NEW YORK STATE
MEDICAID PROGRAM

TRANSPORTATION

BILLING GUIDELINES

TABLE OF CONTENTS

Section I - Purpose Statement

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

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

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

Section II – Claims Submission

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

Electronic Claims

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

Transportation providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements:

- HIPAA 837P Implementation Guide (IG) – A document that explains the proper use of the 837P standards and program specifications. This document is available at www.wpc-edi.com/hipaa.
- NYS Medicaid 837P Companion Guide (CG) – A subset of the IG that provides instructions for the specific requirements of NYS Medicaid for the 837P. This document is available at www.emedny.org.
  - ✓ Select **NYHIPAADESK** from the menu
  - ✓ Click on **eMedNY Phase II HIPAA Transactions**
  - ✓ Look for the box labeled "837 Professional Health Care Claim Transaction" and click on **837 Professional Companion Guide or 837 Professional NON-EMERGENCY TRANSPORTATION Companion Guide**

- NYS Medicaid Technical Supplementary Companion Guide – This document provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications. The Technical Supplementary CG is available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Phase II HIPAA Transactions**

  ✓ Look for the box labeled "Technical Guides" and click on the link **TECHNICAL SUPPLEMENTARY Companion Guide**

Pre-requirements for the Submission of Electronic Claims

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

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

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

ETIN applications are available at www.emedny.org.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **Electronic Transmitter Identification Number**

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

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

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

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

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

✓ Select **NYHIPAADESK** from the Menu

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

✓ Click on **Trading Partner Agreement**

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

Under **Information**:

✓ Click on **eMedNY Phase II**

✓ Click on **eMedNY Provider Testing User Guide**

Communication Methods

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

- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

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

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

✓ Click on **eMedNY Phase II** under "Information"

✓ Click on **eMedNY Provider Testing User Guide**

✓ On the Table of Contents, click on **Overview**

✓ Scroll down to **Access Methods**

FTP
FTP allows for direct or dial-up connection.

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

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

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

ePACES

Additionally, NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837P. ePACES, which is provided free of charge, is ideal for providers with small to medium claim volume.

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

The requirements for using ePACES include:

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

The following transactions can be submitted via ePACES:

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

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

Paper Claims

Transportation providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A). A link to this form appears at the end of this subsection.

General Instructions for Completing Paper Claims

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

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

1 2 3 4 5 6 7 8 9 0

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

Written As	Intended As	Interpreted As
6.00	6.00	6.66 → Zero interpreted as six

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

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

- Characters should not touch each other. For example:

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

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

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

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

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

Claim Form A-eMedNY-000201

To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

LINK WILL BE INSERTED WHEN POSTED ON THE WEB.

General Information About the eMedNY-000201

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

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

		0	2	3	4	5	6	7	8

Billing Instructions for Transportation Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Transportation providers. Although the instructions that follow are based on the eMedNY-000201 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

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

Field by Field Instructions for Claim Form A-eMedNY-000201

Header Section: Fields 1 through 24B

The information entered in the Header Section of the claim form (fields 1 through 24B) must apply to all of the claim lines entered in the Encounter Section of the form.

PROVIDER ID NUMBER (Field 1)

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

The provider's ID number and the provider's name and correspondence address are pre-printed in this field for all providers.

BILLING DATE (Field 2)

Leave this field blank.

GROUP ID NUMBER (Field 3)

Leave this field blank.

LOCATOR CODE (Field 4)

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

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

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

Note: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section on this web page.

SA EXCP CODE (SERVICE AUTHORIZATION EXCEPTION CODE) (Field 5)

Leave this field blank.

Fields 6 and 6A 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 (Field 6)

- 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 (Field 6A)

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

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

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

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

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

- The **Provider ID number**, the **Group ID number**, and the **Patient's Medicaid ID number** must not be adjusted.

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

- The adjustment must contain all claim lines originally submitted in the same document/record (all claim lines with the same TCN) and all applicable fields must be completed with the necessary changes.

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

Example:

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

Figure 1A: Original Claim Form

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
0 1 2 3 4 5 6 7					0 0 3		A V	

ABC Transportation
100 Broadway
Anytown, New York 11111

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
A B 1 2 3 4 5 C	0 5 2 0 1 9 9 0		X	Jane		
				9A. RECIPIENT NAME – LAST: Smith	A B 1 2 3 4 5	

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y N	POSSIBLE DISABILITY? 13A. Y N	FAMILY PLANNING 13B. Y N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER
.	.									

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1					0 1 2 3 4 5 6 7		Mark Lane, M.D.

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY	24A. SIGNATURE	24B. DIAGNOSIS
			▶		.

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 5	0 5	N Y 2 1 1	1 3								1 4.3 0					
	0 4	0 7	0 5	N Y 2 1 1	1 3								1 4.3 0					
	0 4	0 9	0 5	N Y 2 1 1	1 3								1 4.3 0					
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													.					
													.					
													.					
													.					
													.					
	33. CASE MGR			TOTALS									34. .	35. .	35A. .	35B. .	35C. .	36. .

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	10	05

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Figure 1B: Adjustment

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7

2. BILLING DATE: MO | DAY | YR

3. GROUP ID NUMBER:

4. LOCATOR CODE: 0 0 3

5. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM

6. CODE: 7 (A / V)

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

ABC Transportation
100 Broadway
Anytown, New York 11111

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C

8. DATE OF BIRTH: 0 5 2 0 1 9 9 0

8A. SEX: M / F X

9. RECIPIENT NAME – FIRST: Jane

9A. RECIPIENT NAME – LAST: Smith

10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5

11. OFFICE USE ONLY:

12. DIAGNOSIS CODE – PRIMARY:

12A. SECONDARY:

13. EMERGENCY? Y / N

13A. POSSIBLE DISABILITY? Y / N

13B. FAMILY PLANNING Y / N

14. ACCIDENT CODE:

15. PATIENT STATUS CODE:

16. EPSDT/C/THP Y / N

17. RECIPIENT OTHER INSURANCE CODE:

18. ABORT STER CODE:

19. PRIOR APPROVAL NUMBER:

20. PLACE OF SERVICE – CODE: 1 1

20A. ADDRESS:

21. SERVICE PROVIDER ID/LICENSE NUMBER:

21A. PROF CD:

21B. NAME:

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:

22A. PROF CD:

22B. NAME:

23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER: 0 1 2 3 4 5 6 7

23A. PROF CD:

23B. NAME: Mark Lane, M.D.

24.SHARED HEALTH FACILITY ONLY ▶

24A. SIGNATURE:

24B. DIAGNOSIS:

25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
0 4	0 5	0 5	N Y 2 1 1	1 3								1 4.3 0					
0 4	0 7	0 5	N Y 2 1 1	1 3								1 4.3 0					
0 4	1 0	0 5	N Y 2 1 1	1 3								1 4.3 0					
33. CASE MGR			TOTALS									34.	35.	35A.	35B.	35C.	36.

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[redacted]

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37. SIGNATURE: James Strong

37A. COUNTY*:

38. DATE: MO 06 | DAY 05 | YR 05

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

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

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

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

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

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

Example:

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

Figure 2A: Original Claim

1. PROVIDER ID NUMBER: 0 1 2 3 4 5 6 7

2. BILLING DATE: MO | DAY | YR

3. GROUP ID NUMBER:

4. LOCATOR CODE: 0 0 3

5. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM

6. CODE: A V

6A. ORIGINAL CLAIM REFERENCE NUMBER:

ABC Transportation
100 Broadway
Anytown, New York 11111

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C

8. DATE OF BIRTH: 0 5 2 0 1 9 9 0

8A. SEX: M | F: X

9. RECIPIENT NAME – FIRST: Jane

9A. RECIPIENT NAME – LAST: Smith

10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5

11. OFFICE USE ONLY:

DIAGNOSIS CODE
12. PRIMARY:
12A. SECONDARY:

EMER-GENCY? 13. Y N

POSSIBLE DISABILITY? 13A. Y N

FAMILY PLANNING 13B. Y N

14. ACCIDENT CODE:

15. PATIENT STATUS CODE:

EPSDT/ C/THP 16. Y N

17. RECIPIENT OTHER INSURANCE CODE:

18. ABORT STER CODE:

19. PRIOR APPROVAL NUMBER:

PLACE OF SERVICE
20. CODE: 1 1
20A. ADDRESS:

21. SERVICE PROVIDER ID/LICENSE NUMBER:

21A. PROF CD:

21B. NAME:

23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER: 0 1 2 3 4 5 6 7

23A. PROF CD:

23B. NAME: Mark Lane, M.D.

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:

22A. PROF CD:

22B. NAME:

24.SHARED HEALTH FACILITY ONLY ▶

24A. SIGNATURE:

24B. DIAGNOSIS:

25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
0 4	0 5	0 5	N Y 2 1 1	1 3								1 4.3 0					
0 4	0 7	0 5	N Y 2 1 1	1 3								1 4.3 0					
0 4	0 9	0 5	N Y 2 1 1	1 3								1 4.3 0					

33. CASE MGR:

TOTALS

34.:

35.:

35A.:

35B.:

35C.:

36.:

DO NOT STAPLE IN BARCODE AREA

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37. SIGNATURE: James Strong

37A. COUNTY*:

38. DATE: MO 04 | DAY 10 | YR 05

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Figure 2B: Adjustment

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
01234567					003		7 V	05096123456789 01

ABC Transportation
100 Broadway
Anytown, New York 11111

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
AB123456C	05201990		X	Jane		
				9A. RECIPIENT NAME – LAST: Smith	AB123456	

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y	N	POSSIBLE DISABILITY? 13A. Y	N	FAMILY PLANNING 13B. Y	N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y	N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER
.	.													

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11					0123456 7		Mark Lane, M.D.

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY	24A. SIGNATURE	24B. DIAGNOSIS
			▶		.

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	07	05	NY211	13								14.30	.	.	.	.	.
	04	09	05	NY211	13								14.30	.	.	.	.	.
													.	.	.	.	.	.
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33. CASE MGR	TOTALS	34. .	35. .	35A. .	35B. .	35C. .	36. .

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37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	05

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Void

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

When submitting a void, please follow the instructions below:

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

- The void must contain all the claim lines to be cancelled and all applicable fields must be completed.

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

Example:

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

Figure 3A: Original Claim Form

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
01234567					003		A V	

ABC Transportation
100 Broadway
Anytown, New York 11111

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
AB12345C	05201990		X	Jane		
				9A. RECIPIENT NAME – LAST: Smith	AB12345	

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y N	POSSIBLE DISABILITY? 13A. Y N	FAMILY PLANNING 13B. Y N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11					0123456 7		Mark Lane, M.D.

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY	24A. SIGNATURE	24B. DIAGNOSIS
			▶		

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	05	NY211	13								14.30					
	04	05	05	NY211	13								14.30					

33. CASE MGR	TOTALS	34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	05	05

***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Figure 3B: Void

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
0 1 2 3 4 5 6 7					0 0 3		A 8	0 5 0 9 6 9 8 7 6 5 4 3 2 1 2 3

7. RECIPIENT ID NUMBER	8. DATE OF BIRTH	8A. SEX M	F	9. RECIPIENT NAME – FIRST	10. OFFICE ACCOUNT NUMBER (OPTIONAL)	11. OFFICE USE ONLY
				Jane		
A B 1 2 3 4 5 C	0 5 2 0 1 9 9 0		X	9A. RECIPIENT NAME – LAST: Smith	A B 1 2 3 4 5	

ABC Transportation
100 Broadway
Anytown, New York 11111

DIAGNOSIS CODE 12. PRIMARY	12A. SECONDARY	EMER-GENCY? 13. Y N	POSSIBLE DISABILITY? 13A. Y N	FAMILY PLANNING 13B. Y N	ACCIDENT CODE 14.	PATIENT STATUS CODE 15.	EPSDT/ C/THP 16. Y N	RECIPIENT OTHER INSURANCE CODE 17.	ABORT STER CODE 18.	19. PRIOR APPROVAL NUMBER
.	.									

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1					0 1 2 3 4 5 6 7		Mark Lane, M.D.

22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY	24A. SIGNATURE	24B. DIAGNOSIS
			▶		.

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 5	N Y 2 1 1	1 3								1 4.3 0	.	.	.	.	.
	0 4	0 5	0 5	N Y 2 1 1	1 3								1 4.3 0	.	.	.	.	.
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33. CASE MGR	TOTALS	34.	35.	35A.	35B.	35C.	36.
		.	.	.	.	.	.

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	05

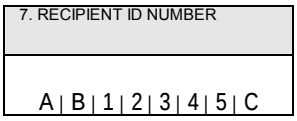
***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Fields 7-9A require Client's (Recipient's) information that may be obtained from the ordering provider, local district, or prior approval roster.

RECIPIENT ID NUMBER (Field 7)

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

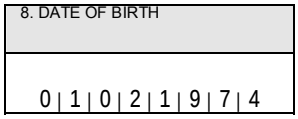
Example:



DATE OF BIRTH (Field 8)

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

Example: Mary Brandon was born on January 2, 1974.



SEX (Field 8A)

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

RECIPIENT NAME (Fields 9 and 9A)

Enter the patient's first name in Field 9 and the last name in Field 9A as they appear on the Common Benefit Identification Card.

OFFICE ACCOUNT NUMBER (OPTIONAL) (Field 10)

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

DIAGNOSIS CODE [Primary/Secondary] (Fields 12 and 12A)

Leave this field blank.

EMERGENCY (Field 13)

Ambulance
Enter an X in the Yes box only when the service 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.

Ambulette, Taxis, Day Program, and Livery
Leave this field blank.

POSSIBLE DISABILITY (Field 13A)

Leave this field blank.

FAMILY PLANNING (Field 13B)

Leave this field blank.

ACCIDENT CODE (Field 14)

If applicable, enter the appropriate code from Appendix A-Code Sets to indicate whether the service rendered to the recipient was for a condition resulting from an accident or a crime.

PATIENT STATUS CODE (Field 15)

Leave this field blank.

EPSDT C/THP CODE (Field 16)

Leave this field blank.

RECIPIENT OTHER INSURANCE CODE (Field 17)

Leave this field blank.

ABORTION/STERILIZATION CODE (Field 18)

Leave this field blank.

PRIOR APPROVAL NUMBER (Field 19)

Enter in this field the 11-digit prior authorization number obtained by the ordering provider and assigned for this service by the appropriate agency of the New York State Department of Health. The prior authorization number appears on the Transportation roster. 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.

Note: For further information about prior authorization, please refer to the Prior Approval Guidelines for this manual.

PLACE OF SERVICE CODE (Field 20)

Leave this field blank.

PLACE OF SERVICE ADDRESS (Field 20A)

Leave this field blank.

SERVICE PROVIDER [Medicaid] ID/LICENSE NUMBER (Field 21)

Ambulette Services Only
Enter the license plate number of the vehicle used for transport in this field.

Example:

22. SERVICE PROVIDER ID/LICENSE NUMBER
| | | N | Y | S | 1 | 2 | 3 | 4

PROF CD (PROFESSION CODE) [Service Provider] (Field 21A)

Leave this field blank.

NAME [Service Provider] (Field 21B)

Leave this field blank.

OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 22)

Ambulette Services Only

Enter the nine-character driver's license number of the transport driver in this field.

Example: The driver's license number is 123456789.

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9

Note: When reporting an out of state driver's license number with more than nine (9) characters, only the first nine (9) characters should be reported (Refer to Example 1 below). If a driver's license number contains fewer than nine (9) characters, the entry must be right justified and zero-filled to complete the nine (9) characters (Refer to Example 2 below).

Example 1: The driver's license number is A123456789B.

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
| A | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8

Example 2: The driver's license number is 3456789.

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
| 0 | 0 | 3 | 4 | 5 | 6 | 7 | 8 | 9

PROF CD (PROFESSION CODE) [Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

NAME [Other Referring/Ordering Provider] (Field 22B)

Leave this field blank.

ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER (Field 23)

Ambulance, Ambulette, and Livery

Non-emergency transportation services must be ordered by a medical practitioner or facility. Enter the ordering provider's Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her license number. This information is provided by the ordering provider and appears on the Transportation Prior Authorization roster.

Instructions for Entering a License Number
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to Appendix A-Code Sets for the Post Office state abbreviations.

When providing non-emergency transportation services to a patient who is restricted to a primary physician or clinic, the **Medicaid ID** number of the patient's primary physician or clinic must be entered in this field. **The license number of the primary physician is not acceptable in this case.**

Note: For emergency Ambulance services, leave this field blank.

Taxi and Day Program
Leave this field blank except when providing services to a patient who is restricted to a primary physician or clinic. In such case, the **Medicaid ID** number of the patient's primary physician or clinic must be entered in this field. **The license number of the primary physician is not acceptable in this case.**

PROF CD (PROFESSION CODE) [Ordering/Referring Provider] (Field 23A)

Ambulance, Ambulette, and Livery
If a license number is indicated in Field 23, the Profession Code that identifies the ordering provider profession must be entered in this field. Profession Codes are listed at www.emedny.org.

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Phase II News**
- ✓ Look for the box labeled "Using License Number in Phase II" and click on **Provider License Type to Profession Code Mapping**

NAME [Ordering/Referring Provider] (Field 23B)

If fields 23 and 23A were completed, enter the ordering provider's name in this field.

SHARED HEALTH FACILITY ONLY (Field 24A)

Leave this field blank.

Encounter Section: (Fields 25-32)

The claim form can accommodate up to nine encounters with a single patient if all the information in the Header Section of the claim (Fields 1–24B) applies to all the encounters.

DATE OF SERVICE (Field 25)

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

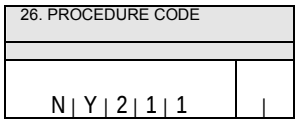
Example: July 1, 2004 = 07/01/04

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

PROCEDURE CODE (Field 26)

This code identifies the type of service that was rendered to the patient. Enter the appropriate five-character Procedure Code in this field. Leave the two spaces to the right of the solid line blank as in the sample below.

Example:



Note: Procedure codes, definitions, prior authorization requirements (if applicable), fees, etc. can be found on this web page under Procedure Codes and Fee Schedule for this manual.

TIMES PERFORMED (Field 27)

If a trip was performed more than one time on the same date of service, enter the number of round trips in this field.

If applicable, enter the number of miles associated with a given transportation service.

Note: Do not bill for an amount of mileage different from the amount that has been authorized. Trips over 99 miles cannot be billed on one line; obtain the mileage code for trips greater than 99 miles from the patient's Local Social Service District.

ORAL CAVITY (Field 28)

Leave this field blank.

TOOTH CODE (Field 29)

Leave this field blank.

SURFACE (Field 29A)

Leave this field blank.

AMOUNT CHARGED (Field 30)

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge. When billing for a round trip, multiply the fee for a one-way trip by two and enter the amount in this field.

Fields 31, 31A, 31B, and 31C are only applicable if the recipient is also a Medicare beneficiary.

Ambulance
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.

If the provider knows that the service rendered **is not covered** by Medicare, contact the local district for approval to enter zero in field 31C and to receive prior authorization for Medicaid reimbursement for the service.

If the service **is covered** by Medicare but Medicare denies **approval** (for example, the service was not medically necessary), Medicaid will also deny payment.

Note: All non-emergency transportation services involving Medicare coverage do not require prior authorization unless the actual service is not covered by Medicare. The provider must first bill Medicare.

Only when the actual service is not covered by Medicare will Medicaid consider prior authorization.

Ambulette, Taxi, Day Program, and Livery
Enter 0.00 in these fields.

MEDICARE CO-INSURANCE (Field 31)

If applicable, enter the Medicare co-insurance amount for the specific procedure.

MEDICARE DEDUCTIBLE (Field 31A)

If applicable, enter the Medicare deductible amount for the specific procedure.

MEDICARE CO-PAY (Field 31B)

If applicable, enter the Medicare co-pay amount for the specific procedure.

MEDICARE PAID (Field 31C)

If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denies payment, enter 0.00.

OTHER INSURANCE PAID (Field 32)

This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage.

Note: **It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier 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 submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.**

If applicable, enter the amount actually paid by the other insurance carrier in this field.

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

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ► The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.
  - ► In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for same type of service. This communication should be documented in the patient's billing record.

The provider bills the insurance company and receives a rejection because:

- ► The service is not covered; or
- ► The deductible has not been met.

- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to or uncooperative in submitting claims to the insurance company. In these cases, the LDSS must be notified prior to zero-filling. Since June 1, 1992, the LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases, the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.

- The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent.

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

Certification Section (Fields 37–38)

SIGNATURE (Field 37)

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

COUNTY (Field 37A)

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, as preprinted in the upper left corner of the claim form, is within the county wherein the claim form is signed.

DATE (Field 38)

Enter the date on which the provider or an authorized representative of the transportation provider 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.

Section III – Remittance Advice

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

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

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

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

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

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

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **HIPAA 835 Transaction Request Form**

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

✓ Select **NYHIPAADESK** from the menu

✓ Click on **eMedNY Phase II HIPAA Transaction**

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

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

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

Paper Remittance Advice

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

Remittance Sorts

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

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

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

To request a sort pattern other than the default, providers must complete the Remittance Sort Request Form, which is available at www.emedny.org.

Under **Information:**

✓ Click on **Provider Enrollment Forms**

✓ Click on **Paper Remittance Sort Request**

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

Remittance Advice Format

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

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

Explanation of Remittance Advice Sections

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

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

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

Section One – Medicaid Check

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC TRANSPORTATION

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

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

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

29
2

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

PAY

DOLLARS/CENTS
$*****143.80

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

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

John
Smith

Check Stub Information

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

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

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

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

Remittance number/date
Provider's name/address

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

Section One – EFT Notification

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

TO: ABC TRANSPORTATION

05080100006

DATE: 2005-08-01
REMITTANCE NO:

PROVIDER ID: 00112233

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

ABC TRANSPORTATION $143.80

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

Information on the EFT Notification Page

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

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

CENTER
Remittance number/date
Provider's name/address

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

Section One – Summout (No Payment)

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

TO: ABC TRANSPORTATION

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

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

ABC TRANSPORTATION
100 BROADWAY
ANYTOWN NY 11111

Information on the Summout Page

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

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

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

PAGE 01
DATE 08/01/05
CYCLE 458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00112233
REMITTANCE NO. 05080100006

REMITTANCE ADVICE MESSAGE TEXT

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

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

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

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

CENTER
Message text

Section Three – Claim Detail

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 08/01/2005
CYCLE 458

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP343444	DAVIS	UU44444R	05206-000000227-0-0	07/11/05	NY211	48.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	05206-000011334-0-0	07/11/05	NY211	16.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	05206-000013556-0-0	07/19/05	NY211	13.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	05206-000032456-0-0	07/20/05	NY211	63.000	77.50	0.00	DENY	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 08/01/2005
CYCLE 458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP112346	DAVIS	UU44444R	05206-000033667-0-0	07/11/05	NY211	13.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	05206-000033667-0-0	07/12/05	NY211	13.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	05206-000045667-0-0	07/14/05	NY211	48.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	05206-000056767-0-0	07/15/05	NY211	66.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	05206-000067767-0-0	06/05/05	NY211	17.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/05
01	CP744495	PARKER	VZ45678P	05206-000088767-0-0	06/05/05	NY211	13.000	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 04
DATE 08/01/2005
CYCLE 458

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID: 00112233
REMITTANCE NO: 05080100006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP8765432	CRUZ	LL11111B	05206-000033467-0-0	07/13/05	NY211	60.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	05206-000033468-0-0	07/14/05	NY211	63.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	05206-000035665-0-0	07/14/05	NY211	13.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	05206-000033660-0-0	07/12/05	NY211	13.000	14.30	0.00	**PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

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

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

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

REMITTANCE TOTALS – GRAND TOTALS

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

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

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

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

Explanation of the Claim Detail Columns

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

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

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DATE 08/01/05
CYCLE 458

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

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

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

Explanation of the Financial Transactions Columns

FCN (FINANCIAL CONTROL NUMBER)
This is a unique identifier assigned to each financial transaction.

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

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

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

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

Totals

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

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

Accounts Receivable

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

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DATE 08/01/05
CYCLE 458

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

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

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

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

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

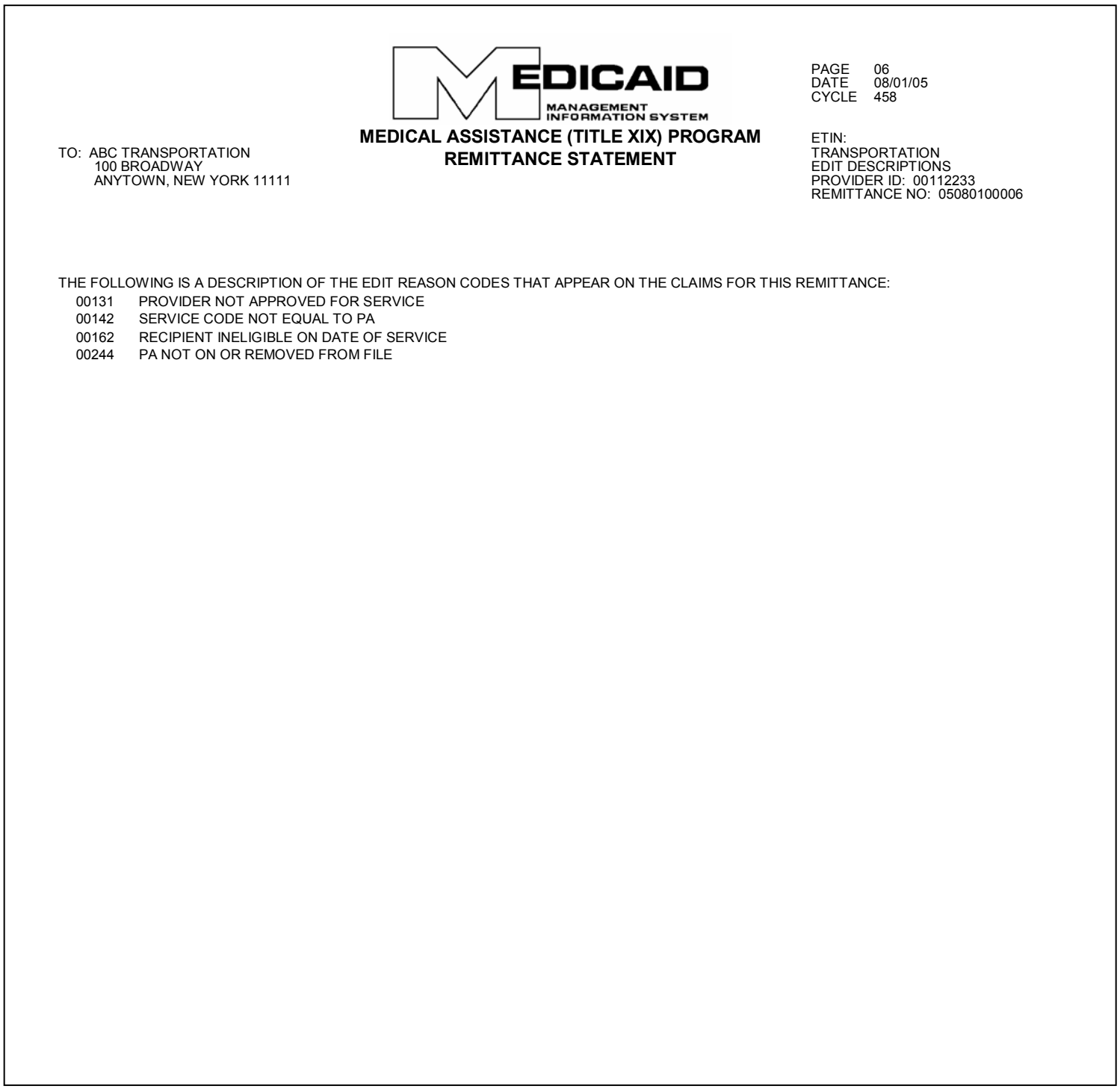
RECOUPMENT % AMOUNT
The deduction (recoupment) scheduled for each cycle.

Total Amount Due the State

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

Section Five – Edit Descriptions

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



MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/01/05
CYCLE 458

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

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

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

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

Appendix A – Code Sets

Accident Codes

Code	Description
0/Blank	Not Applicable
1	Auto Accident
2	Employment
3	Another Party Responsible
4	Other Accident

United States Standard Postal Abbreviations

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

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

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