)   |                         |   |   | 5. INSURED'S SEX<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> |                 |   |   | 6. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b>          |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
|  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>  |                         |   |   | 8. PRIVATE INSURANCE NUMBER   |                 |   |   | 9. INSURED'S EMPLOYER OR OCCUPATION                   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
|  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |                         |   |   | 11. INSURED'S ADDRESS (Street, City, State, Zip Code)                             |                 |   |   | 12. PATIENT'S OR AUTHORIZED SIGNATURE                 |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| <p style="text-align: center;"><b>PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)</b></p>   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 14. DATE OF ONSET OF CONDITION   |                            |   |   | 15. FIRST CONSULTED FOR CONDITION         |                 |                 |   | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS                  |   |                  |   | 17. DATE PATIENT MAY RETURN TO WORK |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  |                            |   |   | 19A. ADDRESS (OR SIGNATURE SHIP ONLY)     |                 |                 |   | 19B. PROF CO   |   |                  |   | 19C. IDENTIFICATION NUMBER          |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 20. NATIONAL DRUG CODE   |                            |   |   | 20A. UNIT                                 |                 |                 |   | 20B. QUANTITY  |   |                  |   | 20C. COST                           |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 21. NAME OF FACILITY (WHERE SERVICES RENDERED) (If other than home or office)  |                            |   |   | 21A. ADDRESS OF FACILITY                  |                 |                 |   | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE              |   |                  |   | LAB CHARGES                         |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 23A. SERVICE PROVIDER NAME   |                            |   |   | 23B. PROF CO                              |                 |                 |   | 23C. IDENTIFICATION NUMBER   |   |                  |   | 23D. STATUS CODE                    |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 23. DIAGNOSIS OR NATURE OF ILLNESS. RELATED SERVICES TO BE COVERED IN COLUMN (A-H) BY REFERRING TO NUMBERS 1, 2 & 3, ETC. ON THIS FORM   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">1.</td> <td style="width: 10%;">20F POSSIBLE DISABILITY</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">X</td> <td style="width: 10%;">N</td> <td style="width: 10%;">20G EPSDT OTHER</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> <td style="width: 10%;">20H FAMILY PLANNING</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">X</td> <td style="width: 10%;">N</td> </tr> <tr> <td>2.</td> <td colspan="11">23A. PRIOR APPROVAL NUMBER</td> </tr> <tr> <td>3.</td> <td colspan="11">23E. PAYMNT SOURCE CODE</td> </tr> </table> |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 1.   | 20F POSSIBLE DISABILITY | Y | X | N   | 20G EPSDT OTHER | Y | N | 20H FAMILY PLANNING                                   | Y | X                | N | 2.              | 23A. PRIOR APPROVAL NUMBER |                 |  |  |  |  |  |  |  |  |  | 3. | 23E. PAYMNT SOURCE CODE |  |  |  |  |  |  |  |  |  |  |
| 1.   | 20F POSSIBLE DISABILITY    | Y | X | N   | 20G EPSDT OTHER | Y               | N | 20H FAMILY PLANNING  | Y | X                | N |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 2.   | 23A. PRIOR APPROVAL NUMBER |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 3.   | 23E. PAYMNT SOURCE CODE    |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 24A. DATE OF SERVICE   |                            |   |   | 24B. PLACE                                |                 |                 |   | 24C. PROCEDURE CD  |   |                  |   | 24D. CHARGES                        |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 24E. MDD   |                            |   |   | 24F. MDD                                  |                 |                 |   | 24G. MDD   |   |                  |   | 24H. MDD                            |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 24I. DIAGNOSIS CODE  |                            |   |   | 24J. DAYS OR UNITS                        |                 |                 |   | 24K. CHARGES   |   |                  |   | 24L. CHARGES                        |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 0 1 2 9 0 9  |                            |   |   | 1 1 9 9 2 1 0 5                           |                 |                 |   | 7 8 6 2  |   |                  |   | 3 0 0 0                             |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 0 1 2 9 0 9  |                            |   |   | 1 1 9 3 0 0 0 0                           |                 |                 |   | 7 8 6 2  |   |                  |   | 1 5 0 0                             |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 0 2 1 0 0 9  |                            |   |   | 1 1 9 9 2 1 1 3                           |                 |                 |   | 7 8 6 2  |   |                  |   | 3 0 0 0                             |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 24M. HOSPITAL UNITS  |                            |   |   | 24N. PROC CD                              |                 |                 |   | 24O. MDD   |   |                  |   | 24P. MDD                            |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10">25. ACCEPT ASSIGNMENT</td> <td colspan="2">27. TOTAL CHARGE</td> <td colspan="2">28. AMOUNT PAID</td> <td colspan="2">29. BALANCE DUE</td> </tr> <tr> <td colspan="10">YES <input type="checkbox"/> NO <input type="checkbox"/></td> <td colspan="2"></td> <td colspan="2"></td> <td colspan="2"></td> </tr> </table>   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  | 25. ACCEPT ASSIGNMENT  |                         |   |   |   |                 |   |   |   |   | 27. TOTAL CHARGE |   | 28. AMOUNT PAID |                            | 29. BALANCE DUE |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 25. ACCEPT ASSIGNMENT  |                            |   |   |   |                 |                 |   |  |   | 27. TOTAL CHARGE |   | 28. AMOUNT PAID                     |  | 29. BALANCE DUE  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| <b>James Strong</b><br>312 Main Street<br>Anytown, New York 11111  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 32. MEDICAI GROUP IDENTIFICATION NUMBER  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 33. LOCATOR CODE   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 34. SA EXOP CODE   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 35. MY FEE HAS BEEN PAID   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 36. DATE SIGNED  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 37. PATIENT'S ACCOUNT NUMBER   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 38. COUNTY OF SUBMITTAL  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 39. CASE MANAGER ID  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 39. OTHER REFERRING ORDERING PROVIDER LICENSE NUMBER   |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 39. PROF CO  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |
| 39. CASE MANAGER ID  |                            |   |   |   |                 |                 |   |  |   |                  |   |                                     |  |  |                         |   |   |   |                 |   |   |   |   |                  |   |                 |                            |                 |  |  |  |  |  |  |  |  |  |    |                         |  |  |  |  |  |  |  |  |  |  |

PHYSICIAN

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

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

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

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

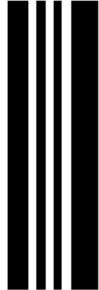
Exhibit 2.4.2.1-3 and Exhibit 2.4.2.1-4 illustrate an example of a claim with an adjustment being made to cancel a line on submitted on the claim. TCN 0902901234567890 contained three individual claim lines, which were paid on January 29, 2009. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Exhibit 2.4.2.1-3 shows the claim as it was originally submitted and Exhibit 2.4.2.1-4 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-3

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM   |  |                                     |  | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM   |  | A CODE V<br>A V   |  | ORIGINAL CLAIM REFERENCE NUMBER   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
|---|--|-------------------------------------|--|---|--|---|--|---|--|--------------------------|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION  |  |                                     |  |   |  |   |  |   |  |                          |  |  |  | 24. TOTAL ANNUAL FAMILY INCOME   |  | 3. INSURED'S NAME (First name, middle initial, last name)                |  |  |  |   |  |  |  |  |  |
| 1. PATIENT'S NAME (First, middle, last)<br><b>JANE SMITH</b>  |  |                                     |  | 2. DATE OF BIRTH<br><b>05/20/1990</b>   |  | 5A. PATIENT'S SEX<br>MALE FEMALE<br><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |  | 6. MEDICARE NUMBER  |  |                          |  | 5A. MEDICAID NUMBER<br><b>A B 1 2 3 4 5 C</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)  |  |                                     |  | 5B. PATIENT'S TELEPHONE NUMBER  |  | 26. PRIVATE INSURANCE NUMBER  |  |   |  | GROUP NO.                |  | REPRODUCTION                                   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 8. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL   |  |                                     |  | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF SPOUSE CHILD OTHER<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |  |   |  | 8. INSURED'S EMPLOYER OR OCCUPATION   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 9. OTHER HEALTH INSURANCE COVERAGE - State name of Policyholder, Plan Name and Address and Policy or Private Insurance Number   |  |                                     |  | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input checked="" type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |  |   |  | 11. INSURED'S ADDRESS (Street, City, State, Zip Code)   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 12. PATIENT'S OR AUTHORIZED SIGNATURE   |  |                                     |  | DATE<br>MM DD YY  |  | 13. INSURED'S SIGNATURE   |  |   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)  |  |                                     |  |   |  |   |  |   |  |                          |  |  |  | 14. DATE OF ONSET OF CONDITION<br>MM DD YY   |  | 15. FIRST CONSULTED FOR CONDITION<br>MM DD YY                            |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17. DATE PATIENT MAY RETURN TO WORK<br>MM DD YY |  | 18. DATES OF DISABILITY<br>TOTAL PARTIAL<br>MM DD YY |  | 19. DATE OF DISABILITY<br>FROM TO<br>MM DD YY            |  |
|   |  |                                     |  |   |  |   |  |   |  |                          |  |  |  | 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  |  |  |  | 19A. ADDRESS (OR SIGNATURE IF ONLY)  |  |   |  | 19B. PROF CO   |  | 19C. IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b> |  |
| 20. NATIONAL DRUG CODE<br><b>0 0 0 1 5 0 5 0 2 4 1</b>  |  |                                     |  | 20A. UNIT<br><b>G R</b>   |  | 20B. QUANTITY<br><b>0 5 0 0</b>   |  | 20C. COST<br><b>2 5 0 0</b>   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 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<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | LAB CHARGES              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 22A. SERVICE PROVIDER NAME  |  |                                     |  | 22B. PROF CO  |  | 22C. IDENTIFICATION NUMBER  |  | 22D. STERILIZATION ABORTION CODE  |  | 22E. STATUS CODE         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 23. DIAGNOSIS OR NATURE OF ILLNESS. SELECT DIAGNOSIS TO RECORD IN COLUMN 1 AND BY REFERENCE TO NUMBER 1, 2, ETC. IN COLUMNS 2-4 |  |                                     |  |   |  |   |  |   |  |                          |  |  |  | 22F. POSSIBLE DISABILITY<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/>            |  | 22G. EPSDT OTHP<br>Y <input type="checkbox"/> N <input type="checkbox"/> |  | 22H. FAMILY PLANNING<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/>      |  | 23A. PRIOR APPROVAL NUMBER                      |  |  |  | 23B. PAYMENT SOURCE CODE<br><b>1 1</b>                   |  |
| 24A. DATE OF SERVICE<br>M M D D Y Y   |  | 24B. PLACE                          |  | 24C. PROCEDURE CODE<br>J 9 0 9 1 5  |  | 24D. ICD<br>1 6 2 9   |  | 24E. DAYS OR UNITS<br>2   |  | 24F. CHARGES<br>5 0 0 0  |  | 24G.   |  | 24H.   |  |  |  |  |  |   |  |  |  |  |  |
| 0 1 2 9 0 9   |  | 1 1                                 |  | 9 9 0 0 0 0   |  | 1 6 2 9   |  |   |  | 1 5 0 0                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 0 1 2 9 0 9   |  | 1 1                                 |  | 9 6 4 1 0   |  | 1 6 2 9   |  |   |  | 3 5 0 0                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 24I. FROM<br>MM DD YY   |  | THROUGH<br>MM DD YY                 |  | 24J. PROC CODE  |  | 24K. ICD  |  |   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 25. CERTIFICATION<br>I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF            |  |                                     |  |   |  |   |  |   |  |                          |  |  |  | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 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<br><b>James Strong, M.D.<br/>312 Main Street<br/>Anytown, New York 11111</b> |  |  |  |  |  |   |  |  |  |  |  |
| 32. MEDICAID GROUP IDENTIFICATION NUMBER  |  |                                     |  | 33C. LOCATOR CODE<br><b>0 0 3</b>   |  | 33D. SA EXOP CODE   |  | 33A. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | TELEPHONE NUMBER ( ) EXT |  | DO NOT WRITE IN THIS SPACE (000) 816291-150002 |  |  |  |  |  |  |  |   |  |  |  |  |  |
| COUNTY OF SUBMITTAL   |  | 33E. DATE SIGNED<br><b>01 29 09</b> |  | 32. PATIENT'S ACCOUNT NUMBER  |  |   |  | A B C 1 2 3 4 5   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 33. OTHER REFERRING ORDERING PROVIDER<br>LICENSE NUMBER   |  |                                     |  | 34. PROF CO   |  | 35. CASE MANAGER ID   |  |   |  |                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |

PHYSICIAN

Exhibit 2.4.2.1-4

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM   |  |  |  | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM |  | A CODE V<br>X V |  | ORIGINAL CLAIM REFERENCE NUMBER<br>0 9 0 2 9 0 1 2 3 4 5 6 7 8 9 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|---|--|-----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
|  <p>DO NOT STAPLE IN BARCODE AREA</p>  |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 1. PATIENT'S NAME (Print, middle init)<br><b>JANE SMITH</b>  |  |  |  | 2. DATE OF BIRTH<br><b>05/20/1990</b>  |  |  |  | 3A. TOTAL ANNUAL FAMILY INCOME   |  |  |  | 3. INSURED'S NAME (Print name, middle initial, last name) |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)   |  |  |  | 5. INSURED'S SEX<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>  |  |  |  | 5A. PATIENT'S SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/> |  |  |  | 6. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b>              |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 6A. MEDICAID NUMBER  |  |  |  | 6B. PRIVATE INSURANCE NUMBER   |  |  |  | 6C. GROUP NO.  |  |  |  | 6D. REDUCTION NO.   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 7. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL  |  |  |  | 7A. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>   |  |  |  | 8. INSURED'S EMPLOYER OR OCCUPATION  |  |  |  | 9. INSURED'S ADDRESS (Street, City, State, Zip Code)      |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 9. OTHER HEALTH INSURANCE COVERAGE - State name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number                 |  |  |  | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |  |  |  | 11. INSURED'S SIGNATURE  |  |  |  | 12. DATE<br>MM DD YY                                      |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. PATIENT'S OR AUTHORIZED SIGNATURE   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 13. INSURED'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. DATE OF ONSET OF CONDITION  |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 15. FIRST CONSULTED FOR CONDITION  |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 17. DATE PATIENT MAY RETURN TO WORK               |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 18. DATES OF DISABILITY FROM TO                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 19A. ADDRESS (OR SIGNATURE SHIP ONLY)  |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 19B. PROF CO  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 19C. IDENTIFICATION NUMBER<br>1 1 2 3 4 5 6 7 8 9 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 19D. DX CODE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20. NATIONAL DRUG CODE<br>0 0 1 5 0 5 0 2 4 1   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 20A. UNIT<br>G R   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 20B. QUANTITY<br>0 5 0 0  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 20C. COST<br>2 5 0 0                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. NAME OF FACILITY (WHERE SERVICES RENDERED) (If other than home or office)   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 21A. ADDRESS OF FACILITY   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  | LAB CHARGES                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22A. SERVICE PROVIDER NAME  |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 22B. PROF CO   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 22C. IDENTIFICATION NUMBER  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22D. STERILIZATION ABORTION CODE                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22E. STATUS CODE                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23. DIAGNOSIS OR NATURE OF ILLNESS - SELECTED ORDER TO PROCEDURE IN COLUMN (A-H) BY REFERRING TO UNIVERSAL 3-LETTER CODE  |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 23A. PRIOR APPROVAL NUMBER   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 23B. PAYMENT SOURCE CODE<br>1 1   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23C. POSSIBLE DISABILITY<br>Y X N                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23D. EP/SOT OTHP<br>Y N N                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23E. FAMILY PLANNING<br>Y X N  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24A. DATE OF SERVICE<br>M M D D Y Y   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 24B. PLACE   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 24C. PROCEDURE CODE<br>J 9 1 0 9 1 5  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24D. MOO  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24E. MOO   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24F. MOO   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24G. MOO   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24H. DIAGNOSIS CODE<br>1 6 2 9 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24I. DAYS OR UNITS<br>2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24J. CHARGES<br>5 0 0 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24K. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24L. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. CERTIFICATION<br>(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)<br><b>James Strong</b><br>SIGNATURE OF PHYSICIAN OR SUPPLIER<br>25A. PROVIDER IDENTIFICATION NUMBER<br>1 1 2 3 4 5 6 7 8 9 |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 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<br><b>James Strong, M.D.</b><br><b>312 Main Street</b><br><b>Anytown, New York 11111</b> |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 32. MEDICAL GROUP IDENTIFICATION NUMBER   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 33. LOCATOR CODE<br>0 0 3                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 34. BA EXOP CODE                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 35. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TELEPHONE NUMBER ( ) EXT<br>DO NOT WRITE IN THIS SPACE |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (1000) 8162111 - 150002        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 36. COUNTY OF SUBMITTAL   |  |  |  |   |  |                 |  |  |  |  |  |  |  |  | 37. DATE SIGNED<br>0 2 1 0 0 9   |  |  |  |  |  |  |  |  |  |  |  |   |  |  | 38. PATIENT'S ACCOUNT NUMBER  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 39. A B C 1 2 3 4 5                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 33. OTHER REFERRING ORDERING PROVIDER LICENSE NUMBER |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 34. PROF CO  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 35. CASE MANAGER ID                                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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### 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 090410123456789 contained two claim lines, which were paid on January 29, 2009. Later, the provider became aware that the patient had other 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 2.4.2.2-2

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM   |  | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM  |  | A CODE V<br>A <input type="checkbox"/> X <input checked="" type="checkbox"/>  |  | ORIGINAL CLAIM REFERENCE NUMBER<br>0 9 0 4 1 0 1 2 3 4 5 6 7 8 9 0 |  |  |              |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--------------|---|--|--|--|--|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION  |  |  |  |   |  |  |  |  |              |   |  |  |  |  |  |
| 1. PATIENT'S NAME (Print, middle, last)<br><b>ROBERT JOHNSON</b>  |  | 2. DATE OF BIRTH<br><b>06/03/1956</b>  |  | 3A. TOTAL ANNUAL FAMILY INCOME  |  | 3. INSURED'S NAME (Print name, middle initial, last name)          |  |  |              |   | 4. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b> |  |  |  |  |
| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)  |  | 5. INSURED'S SEX<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>  |  | 5A. PATIENT'S SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/>            |  | 6. PRIVATE INSURANCE NUMBER  |  |  | 7. GROUP NO. |   | 8. RESIDENCY NO.                             |  |  |  |  |
| 9. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL   |  | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>  |  | 8. INSURED'S EMPLOYER OR OCCUPATION   |  | 9. INSURED'S ADDRESS (Street, City, State, Zip Code)               |  |  |              |   |  |  |  |  |  |
| 10. OTHER HEALTH INSURANCE COVERAGE - Give name of Policyowner, Plan Name and Address, and Policy or Private Insurance Number   |  | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |  | 11. INSURED'S SIGNATURE   |  | 12. DATE<br>MM DD YY   |  |  |              |   |  |  |  |  |  |
| 12. PATIENT'S OR AUTHORIZED SIGNATURE   |  | 13. INSURED'S SIGNATURE  |  | 14. DATE OF ONSET OF CONDITION<br>MM DD YY  |  |  |  |  |              |   |  |  |  |  |  |
| PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)  |  |  |  |   |  |  |  |  |              |   |  |  |  |  |  |
| 14. DATE OF ONSET OF CONDITION<br>MM DD YY  |  | 15. FIRST CONSULTED FOR CONDITION<br>MM DD YY  |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 17. DATE PATIENT MAY RETURN TO WORK<br>MM DD YY                    |  | 18. DATES OF DISABILITY<br>TOTAL PARTIAL FROM TO<br>MM DD YY MM DD YY                |              | 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   |  |  |  |  |  |
| 20. NATIONAL DRUG CODE<br><b>5 5 3 9 0 0 5 5 5 9 0</b>  |  | 20A. UNIT<br><b>G R</b>  |  | 20B. QUANTITY<br><b>0 0 1</b>   |  | 20C. COST<br><b>3 3 0 0</b>  |  | 19A. ADDRESS (FOR SIGNATURE SPP ONLY)  |              | 19B. PROF CO  |  | 19C. IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b> |  |  |  |
| 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<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 22B. STATUS CODE   |  | 22C. STERILIZATION ABORTION CODE   |              | 22D. PAYMENT SOURCE CODE<br><b>1 1</b>  |  |  |  |  |  |
| 23A. SERVICE PROVIDER NAME  |  | 23B. PROF CO   |  | 23C. IDENTIFICATION NUMBER  |  | 23D. STERILIZATION ABORTION CODE                                   |  | 23E. STATUS CODE   |              | 23F. POSSIBLE DISABILITY<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/> |  |  |  |  |  |
| 23G. PRIOR APPROVAL NUMBER  |  | 23H. PAYMENT SOURCE CODE   |  | 23I. FAMILY PLANNING<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> N <input type="checkbox"/> |  | 23J. PAYMENT SOURCE CODE   |  | 23K. DATE OF SERVICE<br>M M D D Y Y  |              |   |  |  |  |  |  |
| 24A. DATE OF SERVICE  |  | 24B. PLACE   |  | 24C. PROCEDURE CD   |  | 24D. MOO   |  | 24E. MOO   |              | 24F. MOO  |  | 24G. MOO   |  |  |  |
| 24H. DIAGNOSIS CODE   |  | 24I. DAYS OR UNITS   |  | 24J. CHARGES  |  | 24K.   |  | 24L.   |              | 24M.  |  |  |  |  |  |
| 24N. FROM   |  | 24O. THROUGH   |  | 24P. PROC CD  |  | 24Q. MOO   |  | 24R.   |              | 24S.  |  |  |  |  |  |
| 25. CERTIFICATION<br>(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)<br><b>James Strong</b><br>SIGNATURE OF PHYSICIAN OR SUPPLIER |  | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 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<br><b>James Strong, M.D.</b><br><b>312 Main Street</b><br><b>Anytown, New York 11111</b>                                      |  | 32. MEDICARE GROUP IDENTIFICATION NUMBER   |  | 33. LOCATOR CODE<br><b>0 0 3</b>  |  | 34. SA ENCP CODE   |  | 35. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |              | 36. TELEPHONE NUMBER (DO NOT WRITE IN THIS SPACE)   |  |  |  |  |  |
| 37. DATE SIGNED<br><b>02 10 09</b>  |  | 38. PATIENT'S ACCOUNT NUMBER<br><b>A B C 1 2 3 4 5</b>   |  | 39. OTHER REFERRING ORDERING PROVIDER LICENSE NUMBER  |  | 40. PROF CO  |  | 41. CASE MANAGER ID  |              |   |  |  |  |  |  |

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### 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

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

### Patient's Sex (Field 5A)

Place an 'X' in the appropriate box to indicate the patient's sex. 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 AANNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.2-2.

Exhibit 2.4.2-2

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

### Was Condition Related To (Field 10)

If applicable, place an 'X' in the appropriate box to indicate whether the service rendered to the 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)

This field should be completed only when claiming the following:

- Ordered Procedure
- Referred Service
- Surgical Assistance

#### Ordered Procedures

If claiming any of the procedures listed below the name of the ordering provider must be entered in this field. If the procedures were performed by the billing physician, the billing physician's name should be entered in this field.

- All Radiology Procedures
- Cardiac Fluoroscopy
- Echocardiography
- Non-invasive Vascular Diagnostic Studies
- Consultations

*Note: Consultation codes must not be claimed for a physician's own patient.*

#### Referred Service

If the patient was referred by another provider enter the name of the referring provider in this field.

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**Surgical Assistance**

If the claim is for surgical assistance services, the primary surgeon's name must be entered in this field.

If no order or referral is involved or the claim is not for surgical assistance, leave this field blank.

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

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

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

Leave this field blank.

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

This field must be completed when the claim involves any of the following:

- Ordered Procedure
- Referred Service
- Surgical Assistance

**Ordered Procedures**

If the service was ordered by another provider (see field 19 for the list of ordered procedures) enter the ordering provider's National Provider ID (NPI) in this field.

**Referred Service**

If the patient was referred for treatment by another physician, enter the referring provider's NPI in this field.

A facility ID cannot be used for the referring/ordering provider. In those instances where an order or referral was made by a facility, the NPI of the practitioner at the facility must be used.

When providing services to a patient who is restricted to a primary physician or facility, the NPI of the patient's primary physician must be entered in this field. *The license number of the primary physician is not acceptable in this case. If a patient is restricted to a facility, the NPI of the practitioner in the facility the patient is restricted to must be entered. The ID of the facility cannot be used.*

**Surgical Assistance**

If the claim is for surgical assistance services, the NPI of the primary operating physician must be entered in this field.

If no order or referral is involved or the claim is not from an assistant surgeon, leave this field blank.

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**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<br>4 + 4 + 2 = 10   | 0XXXX-XXXX-XX<br>5 + 4 + 2 = 11               | 20 - NATIONAL DRUG CODE=<br>0   X   X   X   X   X   X   X   X   X   X |
| XXXXX-XXX-XX<br>5 + 3 + 2 = 10   | XXXXX-0XXX-XX<br>5 + 4 + 2 = 11               | 20 - NATIONAL DRUG CODE=<br>X   X   X   X   X   0   X   X   X   X   X |
| XXXXX-XXXX-X<br>5 + 4 + 1 = 10   | XXXXX-XXXX-0X<br>5 + 4 + 2 = 11               | 20 - NATIONAL DRUG CODE=<br>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

|                 |  |  |  |  |  |  |     |   |   |
|-----------------|--|--|--|--|--|--|-----|---|---|
| 20B - QUANTITY* |  |  |  |  |  |  |     |   |   |
|                 |  |  |  |  |  |  | 0.1 | 5 | 0 |

**Cost (Field 20C)**

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

Exhibit 2.4.2-5

|             |  |  |   |     |   |  |  |  |  |
|-------------|--|--|---|-----|---|--|--|--|--|
| 20C - COST* |  |  |   |     |   |  |  |  |  |
|             |  |  | 4 | 5.0 | 0 |  |  |  |  |

**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.

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Exhibit 2.4.2-6

| MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM<br>TITLE XIX PROGRAM  |  |   |   | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM  |  | A CODE V<br>A V   |  | ORIGINAL CLAIM REFERENCE NUMBER  |  |   |  |   |   |                    |   |              |  |      |  |
|--|--|---|---|--|--|---|--|--|--|---|--|---|---|--------------------|---|--------------|--|------|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION   |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 1. PATIENT'S NAME (Print, middle, last)<br><b>JANE SMITH</b>   |  |   |   | 2. DATE OF BIRTH<br><b>05/20/1990</b>  |  | 3A. TOTAL ANNUAL FAMILY INCOME  |  | 3. INSURED'S NAME (Print name, middle initial, last name)  |  |   |  |   |   |                    |   |              |  |      |  |
| 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)   |  |   |   | 5. INSURED'S SEX<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>  |  | 5A. PATIENT'S SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/>      |  | 6. MEDICARE NUMBER   |  |   |  |   | 6A. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b> |                    |   |              |  |      |  |
| 7. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL  |  |   |   | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>  |  |   |  | 8. PRIVATE INSURANCE NUMBER  |  |   |  | GROUP NO.                                       |   | RECIPROCALITY NO.  |   |              |  |      |  |
| 9. OTHER HEALTH INSURANCE COVERAGE - State name of Policyholder, Plan Name and Address, and Policy or Private Insurance Number |  |   |   | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input type="checkbox"/> |  |   |  | 8. INSURED'S EMPLOYER OR OCCUPATION  |  |   |  |   |   |                    |   |              |  |      |  |
| 11. INSURED'S ADDRESS (Street, City, State, Zip Code)  |  |   |   | 12. PATIENT'S OR AUTHORIZED SIGNATURE  |  | DATE<br>MM DD YY  |  | 13. INSURED'S SIGNATURE  |  |   |  |   |   |                    |   |              |  |      |  |
| PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)   |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 14. DATE OF ONSET OF CONDITION<br>MM DD YY   |  |   | 15. FIRST CONSULTED FOR CONDITION<br>MM DD YY |  |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 16A. EVERGIBNEY RELATED<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 17. DATE PATIENT MAY RETURN TO WORK<br>MM DD YY |   |                    | 18. DATES OF DISABILITY<br>FROM MM DD YY TO MM DD YY<br>TOTAL PARTIAL |              |  |      |  |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE<br>Peter Smith   |  |   |   | 19A. ADDRESS (FOR SIGNATURE SHEET ONLY)  |  |   |  | 19B. PROF CO   |  | 19C. IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b>                              |  |   | 19D. DX CODE                                  |                    |   |              |  |      |  |
| 20. NATIONAL DRUG CODE<br><b>0 0 7 0 3 6 8 0 1 0 1</b>   |  |   |   | 20A. UNIT<br><b>G R</b>  |  | 20B. QUANTITY<br><b>0 1 5 0</b>   |  | 20C. COST<br><b>4 5 0 0</b>  |  |   |  |   |   |                    |   |              |  |      |  |
| 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<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |   |  | LAB CHARGES                                     |   |                    |   |              |  |      |  |
| 22A. SERVICE PROVIDER NAME   |  |   |   | 22B. PROF CO   |  | 22C. IDENTIFICATION NUMBER  |  | 22D. STERILIZATION ABORTION CODE   |  |   |  | 22E. STATUS CODE                                |   |                    |   |              |  |      |  |
| 23. DIAGNOSIS OR NATURE OF ILLNESS: SELECT DIAGNOSIS TO PROCEDURE IN COLUMN WITH REFERENCE TO NUMBERS 1, 2 & 3. ICD-9-CM CODE  |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 1. POSSIBLE DISABILITY <input type="checkbox"/> Y <input checked="" type="checkbox"/> N  |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 2. EPIDOT OTHP <input type="checkbox"/> Y <input type="checkbox"/> N   |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 24. FAMILY PLANNING <input type="checkbox"/> Y <input checked="" type="checkbox"/> N   |  |   |   |  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 23A. PRIOR APPROVAL NUMBER   |  |   |   | 23B. PAYMENT SOURCE CODE<br><b>1 1</b>   |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 24A. DATE OF SERVICE<br>M M D D Y Y  |  | 24B. PLACE<br>1 1   |   | 24C. PROCEDURE CODE<br>J 1 9 5 5   |  | 24D. MOD<br>1 6 2 9   |  | 24E. MOD<br>1 6 2 9  |  | 24F. MOD<br>3 5 0 0   |  | 24G. DIAGNOSIS CODE                             |   | 24H. DAYS OR UNITS |   | 24I. CHARGES |  | 24J. |  |
| 0 9 0 9 0 9  |  | 1 1   |   | J 1 9 5 5  |  | 1 6 2 9   |  | 1 6 2 9  |  | 3 5 0 0   |  |   |   |                    |   |              |  |      |  |
| 0 9 0 9 0 9  |  | 1 1   |   | 9 4 6 1 0  |  |   |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 24K. FROM<br>MM DD YY  |  | 24L. THROUGH<br>MM DD YY  |   | 24M. PROC CD   |  | 24N. MOD  |  |  |  |   |  |   |   |                    |   |              |  |      |  |
| 25. CERTIFICATION<br>(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)         |  | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  | 27. TOTAL CHARGE  |  | 28. AMOUNT PAID  |  | 29. BALANCE DUE   |  |   |   |                    |   |              |  |      |  |
| <b>James Strong</b><br>SIGNATURE OF PHYSICIAN OR SUPPLIER  |  |   |   | 30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER  |  |   |  | 31. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE<br><b>James Strong, M.D.<br/>312 Main Street<br/>Anytown, New York 11111</b> |  |   |  |   |   |                    |   |              |  |      |  |
| 32A. PROVIDER IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b>  |  |   |   | 32B. MEDICARE GROUP IDENTIFICATION NUMBER  |  | 32C. LOCATOR CODE<br><b>0 0 3</b>   |  | 32D. SA ENCP CODE  |  | 32E. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |                    |   |              |  |      |  |
| 33. COUNTY OF SUBMITTAL  |  | 32E. DATE SIGNED<br><b>09 09 09</b>   |   | 33. PATIENT'S ACCOUNT NUMBER<br><b>A B C 1 2 3 4 5</b>   |  |   |  | 34. TELEPHONE NUMBER<br>DO NOT WRITE IN THIS SPACE   |  |   |  | EXT. (1206) 8162117-15000                       |   |                    |   |              |  |      |  |
| 33. OTHER REFERRING ORDERING PROVIDER / LICENSE NUMBER   |  |   |   | 34. PROF CO  |  | 35. CASE MANAGER ID   |  |  |  |   |  |   |   |                    |   |              |  |      |  |

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## Name of Facility Where Services Rendered (Field 21)

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

## Address of Facility (Field 21A)

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

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

## Service Provider Name (Field 22A)

If the service was provided by a physician's assistant, certified diabetes educator, certified asthma educator or a social worker enter his/her name in this field. Otherwise, leave this field blank.

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

Leave this field blank.

## Identification Number [Service Provider] (Field 22C)

If the service was provided by a physician's assistant, certified diabetes educator, certified asthma educator or by a social worker, enter the service provider's NPI in this field. Otherwise, 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, *LDSS-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 LDSS-3134 form attached to it.

### NOTES:

- *The following medical procedures are not induced abortions; therefore when billing for these procedures, leave this field blank.*
  - *Spontaneous abortion (miscarriage);*
  - *Termination of ectopic pregnancy;*

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- *Drugs or devices to prevent implantation of the fertilized ovum;*
- *Menstrual extraction.*
- *Medicaid does not reimburse providers for hysterectomies performed for the purpose of sterilization. Please refer to the Policy Guidelines on the web page for this manual, which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*

### Status Code (Field 22E)

Leave this field blank.

### Possible Disability (Field 22F)

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

### EPSDT C/THP (Field 22G)

This field must be completed if the physician bills for a periodic health supervision (well care) examination for a patient under 21 years of age, whether billing a Preventive Medicine Procedure Code or a Visit Code with a well care diagnosis. If applicable, place an 'X' in the Y box for YES.

### Family Planning (Field 22H)

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

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

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)

If the provider is billing for a service that requires Prior Approval/Prior Authorization, enter in this field the 11-digit prior approval number assigned for this service by the appropriate agency of the New York State Department of Health. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval.

### NOTES:

- *For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to Information for All Providers, Inquiry section on the web page for this manual, which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*
- *For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual, which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*
- *For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules which can be found on the web page for this manual, which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*

## 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. PAYMT 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
- 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.

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- 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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician 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<br><b>1 1</b><br>M / 0 / / /   | Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.                                     | Code 1 – No Other Insurance involvement. Field 24L must be left blank.   |
| 23B. PAYM'T SOURCE CO<br><b>1 2</b><br>M / 2 / * / * | Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.                                     | Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. **You must indicate the two-digit insurance code. |
| 23B. PAYM'T SOURCE CO<br><b>1 3</b><br>M / 3 / * / * | Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.                                     | Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.           |
| 23B. PAYM'T SOURCE CO<br><b>2 1</b><br>M / 1 / / /   | Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount. | Code 1 – No Other Insurance involvement. Field 24L must be left blank.   |
| 23B. PAYM'T SOURCE CO<br><b>2 2</b><br>M / 2 / * / * | Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount. | Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. **You must indicate the two-digit insurance code. |
| 23B. PAYM'T SOURCE CO<br><b>2 3</b><br>M / 3 / * / * | Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount. | Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.           |
| 23B. PAYM'T SOURCE CO<br><b>3 1</b><br>M / 1 / / /   | Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.     | Code 1 – No Other Insurance involvement. Field 24L must be left blank.   |
| 23B. PAYM'T SOURCE CO<br><b>3 2</b><br>M / 2 / * / * | Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.     | Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. **You must indicate the two-digit insurance code. |
| 23B. PAYM'T SOURCE CO<br><b>3 3</b><br>M / 3 / * / * | Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.     | Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.           |

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## 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.

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.

### 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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*

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

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

### Special Instructions for Claiming Medicare Deductible

When billing for the Medicare *deductible*, modifier “U2” must be used in conjunction with the Procedure Code for which the deductible is applicable. **Do not enter** the “U2” modifier if billing for Medicare coinsurance.

**NOTE:** *Modifier values and their definitions can be found on the web page for this manual under Procedure Codes and Fee Schedule, which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician 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

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

**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.

### Instructions for Anesthesia Claims Only

For anesthesia, each interval of 15 minutes of anesthesia time equals one unit. The total number of anesthesia units are computed as follows:

- Determine the number of 15-minute intervals in the total time that anesthesia was being administered.
- Add to that result the anesthesia basic value for the procedure.

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## Charges (Field 24J)

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

### Amount Charged

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

### Medicare Approved Amount

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

- If billing for the Medicare *deductible*, the Medicare Approved amount should equal the Deductible amount claimed, which must not exceed the established amount for the year in which the service was rendered.
- If billing for the Medicare *coinsurance*, the Medicare Approved amount should equal the sum of the amount paid by Medicare plus the Medicare co-insurance amount plus the Medicare deductible amount, if any.

### 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.

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## Unlabeled (Field 24L)

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

- When Box O has an entry value of **2**, enter the other insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid by all other insurance carriers in this field.
- When Box O has an entry value of **3**, enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.

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

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

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

**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)

In the FROM box, enter the date of the first hospital visit in the format MM/DD/YY. In the THROUGH box, enter the date of the last hospital visit in the format MM/DD/YY.

### Proc Code [Procedure Code] (Field 24N)

If dates were entered in 24M, enter the appropriate five-character procedure code for the visit. Block billing may be used with the following procedure codes:

- 90238
- 90240 through 90282
- 94997
- 99231 through 99233
- 99296 through 99297
- 99433

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

If the procedure code entered in 24N requires the addition of a modifier to further define the procedure, enter the modifier in this field.

**NOTE:** *The last row of Fields 24H, 24J, 24K, and 24L must be used to enter the appropriate information to complete the block billing of Inpatient Hospital Visits. For Fields 24J, 24K, and 24L enter the total Charges/Medicare Approved Amount, Medicare Paid Amount or Other Insurance Paid Amount that results from multiplying the amount for each individual visit times the number of days entered in field 24M.*

## 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.

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## 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)

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

For a **Shared Health Facility**, enter the NPI assigned to the facility.

If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, 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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).*

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

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

**NOTE:** *If the services being claimed require a specialty that is exempted from the Utilization Threshold program (see list of exempted specialties in Appendix A-Codes), the value '7' must be entered in this field.*

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For more information on the UT Program, please refer to Information for All Providers, General Policy, subsection “Utilization Threshold Program” , which can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the webpage as follows: [Physician Manual](#).

If not applicable leave this field blank.

### County of Submittal (Unnumbered Field)

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

### Date Signed (Field 25E)

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

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

PHYSICIAN

**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 Chiropractors/Portable X-Ray Supplier'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](http://www.emedny.org) by clicking on the link to the webpage as follows: [Information for All Providers](#).

The remittance advice is composed of five sections.

**Section One** may be one of the following:

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

**Section Two:** Provider Notification (special messages)

**Section Three:** Claim Detail

**Section Four:**



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

**Section Five:** Edit (Error) Description

### 3.1 Section One – Medicaid Check

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

Exhibit 3.1-1

|   |  |                              |   |                   |                 |   |             |                     |   |               |                   |
|---|--|------------------------------|---|-------------------|-----------------|---|-------------|---------------------|---|---------------|-------------------|
| TO: JAMES STRONG, M.D.  |  | DATE: 2010-05-31             |   |                   |                 |   |             |                     |   |               |                   |
|   |  | REMITTANCE NO: 07080600006   |   |                   |                 |   |             |                     |   |               |                   |
|   |  | PROV ID: 00112233/1123456789 |   |                   |                 |   |             |                     |   |               |                   |
| 00112233/1123456789 2010-05-31<br>JAMES STRONG, M.D.<br>100 BROADWAY<br>ANYTOWN NY 11111  |  |                              |   |                   |                 |   |             |                     |   |               |                   |
| YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE  |  |                              |   |                   |                 |   |             |                     |   |               |                   |
| <table border="1"> <thead> <tr> <th>DATE</th> <th>REMITTANCE NUMBER</th> <th>PROVIDER ID NO.</th> </tr> </thead> <tbody> <tr> <td>2010-05-31<br/><small>VOID AFTER 90 DAYS</small></td> <td>07080600006</td> <td>00112233/1123456789</td> </tr> </tbody> </table> |  |                              | DATE  | REMITTANCE NUMBER | PROVIDER ID NO. | 2010-05-31<br><small>VOID AFTER 90 DAYS</small> | 07080600006 | 00112233/1123456789 | <table border="1"> <thead> <tr> <th>DOLLARS/CENTS</th> </tr> </thead> <tbody> <tr> <td>PAY \$*****143.80</td> </tr> </tbody> </table> | DOLLARS/CENTS | PAY \$*****143.80 |
| DATE  | REMITTANCE NUMBER  | PROVIDER ID NO.              |   |                   |                 |   |             |                     |   |               |                   |
| 2010-05-31<br><small>VOID AFTER 90 DAYS</small>   | 07080600006  | 00112233/1123456789          |   |                   |                 |   |             |                     |   |               |                   |
| DOLLARS/CENTS   |  |                              |   |                   |                 |   |             |                     |   |               |                   |
| PAY \$*****143.80   |  |                              |   |                   |                 |   |             |                     |   |               |                   |
| TO THE ORDER OF<br>JAMES STRONG, M.D.<br>100 BROADWAY<br>ANYTOWN NY 11111   |  |                              | John Smith<br><small>AUTHORIZED SIGNATURE</small> |                   |                 |   |             |                     |   |               |                   |
| MEDICAL ASSISTANCE (TITLE XIX) PROGRAM<br>CHECKS DRAWN ON<br>KEY BANK N.A.<br>60 STATE STREET, ALBANY, NEW YORK 12207   |  |                              |   |                   |                 |   |             |                     |   |               |                   |

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2

PHYSICIAN

### 3.1.1 Medicaid Check Stub Field Descriptions

#### Upper Left Corner

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

#### Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

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

#### Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

### 3.1.2 Medicaid Check Field Descriptions

#### Left Side

Table

Date: The date on which the check was issued

Remittance Number

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

Provider's Name/Address

#### Right Side

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



### 3.2 Section One – EFT Notification

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

Exhibit 3.2-1

TO: JAMES STRONG, M.D.



DATE: 2010-05-31  
REMITTANCE NO: 07080600006  
PROVID: 00112233/1123456879

00112233/1123456879 2010-05-31  
JAMES STRONG, M.D.  
100 BROADWAY  
ANYTOWN NY 11111

JAMES STRONG, M.D. \$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: JAMES STRONG, M.D.



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

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

JAMES STRONG, M.D.  
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

|  |  |  |
|--|--|--|
|   |  | PAGE 01<br>DATE 05/31/10<br>CYCLE 1710   |
| <b>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM<br/>         REMITTANCE STATEMENT</b>  |  |  |
| TO: JAMES STRONG, M.D.<br>100 BROADWAY<br>ANYTOWN, NEW YORK 11111  |  | ETIN:<br>PROVIDER NOTIFICATION<br>PROV ID: 00112233/1123456879<br>REMITTANCE NO: 07080600006 |
| <p>REMITTANCE ADVICE MESSAGE TEXT</p> <p>*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***</p> <p>PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.</p> <p>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.</p> <p>PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.</p> <p>TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT <a href="http://WWW.EMEDNY.ORG">WWW.EMEDNY.ORG</a>. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.</p> <p>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.</p> <p>IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.</p> <p>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 <a href="mailto:NYHIPPADESK@CSC.COM">NYHIPPADESK@CSC.COM</a> OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.</p> |  |  |

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### 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 pending and denied during the specific cycle.

Exhibit 3.5-1



**MEDICAID**  
MANAGEMENT INFORMATION SYSTEM

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

TO: JAMES STRONG, M.D.  
100 BROADWAY  
ANYTOWN, NEW YORK 11111

PAGE 02  
DATE 05/31/2010  
CYCLE 1710


ETIN:  
PRACTITIONER  
PROVID: 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     | CP1111111             | DOE         | XX12345X         | 07206-000000227-0-0 | 05/11/10        | 90829      | 1.000 | 52.80   | 0.00 | DENY   | 00162 00244 |
| 01     | CP2222222             | SAMPLE      | XX23456X         | 07206-000011334-0-0 | 05/12/10        | 90804      | 1.000 | 17.60   | 0.00 | DENY   | 00244       |
| 01     | CP3333333             | EXAMPLE     | XX34567X         | 07206-000013556-0-0 | 05/14/10        | 91105      | 1.000 | 14.30   | 0.00 | DENY   | 00162       |
| 01     | CP4444444             | SPECIMEN    | XX45678X         | 07206-000032456-0-0 | 05/15/10        | 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

|  |                       |             |                  |                     |                 |  |  |         |        |        |                              |
|---|-----------------------|-------------|------------------|---------------------|-----------------|--|--|---------|--------|--------|------------------------------|
| MEDICAL ASSISTANCE (TITLE XIX) PROGRAM<br>REMITTANCE STATEMENT                    |                       |             |                  |                     |                 |  |  |         |        |        |                              |
| TO: JAMES STRONG, M.D.<br>100 BROADWAY<br>ANYTOWN, NEW YORK 11111                 |                       |             |                  |                     |                 | PAGE 03<br>DATE 05/31/2010<br>CYCLE 1710<br><br>ETIN:<br>PRACTITIONER<br>PROVID: 00112233/1123456789<br>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  | 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   | 14.00  | ADJT   |                              |
|   |                       |             |                  |                     |                 |  | * = PREVIOUSLY PENDED CLAIM<br>** = NEW PEND |         |        |        |                              |
| TOTAL AMOUNT ORIGINAL CLAIMS  |                       |             |                  | PAID                | 147.40          | NUMBER OF CLAIMS   | 4  |         |        |        |                              |
| NET AMOUNT ADJUSTMENTS  |                       |             |                  | PAID                | 3.60-           | NUMBER OF CLAIMS   | 1  |         |        |        |                              |
| NET AMOUNT VOIDS  |                       |             |                  | PAID                | 0.00            | NUMBER OF CLAIMS   | 0  |         |        |        |                              |
| NET AMOUNT VOIDS - ADJUSTS  |                       |             |                  |                     | 3.60-           | NUMBER OF CLAIMS   | 1  |         |        |        |                              |

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Exhibit 3.5-3



PAGE 04  
DATE 05/31/2010  
CYCLE 1710

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT

TO: JAMES STRONG, M.D.  
100 BROADWAY  
ANYTOWN, NEW YORK 11111

ETIN:  
PRACTITIONER  
PROVID: 00112233/1123456879  
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     | CP111111              | DOE         | XX12345X         | 07206-000033467-0-0 | 05/11/10        | 90828      | 1.000 | 69.30   | 0.00 | **PEND | 00162  |
| 02     | CP222222              | SAMPLE      | XX23456X         | 07206-000033468-0-0 | 05/12/10        | 90814      | 1.000 | 71.04   | 0.00 | **PEND | 00162  |
| 01     | CP333333              | EXAMPLE     | XX34567X         | 07206-000035665-0-0 | 05/14/10        | 91105      | 1.000 | 14.30   | 0.00 | **PEND | 00142  |
| 01     | CP444444              | SPECIMEN    | XX45678X         | 07206-000033660-0-0 | 05/15/10        | 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 - PRACTITIONER |  |        |                  |   |
| VOIDS - ADJUSTS                  |  | 3.60-  | NUMBER OF CLAIMS | 1 |
| TOTAL PENDING                    |  | 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 PENDING       |  | 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 |

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Exhibit 3.5-4



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

TO: JAMES STRONG, M.D.  
100 BROADWAY  
ANYTOWN, NEW YORK 11111

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

ETIN:  
PRACTITIONER  
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 |

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### 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: **PRACTITIONER**

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**.

PHYSICIAN

## 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 recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

Exhibit 3.6.1-1

TO: JAMES STRONG, M.D.  
100 BROADWAY  
ANYTOWN, NEW YORK 11111



**MEDICAID**  
MANAGEMENT  
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT

PAGE 07  
DATE 05/31/10  
CYCLE 1710

ETIN:  
FINANCIAL TRANSACTIONS  
PROVID: 00112233/1123456789  
REMITTANCE NO: 07080800006

| FCN             | FINANCIAL<br>REASON CODE | FISCAL<br>TRANS TYPE          | DATE     | AMOUNT    |
|-----------------|--------------------------|-------------------------------|----------|-----------|
| 201005060236547 | 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

This is a unique identifier assigned to each financial transaction.

#### Financial Reason Code

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

#### Financial Transaction Type

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

#### Date

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

#### Amount

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

### 3.6.1.2 Explanation of Totals Section

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


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



### 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 recoupments were applied. If there are no outstanding negative balances, this section is not produced.

Exhibit 3.6.2-1

|   |  |   |              |
|---|--|---|--------------|
| <p>TO: JAMES STRONG, M.D.<br/>100 BROADWAY<br/>ANYTOWN, NEW YORK 11111</p>    |  <p><b>MEDICAID</b><br/>MANAGEMENT<br/>INFORMATION SYSTEM</p> | <p>PAGE 08<br/>DATE 05/31/10<br/>CYCLE 1710</p> <p>ETIN:<br/>ACCOUNTS RECEIVABLE<br/>PROVID: 00112233/1123456789<br/>REMITTANCE NO: 07080600006</p> |              |
| <p><b>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM<br/>REMITTANCE STATEMENT</b></p> |  |   |              |
| 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 recoupments, if any, were applied). This balance may be equal to or less than the original balance.

#### Recoupment % Amount

The deduction (recoupment) scheduled for each cycle.


#### Total Amount Due the State

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

### 3.7 Section Five – Edit (Error) Description

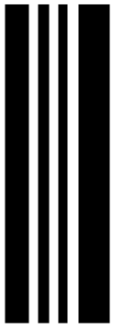
The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

Exhibit 3.7-1

|   |  |   |  |
|---|--|---|--|
| <p>TO: JAMES STRONG, M.D.<br/>100 BROADWAY<br/>ANYTOWN, NEW YORK 11111</p>                                    |  <p><b>MEDICAID</b><br/>MANAGEMENT<br/>INFORMATION SYSTEM<br/>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM<br/>REMITTANCE STATEMENT</p> | <p>PAGE 06<br/>DATE 05/31/10<br/>CYCLE 1710</p> | <p>ETIN:<br/>PRACTITIONER<br/>EDIT DESCRIPTIONS<br/>PROVID: 00112233/1123456789<br/>REMITTANCE NO: 07080600006</p> |
| <p>THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:</p> |  |   |  |
| <p>00131<br/>00142<br/>00162<br/>00244</p>  | <p>PROVIDER NOT APPROVED FOR SERVICE<br/>SERVICE CODE NOT EQUAL TO PA<br/>RECIPIENT INELIGIBLE ON DATE OF SERVICE<br/>PA NOT ON OR REMOVED FROM FILE</p>   |   |  |

# 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<br>TITLE XIX PROGRAM   |  |                                     |   | ONLY TO BE USED TO ADJUST/VOID PAID CLAIM  |  | A CODE V<br>A V   |  | ORIGINAL CLAIM REFERENCE NUMBER   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
|---|--|-------------------------------------|---|--|--|---|--|---|--|--|--|---|--|--|---------------------|--|--|--------------|--|------|--|------|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION  |  |                                     |   |  |  |   |  |   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| <br>DO NOT STAMP IN BARCODE AREA   |  |                                     |   | 1. PATIENT'S NAME (First, middle, last)<br><b>JANE SMITH</b>   |  |   |  | 2. DATE OF BIRTH<br><b>05/20/1990</b>   |  | 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<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>   |  | 5A. PATIENT'S SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/> |  | 6. MEDICARE NUMBER<br><b>A B 1 2 3 4 5 C</b>  |  |  | 6A. MEDICAID NUMBER |  |  |              |  |      |  |      |  |
|   |  |                                     |   | 6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL   |  |   |  | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> |  |  |  | 8. PRIVATE INSURANCE NUMBER   |  | GROUP NO.  |                     | REC/PRO/DY/NO                          |  |              |  |      |  |      |  |
| 9. OTHER HEALTH INSURANCE COVERAGE - Share name of Policyowner, Plan Name and Address and Policy or Private Insurance Number  |  |                                     |   | 10. WAS CONDITION RELATED TO<br>PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input checked="" type="checkbox"/><br>AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input checked="" type="checkbox"/> |  |   |  | 11. INSURED'S EMPLOYER OR OCCUPATION  |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 12. PATIENT'S OR AUTHORIZED SIGNATURE   |  |                                     |   | DATE<br>MM DD YY   |  | 13. INSURED'S SIGNATURE   |  |   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)  |  |                                     |   |  |  |   |  |   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 14. DATE OF ONSET OF CONDITION<br>MM DD YY  |  |                                     | 15. FIRST CONSULTED FOR CONDITION<br>MM DD YY |  |  | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 17A. EVER DISCIPLY RELATED<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 17. DATE PATIENT MAY RETURN TO WORK<br>MM DD YY  |  |   | 18. DATES OF DISABILITY<br>TOTAL PARTIAL FROM<br>MM DD YY MM DD YY |  |                     | 19. MM DD YY                           |  |              |  |      |  |      |  |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   |  |                                     |   | 19A. ADDRESS (OR SIGNATURE IF ONLY)  |  |   |  | 19B. PROF. CD.  |  | 19C. IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b>   |  |   |  | 19D. DX CODE   |                     |  |  |              |  |      |  |      |  |
| 20. NATIONAL DRUG CODE  |  |                                     |   | 20A. UNIT  |  | 20B. QUANTITY   |  | 20C. COST   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 21. NAME OF FACILITY (WHERE SERVICES RENDERED) (If other than home or office)   |  |                                     |   | 21A. ADDRESS OF FACILITY   |  |   |  | 22. WAS LABORATORY/WORK PERFORMED OUTSIDE YOUR OFFICE<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 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 ILLNESS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO ILLNESS 1, 2, 3, ETC. OR DX CODE   |  |                                     |   |  |  |   |  |   |  | 23F. POSSIBLE DISABILITY<br>Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/>  |  | 23G. EPBDT/DIHP<br>Y <input type="checkbox"/> N <input type="checkbox"/>              |  | 23H. FAMILY PLANNING<br>Y <input type="checkbox"/> X <input checked="" type="checkbox"/> |                     | 23E. PAYMENT SOURCE CODE<br><b>1 1</b> |  |              |  |      |  |      |  |
| 24A. DATE OF SERVICE<br>MM DD YY  |  | 24B. PLACE                          |   | 24C. PROCEDURE CD.   |  | 24D. MOD  |  | 24E. MOD  |  | 24F. MOD   |  | 24G. MOD  |  | 24H. DIAGNOSIS CODE  |                     | 24I. DAYS OR UNITS                     |  | 24J. CHARGES |  | 24K. |  | 24L. |  |
| 0 1 2 9 0 9   |  | 1 1                                 |   | 9 9 2 0 5  |  |   |  |   |  |  |  |   |  | 7 8 6 2  |                     |  |  | 3 0 0 0      |  |      |  |      |  |
| 0 1 2 9 0 9   |  | 1 1                                 |   | 9 3 0 0 0  |  |   |  |   |  |  |  |   |  | 7 8 6 2  |                     |  |  | 1 5 0 0      |  |      |  |      |  |
| 0 2 0 8 0 9   |  | 1 1                                 |   | 9 9 2 1 3  |  |   |  |   |  |  |  |   |  | 7 8 6 2  |                     |  |  | 3 0 0 0      |  |      |  |      |  |
| 24M. HOSPITAL AGENCY  |  | FROM<br>MM DD YY                    |   | THROUGH<br>MM DD YY  |  | 24N. PROC CD.   |  | 24O. MOD  |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 25. CERTIFICATION<br>(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)<br><b>James Strong</b><br>SIGNATURE OF PHYSICIAN OR SUPPLIER |  |                                     |   | 26. ACCEPT ASSIGNMENT<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 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<br><b>James Strong, MD<br/>312 Main Street<br/>Anytown, New York 11111</b>   |  |   |  | TELEPHONE NUMBER ( ) EXT. (000) 000-0000<br>DO NOT WRITE IN THIS SPACE  |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 32A. PROVIDER IDENTIFICATION NUMBER<br><b>1 1 2 3 4 5 6 7 8 9</b>   |  |                                     |   | 32B. MEDICAID/GROUP IDENTIFICATION NUMBER  |  |   |  | 32C. LOCATOR CODE<br><b>0 0 3</b>   |  | 32D. SA ENCP CODE  |  | 32A. MY FEE HAS BEEN PAID<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                     |  |  |              |  |      |  |      |  |
| COUNTY OF SUBMITTAL   |  | 32E. DATE SIGNED<br><b>02 10 09</b> |   | 32. PATIENT'S ACCOUNT NUMBER<br><b>A B C 1 2 3 4 5</b>   |  |   |  |   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |
| 33. OTHER REFERRING ORDERING PROVIDER<br>LICENSE NUMBER   |  |                                     |   | 34. PROF. CD.  |  | 35. CASE MANAGER ID   |  |   |  |  |  |   |  |  |                     |  |  |              |  |      |  |      |  |

PHYSICIAN

# APPENDIX B

## CODE SETS

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

**Place of Service**

| <b>Code</b> | <b>Description</b>                                 |
|-------------|--|
| 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                            |

**SA (Service Authorization) Exception Code**

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

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

**Specialty Codes Exempted from Utilization Thresholds**

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



**Sterilization/Abortion Codes**

| <b>Code</b> | <b>Description</b>  |
|-------------|---|
| 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**

| <b>State</b>         | <b>Abbrev.</b> | <b>State</b>   | <b>Abbrev.</b> |
|----------------------|----------------|----------------|----------------|
| 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**

|                   | <b><u>Abbrev.</u></b> |
|-------------------|-----------------------|
| 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.

PHYSICIAN

LDSS-3134 (2/01)

**STERILIZATION  
CONSENT FORM**

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

**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 . When I asked for the (doctor or clinic) 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 11 . him/her the consent form in                      language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

12 . Interpreter Date

■ **STATEMENT OF PERSON OBTAINING CONSENT** ■

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

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

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

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

15 . Signature of person obtaining consent Date  
16 .  
17 . Facility  
Address

■ **PHYSICIAN'S STATEMENT** ■

Shortly before I performed a sterilization operation upon 18 . on 19 . Name of individual to be sterilized Date of sterilization  
20 . I explained to him/her the nature of the sterilization operation 21 . the Specify type of operation

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 at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the 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 performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable 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 . and saw the patient sign the consent form in his/her handwriting.  
(patient's name)

|                      |             |             |
|----------------------|-------------|-------------|
| SIGNATURE OF WITNESS | TITLE       | DATE        |
| X <u>30 .</u>        | <u>31 .</u> | <u>32 .</u> |

**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 <u>33 .</u>        | <u>34 .</u> | X <u>35 .</u>        | <u>36 .</u> |

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

PHYSICIAN

# 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.

PHYSICIAN

**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

## 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.

PHYSICIAN

**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.

PHYSICIAN



**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.



# 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.

PHYSICIAN

**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.

PHYSICIAN

**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](http://www.emedny.org).**