

**NEW YORK STATE  
MEDICAID PROGRAM**

**DENTAL**

**BILLING GUIDELINES**

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## 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 Dental providers and should be used by the provider as an instructional as well as a reference tool.

## Section II – Claims Submission

Dental providers can submit their claims to NYS Medicaid in electronic or paper formats (except for Dental Clinics, which must only submit electronic claims).

### 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.

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

- **HIPAA 837D Implementation Guide (IG)** explains the proper use of the 837D standards and program specifications. This document is available at [www.wpc-edi.com/hipaa](http://www.wpc-edi.com/hipaa).
- **NYS Medicaid 837D Companion Guide (CG)** is a subset of the IG that provides specific instructions on the NYS Medicaid requirements for the 837D transaction.
- **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.

These documents are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[\*\*eMedNY Companion Guides and Sample Files\*\*](#)

## 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/Paper Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and password
- A Trading Partner Agreement
- Testing

### **ETIN**

This is a submitter identifier issued by the eMedNY Contractor that must be used in every electronic submission 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.

The ETIN application is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below;

### **[Provider Enrollment Forms](#)**

#### **Certification Statement**

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

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

The Certification Statement is available on the third page of the ETIN application at [www.emedny.org](http://www.emedny.org) or can be accessed by clicking on the link above.

### **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. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

### **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](http://www.emedny.org) by clicking on the link to the web page below:

#### **[Provider Enrollment Forms](#)**

### **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](http://www.emedny.org) by clicking on the link to the web page below:

#### **[eMedNY Companion Guides and Sample Files](#)**

### **Communication Methods**

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

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

## ePACES

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

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

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Self Help](#)

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

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

## **FTP**

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**[Provider Enrollment Forms](#)**

## **CPU to CPU**

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

## **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. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B can be found at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

**[Provider Enrollment Forms](#)**

**Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU, or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**



## Paper Claims

Dental providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A). 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.

### [Dental - Sample Claim](#)

## 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										
<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. For example:

Written As	Intended As	Interpreted As		
<table border="1"><tr><td>2</td></tr></table>	2	2	<table border="1"><tr><td>7</td></tr></table> → Two interpreted as seven	7
2				
7				
<table border="1"><tr><td>3</td></tr></table>	3	3	<table border="1"><tr><td>2</td></tr></table> → Three interpreted as two	2
3				
2				

## Dental Billing Guidelines

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- Characters should not touch each other. For example:

**Written As**

23

**Intended As**

23

**Interpreted As**

illegible



Entry cannot be interpreted properly

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign (\$) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections (i.e. information written over 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**

## 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.

[Dental - Sample Claim](#)

### 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 has 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 Dental Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Dental 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, pending, 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.

Enter the provider's ID number and the provider's name and correspondence address in this field.

**Note: Until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.**

#### **BILLING DATE (Field 2)**

Leave this field blank.

#### **GROUP ID NUMBER (Field 3)**

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

For a **Group Practice**, enter the Group ID number 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 a case, the Medicaid Provider ID number of the group member that rendered the service must be entered in Field 1.

For a **Shared Health Facility**, enter in this field the eight-digit identification number that was assigned to the facility by the New York State Department of Health at the time of enrollment in the Medicaid program.

If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, leave this field blank.

### **Dental Schools and Orthodontic Clinics**

Leave this field blank.

**Note: Until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.**

### **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 afterward that a new location is added.

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. 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 the web page for this manual.**

### **SA EXCP CODE [Service Authorization Exception Code] (Field 5)**

#### **For Dental Clinic Claims Only**

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 A - Code Sets.

For more information on the UT Program, please refer to Information for All Providers, General Policy, which can be found on the web page for this manual.

If not applicable, 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)**

**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 (Field 6A)**

**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.

**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 0709819876543200 is shared by three individual claim lines. This TCN was paid on April 18, 2007. 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 NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER  0 1 2 3 4 5 6 7				2. BILLING DATE			3. GROUP ID NUMBER				4. LOCATOR CODE		5. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM									
				MO	DAY	YR					0 0 3						6. CODE		6A. ORIGINAL CLAIM REFERENCE NUMBER					
James Strong, DDS 312 Main Street Anytown, New York 11111				7. RECIPIENT ID NUMBER				8. DATE OF BIRTH				8A. SEX		9. RECIPIENT NAME - FIRST <b>Jane</b>				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				M F X		9A. RECIPIENT NAME - LAST <b>Smith</b>				A B 1 2 3 4 5						
				DIAGNOSIS CODE				EMERGENCY?		POSSIBLE DISABILITY?		FAMILY PLANNING		ACCIDENT CODE		PATIENT STATUS CODE		EPSDT/C/THP		RECIPIENT OTHER INSURANCE CODE		ABORT STER CODE		19. PRIOR APPROVAL NUMBER
12. PRIMARY				12A. SECONDARY				13. Y N		13A. Y N		13B. Y N		14.		15.		16. Y N		17.		18.		
PLACE OF SERVICE				21. SERVICE PROVIDER ID/LICENSE NUMBER				21A. PROF CD		21B. NAME				23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER				23A. PROF CD		23B. NAME				
20. CODE		20A. ADDRESS		22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER				22A. PROF CD		22B. NAME				24. SHARED HEALTH FACILITY ONLY		24A. SIGNATURE				24B. DIAGNOSIS				
1 1																								

25. DATE OF SERVICE			26. PROCEDURE CODE				27. TIMES PERFORMED	28. ORAL CAVITY	29. DENTAL					30. AMOUNT CHARGED		31. CO-INSURANCE				32. OTHER INSURANCE PAID					
MO	DAY	YR							29A. SURFACE							31A. DEDUCTIBLE		31B. CO-PAY		31C. PAID					
								M	I/O	D	F/B	L													
0 4	0 4	0 7	D	3	2	2	0							8	7	0	0								
0 4	0 4	0 7	D	2	9	3	3							1	3	0	0								
0 4	0 4	0 7	D	3	3	5	1							6	7	0	0								
								33. CASE MGR	TOTALS					34.		35.		35A.		35B.		35C.		36.	

DO NOT STAPLE IN BARCODE AREA

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

37. SIGNATURE <b>James Strong</b>		37A. COUNTY*		38. DATE		
				MO	DAY	YR
				04	05	07



## Figure 1B: Adjustment NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

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			6A. ORIGINAL CLAIM REFERENCE NUMBER 0 7 0 9 8 1 9 8 7 6 5 4 3 2 0 0							7A			V												
James Strong, DDS 312 Main Street Anytown, New York 11111				7. RECIPIENT ID NUMBER			8. DATE OF BIRTH 0 5 2 0 1 9 9 0			8A. SEX M F X		9. RECIPIENT NAME - FIRST Jane				10. OFFICE ACCOUNT NUMBER (OPTIONAL)				11. OFFICE USE ONLY									
				9A. RECIPIENT NAME - LAST Smith			12. PRIMARY DIAGNOSIS CODE			12A. SECONDARY		EMERGENCY? 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	
				20. CODE 1 1		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							
				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			26. PROCEDURE CODE			27. TIMES PERFORMED	28. ORAL CAVITY	29. DENTAL					30. AMOUNT CHARGED		31. CO-INSURANCE		31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID		
MO	DAY	YR						29A. SURFACE														
								M	I/O	D	F/B	L										
0 4	0 4	0 7	D	3	2 2 0									8 7 0 0								
0 4	0 4	0 7	D	2	9 3 3									1 3 0 0 0								
0 4	0 1	0 7	D	3	3 5 1									8 7 0 0								
33. CASE MGR							TOTALS						34.		35.		35A.	35B.	35C.	36.		

DO NOT STAPLE IN BARCODE AREA

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

37. SIGNATURE  <b>James Strong</b>			37A. COUNTY*			38. DATE MO DAY YR <b>06 05 07</b>		
--	--	--	--------------	--	--	--	--	--

\*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 0709818765432100 contained three individual claim lines, which were paid on April 18, 2007. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Refer to Figures 2A and 2B for an illustration of this example.

## Figure 2A: Original Claim Form NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

<b>James Strong, DDS</b> <b>312 Main Street</b> <b>Anytown, New York 11111</b>				1. PROVIDER ID NUMBER			2. BILLING DATE			3. GROUP ID NUMBER			4. LOCATOR CODE		5. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM										
				MO   DAY   YR			MO   DAY   YR			0   0   3		A   V		6. CODE   6A. ORIGINAL CLAIM REFERENCE NUMBER													
				7. RECIPIENT ID NUMBER			8. DATE OF BIRTH			8A. SEX		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			M   F		Jane			A   B   1   2   3   4   5												
				DIAGNOSIS CODE			EMERGENCY?		POSSIBLE DISABILITY?		FAMILY PLANNING		ACCIDENT CODE		PATIENT STATUS CODE		EPSDT/ C/THP		RECIPIENT OTHER INSURANCE CODE		ABORT STER CODE		19. PRIOR APPROVAL NUMBER				
				12. PRIMARY			12A. SECONDARY			13. Y   N		13A. Y   N		13B. Y   N		14.		15.		16. Y   N		17.		18.			
				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						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			26. PROCEDURE CODE			27. TIMES PERFORMED	28. ORAL CAVITY	29. DENTAL					30. AMOUNT CHARGED		31. CO-INSURANCE				32. OTHER INSURANCE PAID			
								29A. SURFACE							31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID					
MO	DAY	YR						M	I/O	D	F/B	L										
0	4	0	7	D	3	2	2	0						8	7	0	0					
0	4	0	7	D	2	9	3	3						1	3	0	0					
0	4	0	7	D	3	3	5	1						6	7	0	0					
33. CASE MGR							TOTALS					34.		35.		35A.	35B.	35C.		36.		

DO NOT STAPLE IN BARCODE AREA

**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		
<b>James Strong</b>						MO	DAY	YR
						04	05	07



**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 0709811234567800 contained two claim lines, which were paid on April 18, 2007. 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 NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

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																									
James Strong, DDS 312 Main Street Anytown, New York 11111				7. RECIPIENT ID NUMBER			8. DATE OF BIRTH 0 5 2 0 1 9 9 0			8A. SEX M F X		9. RECIPIENT NAME - FIRST Jane			10. OFFICE ACCOUNT NUMBER (OPTIONAL)			11. OFFICE USE ONLY													
				9A. RECIPIENT NAME - LAST Smith			12. PRIMARY DIAGNOSIS CODE A B 1 2 3 4 5 C					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 A B 1 2 3 4 5	
				20. CODE 1 1		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										
				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	29. DENTAL					30. AMOUNT CHARGED	31. MEDICARE				32. OTHER INSURANCE PAID
				29. TOOTH	29A. SURFACE					31A. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	
					M	I/O	D	F/B	L					
0 4 0 4 0 7	D 3 2 2 0			0 1						8 7 0 0				
0 4 0 4 0 7	D 2 9 3 3			0 2						1 3 0 0 0				
33. CASE MGR				TOTALS					34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

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

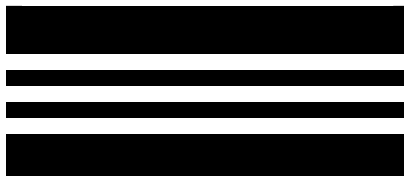
37. SIGNATURE  <b>James Strong</b>		37A. COUNTY*	38. DATE MO DAY YR <b>04 05 07</b>		
--	--	--------------	--	--	--

## Figure 3B: Void NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

<b>James Strong, DDS</b> <b>312 Main Street</b> <b>Anytown, New York 11111</b>		1. PROVIDER ID NUMBER			2. BILLING DATE			3. GROUP ID NUMBER			4. LOCATOR CODE		5. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM																
		MO   DAY   YR			MO   DAY   YR			0   0   3		A   8		0   7   0   9   8   1   1   2   3   4   5   6   7   8   0   0																			
7. RECIPIENT ID NUMBER				8. DATE OF BIRTH				8A. SEX		9. RECIPIENT NAME - FIRST				10. OFFICE ACCOUNT NUMBER (OPTIONAL)				11. OFFICE USE ONLY													
								M   F   X		Jane																					
A   B   1   2   3   4   5   C				0   5   2   0   1   9   9   0						Smith								A   B   1   2   3   4   5													
12. PRIMARY						12A. SECONDARY						EMERGENCY?		POSSIBLE DISABILITY?		FAMILY PLANNING		ACCIDENT CODE		PATIENT STATUS CODE		EPSDT/ C/THP		RECIPIENT OTHER INSURANCE CODE		ABORT STER CODE		19. PRIOR APPROVAL NUMBER			
												Y   N		Y   N		Y   N															
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																															
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			26. PROCEDURE CODE			27. TIMES PERFORMED	28. ORAL CAVITY	29. DENTAL					30. AMOUNT CHARGED			31. CO-INSURANCE				32. OTHER INSURANCE PAID				
								29A. SURFACE								31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID						
MO	DAY	YR						M	I/O	D	F/B	L												
0	4	0	7	D	3	2	2	0																
0	4	0	7	D	2	9	3	3																
33. CASE MGR							TOTALS					34.			35.		35A.		35B.		35C.		36.	

**DO NOT STAPLE IN BARCODE AREA**



**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		
<b>James Strong</b>				MO	DAY	YR
				06	05	07

\*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 information obtained from the Client's (Recipient's) Medicaid Common Benefit Identification Card.**

**RECIPIENT ID NUMBER (Field 7)**

Enter the patient's identification number (Client ID number). Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

**Example:**

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

**DATE OF BIRTH (Field 8)**

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

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

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

**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.

**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)**

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.

**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)**

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 the Information for All Providers, Inquiry section on the web page for this manual.**
- **For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual.**
- **For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.**

**PLACE OF SERVICE CODE (Field 20)**

This **two-digit** code indicates the type of location where the service was rendered. Please note that the Place of Service Code is different from the locator code. Select the appropriate code from Appendix A-Code Sets.

**Dental Schools**

Enter 99 (Other) in this field and complete Field 20A.

**PLACE OF SERVICE ADDRESS (Field 20A)**

**Dental Schools**

Enter the exact address of the location where the service was performed.

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

**Dental Schools**

Enter the Medicaid ID number or the license number of the supervising dentist.

**Orthodontic Clinics**

Enter the Medicaid ID number or the license number of the dentist who rendered the service. If more than one dentist rendered the service, enter the Medicaid ID number or the license number of the principal dentist.

**Dental Practitioners**

Leave this field blank.

**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.

**PROF CD [Profession Code - Service Provider] (Field 21A)**

**Orthodontic Clinics and Dental Schools**

If a license number is indicated in Field 21, the Profession Code that identifies the service provider's profession must be entered in this field. Profession Codes are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[eMedNY Crosswalks](#)

**Dental Practitioners**

Leave this field blank.

**NAME [Service Provider] (Field 21B)**

**Orthodontic Clinics and Dental Schools**

If a license is entered in Field 21 because the service provider is not enrolled in the Medicaid Program, the service provider's name must be entered in this field.

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

Leave this field blank.

**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.

***Fields 23, 23A, and 23B must be completed when the recipient has been referred by another provider.***

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

If the patient was referred for treatment by another provider, enter the referring provider's Medicaid ID number in this field. If the referring dentist is not enrolled in Medicaid, enter his/her license number. If no referral was involved, leave this field blank.

If the patient is restricted to another dental provider, the dentist rendering services must enter the **Medicaid ID** number of the patient's primary dental provider in this field. **The license number of the primary dental provider is not acceptable in this case.**

**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.

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

If a license number is indicated in Field 23, the Profession Code that identifies the referring provider's profession must be entered in this field. Profession Codes are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[eMedNY Crosswalks](#)

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

If the patient was referred by another provider, enter the referring provider's name in this field.

**SHARED HEALTH FACILITY ONLY (Field 24A)**

If services were rendered in a Shared Health Facility and the patient was referred by another provider in the same Shared Health Facility, obtain the referring provider's signature in this field.

**Encounter Section: Fields 25 through 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, 2007 = 07/01/07

**Orthodontists and Orthodontic Clinics**

Enter only the last date of service in the quarter for which you are billing.

**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:**

26. PROCEDURE CODE				
D	3	2	2	0

**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 below under Procedure Codes and Fee Schedule:**

[Dental Manual](#)

**TIMES PERFORMED (Field 27)**

If a procedure was performed more than one time on the same date of service, enter the number of times in this field. If the procedure was performed only one time or the procedure code requires completion of Fields 28 and 29, this field may be left blank.

**ORAL CAVITY (Field 28)**

If applicable, enter the appropriate Oral Cavity Code from Appendix A- Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at [www.emedny.org](http://www.emedny.org) by clicking on the link below under Procedure Codes and Fee Schedule:

[Dental Manual](#)

**TOOTH CODE (Field 29)**

When appropriate, enter the number(s) or letter(s) that identify the tooth on which the procedure was performed. Tooth Codes can be found in Appendix A-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at [www.emedny.org](http://www.emedny.org) by clicking on the link below under Procedure Codes and Fee Schedule:

[Dental Manual](#)

**Notes:**

- A permanent tooth is identified by a two-digit number. For example: 01.
- A primary tooth is identified by a capital letter. For example: F.

**SURFACE (Field 29A)**

If applicable, enter the code that indicates the tooth surface being restored. Please **write the letter code** in the appropriate column; **do not enter an X**. An entry in this field requires a Tooth Code in Field 29. Surface Codes can be found in Appendix A-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

[Dental Manual](#)

**AMOUNT CHARGED (Field 30)**

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge.

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

**Notes:**

- **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, enter zero in field 31C.**

**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.

## Dental Billing Guidelines

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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 of 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 the 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 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 through 38**

**SIGNATURE (Field 37)**

The provider or an authorized representative of a dental school 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, entered in Field 1, 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 dental 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 on the web page for this manual.**

## 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 eMedNY Contractor 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 complete the Electronic Remittance Request Form, which is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

#### [Provider Enrollment Forms](#)

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

#### [eMedNY Companion Guides and Sample Files](#)

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

Providers who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at [www.emedny.org](http://www.emedny.org). If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction 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.

### 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 Paper Remittance Sort Request Form, which is available at [www.emedny.org](http://www.emedny.org) by clicking on the link to the web page below:

### [Provider Enrollment Forms](#)

For additional information, providers may call the eMedNY Call Center 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 Dental 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).



TO: JAMES STRONG, DDS

DATE: 2007-08-06  
 REMITTANCE NO: 07080600006  
 PROVIDER ID/NPI: 00112233/0123456789

07080600006 2007-08-06  
 JAMES STRONG, DDS  
 312 MAIN STREET  
 ANYTOWN NY 11111

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

29  
2

DATE	REMITTANCE NUMBER	PROVIDER ID/NPI
2007-08-06 <small>VOID AFTER 90 DAYS</small>	07080600006	00112233/0123456789

PAY	DOLLARS/CENTS
	\$*****143.80

TO  
THE  
ORDER  
OF

07080600006 2007-08-06  
 JAMES STRONG, DDS  
 312 MAIN STREET  
 ANYTOWN NY 11111



John Smith  
AUTHORIZED SIGNATURE

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

***Check Stub Information***

**UPPER LEFT CORNER**

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

**UPPER RIGHT CORNER**

Date on which the remittance advice was issued

Remittance number

\* Provider ID/NPI

**CENTER**

Remittance number/date

Provider's name/address

***Medicaid Check***

**LEFT SIDE**

**Table**

Date on which the check was issued

Remittance number

\* Provider ID/NPI

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.

**\* Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

**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: JAMES STRONG, DDS



DATE: 2007-08-06  
REMITTANCE NO: 07080600006  
PROVIDER ID/NPI: 00112233/0123456789

07080600006 2007-08-06  
JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN NY 11111

JAMES STRONG, DDS \$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/NPI

**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: JAMES STRONG, DDS



DATE: 08/06/2007  
REMITTANCE NO: 07080600006  
PROVIDER ID/NPI: 00112233/0123456879

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

JAMES STRONG, DDS  
312 MAIN STREET  
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/NPI

**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 08/06/07  
CYCLE 1563

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
PROVIDER NOTIFICATION  
PROVIDER ID/NPI 00112233/0123456789  
REMITTANCE NO 07080600006

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

***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/NPI

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.



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

PAGE 02  
DATE 08/06/2007  
CYCLE 1563

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
DENTAL  
PROVIDER ID/NPI: 00112233/0123456789  
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	CP343444	DAVIS	UU44444R	07206-00000227-0-0	07/11/07	D0120	1.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	07206-000011334-0-0	07/11/07	D0272	1.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	07206-000013556-0-0	07/19/07	D1204	1.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	07206-000032456-0-0	07/20/07	D0290	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

**Dental Billing Guidelines**



PAGE 03  
DATE 08/06/2007  
CYCLE 1563

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

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
DENTAL  
PROVIDER ID/NPI: 00112233/0123456879  
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	CP112346	DAVIS	UU44444R	07206-000033667-0-0	07/11/07	D1203	1.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	07206-000033667-0-0	07/12/07	D1204	1.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	07206-000045667-0-0	07/14/07	D0320	1.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	07206-000056767-0-0	07/15/07	D3220	1.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	07206-000067767-0-0	06/05/07	D0272	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/07
01	CP744495	PARKER	VZ45678P	07206-000088767-0-0	06/05/07	D1204	1.000	14.30	14.00	ADJT	

\* = PREVIOUSLY PENDED CLAIM  
\*\* = NEW PEND

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

## Dental Billing Guidelines



PAGE 04  
DATE 08/06/2007  
CYCLE 1563

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

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
DENTAL  
PROVIDER ID/NPI: 00112233/0123456789  
REMITTANCE NO: 07080600006

LN.	OFFICE ACCOUNT NO	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP8765432	CRUZ	LL11111B	07206-000033467-0-0	07/13/07	D3220	1.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	07206-000033468-0-0	07/14/07	D7450	1.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	07206-000035665-0-0	07/14/07	D1204	1.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	07206-000033660-0-0	07/12/07	D1204	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 – DENTAL				
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

Dental Billing Guidelines



PAGE: 05  
DATE: 08/06/07  
CYCLE: 1563

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

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

ETIN:  
DENTAL  
GRAND TOTALS  
PROVIDER ID/NPI: 00112233/0123456789  
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



***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 the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)

Provider Service Classification: **DENTAL**

\* Provider ID/NPI

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 client'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 Dental 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.

		PAGE 07		
		DATE 08/06/07		
TO: JAMES STRONG, DDS 312 MAIN STREET ANYTOWN, NEW YORK 11111		CYCLE 1563		
<b>MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT</b>				
ETIN: FINANCIAL TRANSACTIONS PROVIDER ID/NPI: 00112233/0123456789 REMITTANCE NO: 07080600006				
FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	\$\$\$
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.



TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

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

PAGE 08  
DATE 08/06/07  
CYCLE 1563

ETIN:  
ACCOUNTS RECEIVABLE  
PROVIDER ID/NPI: 00112233/0123456789  
REMITTANCE NO: 07080600006

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

TOTAL AMOUNT DUE THE STATE \$XXX.XX

***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.



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

TO: JAMES STRONG, DDS  
312 MAIN STREET  
ANYTOWN, NEW YORK 11111

PAGE 06  
DATE 08/06/07  
CYCLE 1563

ETIN:  
DENTAL  
EDIT DESCRIPTIONS  
PROVIDER ID/NPI: 00112233/0123456789  
REMITTANCE NO: 07080600006

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

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

## Appendix A – Code Sets

### Accident Codes

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

### Oral Cavity Designations

<b>Code</b>	<b>Description</b>
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant
L	Left
R	Right

**Place of Service Codes**

<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
25	Birth center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
60	Mass immunization center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

**SA Exception Codes**

<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

**Tooth Codes**

<b>Code</b>	<b>Description</b>
01	Permanent Third Molar – Upper Right
02	Permanent Second Molar – Upper Right
03	Permanent First Molar – Upper Right
04	Permanent Second Premolar – Upper Right
05	Permanent First Premolar – Upper Right
06	Permanent Canine – Upper Right
07	Permanent Lateral Incisor – Upper Right
08	Permanent Central Incisor – Upper Right
09	Permanent Central Incisor – Upper Left
10	Permanent Lateral Incisor – Upper Left
11	Permanent Canine – Upper Left
12	Permanent First Premolar- Upper Left
13	Permanent Second Premolar – Upper Left
14	Permanent First Molar – Upper Left
15	Permanent Second Molar – Upper Left
16	Permanent Third Molar – Upper Left
17	Permanent Third Molar – Lower Left
18	Permanent Second Molar – Lower Left
19	Permanent First Molar – Lower Left
20	Permanent Second Premolar – Lower Left
21	Permanent First Premolar – Lower Left
22	Permanent Canine – Lower Left
23	Permanent Lateral Incisor – Lower Left
24	Permanent Central Incisor – Lower Left
25	Permanent Central Incisor – Lower Right
26	Permanent Lateral Incisor – Lower Right
27	Permanent Canine- Lower Right
28	Permanent First Premolar – Lower Right
29	Permanent Second Premolar – Lower Right
30	Permanent First Molar – Lower Right
31	Permanent Second Molar – Lower Right
32	Permanent Third Molar – Lower Right
51	Supernumerary 01
52	Supernumerary 02
53	Supernumerary 03
54	Supernumerary 04
55	Supernumerary 05
56	Supernumerary 06
57	Supernumerary 07
58	Supernumerary 08
59	Supernumerary 09

**Tooth Codes (cont.)**

<b>Code</b>	<b>Description</b>
60	Supernumerary 10
61	Supernumerary 11
62	Supernumerary 12
63	Supernumerary 13
64	Supernumerary 14
65	Supernumerary 15
66	Supernumerary 16
67	Supernumerary 17
68	Supernumerary 18
69	Supernumerary 19
70	Supernumerary 20
71	Supernumerary 21
72	Supernumerary 22
73	Supernumerary 23
74	Supernumerary 24
75	Supernumerary 25
76	Supernumerary 26
77	Supernumerary 27
78	Supernumerary 28
79	Supernumerary 29
80	Supernumerary 30
81	Supernumerary 31
82	Supernumerary 32
A	Primary Second Molar – Upper Right
AS	Supernumerary A
B	Primary First Molar – Upper Right
BS	Supernumerary B
C	Primary Canine – Upper Right
CS	Supernumerary C
D	Primary Lateral Incisor – Upper Right
DS	Supernumerary D
E	Primary Central Incisor – Upper Right
ES	Supernumerary E
F	Primary Central Incisor – Upper Left
FS	Supernumerary F
G	Primary Lateral Incisor – Upper Left
GS	Supernumerary G
H	Primary Canine – Upper Left
HS	Supernumerary H
I	Primary First Molar – Upper Left
IS	Supernumerary I

**Tooth Codes (cont.)**

<b>Code</b>	<b>Description</b>
J	Primary Second Molar – Upper Left
JS	Supernumerary J
K	Primary Second Molar – Lower Left
KS	Supernumerary K
L	Primary First Molar – Lower Left
LS	Supernumerary L
M	Primary Canine – Lower Left
MS	Supernumerary M
N	Primary Lateral Incisor – Lower Left
NS	Supernumerary N
O	Primary Central Incisor – Lower Left
OS	Supernumerary O
P	Primary Central Incisor – Lower Left
PS	Supernumerary P
Q	Primary Lateral Incisor – Lower Left
QS	Supernumerary Q
R	Primary Canine – Lower Right
RS	Supernumerary R
S	Primary First Molar – Lower Right
SS	Supernumerary S
T	Primary Second Molar – Lower Right
TS	Supernumerary T

**Surface Codes**

<b>Code</b>	<b>Description</b>
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial
O	Occlusal



**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	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

<b>American Territories</b>	<b>Abbrev.</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.**