



## DME/HEARING AID – EMEDNY 150001 CLAIM FORM INSTRUCTIONS

The following guide contains instructions for proper claim form completion when submitting claims for DME/HEARING AID Services using the eMedNY 150001 claim form. The field-by-field description provided indicates which entries are required when submitting claims to the eMedNY system. Refer to the appropriate MMIS Provider Manual if further information is required.

### Field by Field Instructions

**CODE A/V** – This field is only used to adjust or void a previously paid claim. Place an X over the A if submitting an Adjustment or an X over the V if submitting a Void.

**ORIGINAL CLAIM REFERENCE NUMBER** – This field is only used to adjust or void a previously paid claim. Enter the Transaction Control Number (TCN) of the claim that was previously processed. This field has been expanded to 16 spaces to accommodate the 16-digit TCN that replaces the 15-digit CRN.

- If you are submitting an adjustment or void to a claim that was processed prior to Phase II Implementation, enter the 15-digit CRN in the first 15 spaces and leave the last space blank.
- If you are submitting an adjustment to a claim that was processed after Phase II Implementation, enter the 16-digit TCN in this field. You must enter all claim lines that were submitted on the original claim. If you want to void a single line of a claim that processed with 2 or more lines, you must submit an adjustment and omit the line you want to void.
- If you are submitting a void to a claim that was processed after Phase II Implementation, enter the 16-digit TCN in this field. Submitting a void will void the entire claim.

1. **PATIENT'S NAME** – Enter the Client's first name followed by the last name.

2. **DATE OF BIRTH** – Enter the Client's date of birth in MMDDYYYY format.

5A. **PATIENT'S SEX** – Place an X on M for Male or on F for Female to indicate the Client's sex.

6A. **RECIPIENT ID NUMBER** – Enter the Client ID Number. Format must be 2 alpha-5 numeric-1 alpha.

10. **WAS CONDITION RELATED TO** – Place an X in the appropriate box to indicate if the condition being treated is related to:

- Patients Employment
- Auto Accident
- Crime Victim
- Other Liability

If one of the above is not involved, this field should be blank.

19B. **PROF CD** – Enter the 3-digit profession code when a license number is entered in field 19C – Identification Number. The profession code identifies the profession assigned to the license number and is completed only when the Referring/Ordering Provider's License Number is used. If an MMIS Provider ID Number is entered in field 19C – Identification Number - the Prof Cd field must be blank.



**19C. IDENTIFICATION NUMBER** – 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. 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 the end of this document for Post Office state abbreviations.

When a prescription or order originates from a hospital or clinic, and is written by an intern or resident, the supervising physician's Medicaid ID number should be entered. If the supervising physician is not enrolled in the Medicaid program, his or her state license number may be used instead. When the order is originated in an Article 28 facility and these numbers are unavailable; it is permissible to use the facility's Medicaid ID number.

#### **Restricted Recipient**

When providing services to a patient who is restricted to a primary provider (physician, clinic, dentist, etc.) and the primary provider orders the medical/surgical supplies, durable medical equipment, etc., enter this provider's Medicaid Provider ID number in this field.

#### **Do not enter the primary's Provider License number.**

If the restricted recipient was referred by his/her primary provider to another provider who orders services, the ordering provider's Medicaid ID number must be entered in this field. If the ordering provider is not an enrolled Medicaid provider, enter his/her license number. The **recipient's primary provider's Medicaid ID number** must be entered in **field 33**.

**Note:** When submitting claims for equipment repairs or replacements and an order is not required, enter a Profession Code in field 19B and AB000099 in this field.

**22F. POSSIBLE DISABILITY** - Place an X on Y for Yes or on N for No to indicate if the service rendered was for treatment of a condition that appears to be of a disabling nature.

**23A. PRIOR APPROVAL NUMBER** – Enter the Prior Approval Number in this field if applicable. **If the claim involves more than one Prior Approval, then a separate claim must be submitted for each Prior Approval used.**

**23B. PAYMENT SOURCE CODE** - There must be an entry of 1, 2 or 3 on both the M and the O boxes to indicate the involvement of Medicare or Other Insurance.

Box M = Medicare - Entries must be consistent with fields 24J and 24K.

- 1 – No Medicare Involved – This indicates that the Client does not have Medicare. Field 24J will be the amount charged. Field 24K will be blank.
- 2 – Medicare Approved – This indicates that Medicare has approved the service. Field 24J will be the amount Medicare approved and Field 24K will be the amount Medicare paid.
- 3 – Medicare Denied – This indicates that Medicare has denied the service. Field 24J will be the amount charged and 24K must have a paid amount of 0.00.

Box O = Other Insurance - Entries must be consistent with fields 24L.

- 1 – No Other Insurance – This indicates that the Client does not have Other Insurance. Field 24J will be the amount charged. Field 24L will be blank.
- 2 – Other Insurance Is Involved - This indicates that the Client does have Other Insurance. Field 24J will be the amount charged. Field 24L will be the amount the Other Insurance paid. The 2-character insurance code must be entered in the 2 spaces following box O. This identifies who the Other Insurance carrier is.



3 – Patient Participation - This indicates that the Client has a spend-down. Field 24J will be the amount charged. Field 24L will be the amount the Client paid towards the spend-down. The 2-character insurance code must be completed with 05 – Other.

**Note:** The attached Payment Source Code chart gives every possible combination of entries that can be made in field 23B and illustrates the relationship between field 23B and fields 24J, 24K and 24L.

**24A. DATE OF SERVICE** - Enter the date of service using 6 digits – MMDDYY format.

**24B. PLACE** – Enter the 2-digit place of service code that indicates the type of location where the service was rendered. Refer to the end of this document for a complete list of place of service codes.

**24C. PROCEDURE CD (ITEM CODE)** – Enter the 5-character procedure code assigned to the service you are billing.

**24D. MOD** – If the procedure requires the addition of a 2-character modifier to further define the service, enter it in this field. Only modifiers that are listed in the Procedure Code section of the MMIS Provider Manual are acceptable for billing.

**24H. DIAGNOSIS CODE** – Enter the ICD-9-CM code that describes the main condition or symptom of the Client for which the procedure was performed.

**24I. DAYS OR UNITS (Quantity)** – An entry must be made in this field. If the same procedure is performed more than one time on the same date of service, enter the number of times here.

**24J. CHARGES** – This field will contain either the amount charged or the Medicare Approved amount. The entry in this field must correspond with the entry in field 23B.

**24K. (MEDICARE PAID AMOUNT)** - This field will either be blank (if Medicare is not involved) or will contain the Medicare Paid amount. The entry in this field must correspond with the entry in field 23B.

**24L. (OTHER INS PAID AMOUNT)** - This field will either be blank (if Third Party Insurance is not involved) or will contain the Other Insurance Paid amount. The entry in this field must correspond with the entry in field 23B.

**25. CERTIFICATION (SIGNATURE)** – The Provider must sign the claim form. The signature must be original. Copies and rubber stamps will not be accepted. Please note that the certification statement is on the back of the claim form.

**25A. PROVIDER ID** – Enter the 8-digit MMIS Provider ID Number assigned to you at the time of enrollment.

**25C. LOCATOR CODE** - Enter the appropriate locator code that was assigned at the time of enrollment. Entries in the locator code field are 003 or higher. This field was expanded to 3 digits. Add a zero in front of the current 2-digit locator code.

**25E. DATE SIGNED** - Enter the billing date (the date you are completing the claim form) using 6 digits – MMDDYY format.

**31. PROVIDER NAME AND ADDRESS** – Enter the Provider’s name and correspondence address as it appears on their eMedNY Provider file.

**32. PATIENT’S ACCOUNT NUMBER** – This is an optional field. You may enter up to 20 characters in this field to identify a client. Information entered here will also appear on your remittance statement.

**PAYMENT SOURCE CODE**

23B. PAYM'T SOURCE CO

M / O / /

**BOX M****BOX O**

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

\*\* - Other Insurance Code

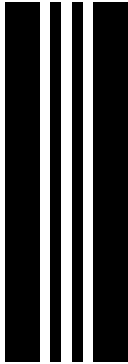
**MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM**

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

CODE  
A V

ORIGINAL TRANSACTION CONTROL NUMBER

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**



DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last)		2. DATE OF BIRTH M   M   D   D   Y   Y   Y		2A. TOTAL ANNUAL FAMILY INCOME		4. INSURED'S NAME (First name, middle initial, last name)								
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)				5. INSURED'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		5A. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. MEDICARE NUMBER			6A. MEDICAID NUMBER			
6. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL				7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>				6B. PRIVATE INSURANCE NUMBER			GROUP NO.		RECIPROCIITY NO.	
9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policy Holder, Plan Name and Address and Policy or Private Insurance Number				10. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT <input type="checkbox"/> CRIME VICTIM <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER LIABILITY <input type="checkbox"/>				8. INSURED'S EMPLOYER OR OCCUPATION						
12. PATIENT'S OR AUTHORIZED SIGNATURE				DATE MM   DD   YY		13. INSURED'S ADDRESS (Street, City, State, Zip Code)								
						INSURED'S SIGNATURE								

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

14. DATE OF ONSET OF CONDITION MM   DD   YY		15. FIRST CONSULTED FOR CONDITION MM   DD   YY		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>		16A. EMERGENCY RELATED YES <input type="checkbox"/> NO <input type="checkbox"/>		17. DATE PATIENT MAY RETURN TO WORK MM   DD   YY		18. DATES OF DISABILITY TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/>		FROM MM   DD   YY		TO MM   DD   YY			
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						19A. ADDRESS (OR SIGNATURE SHF ONLY)				19B. PROF CD		19C. IDENTIFICATION NUMBER				19D. DX CODE	
20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES MM   DD   YY		ADMITTED MM   DD   YY		DISCHARGED MM   DD   YY		20A. NAME OF HOSPITAL				20B. SURGERY DATE MM   DD   YY		20C. TYPE OF SURGERY					
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)						21A. ADDRESS OF FACILITY				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES <input type="checkbox"/> NO <input type="checkbox"/>				LAB CHARGES			
22A. SERVICE PROVIDER NAME						22B. PROF CD		22C. IDENTIFICATION NUMBER				22D. STERILIZATION ABORTION CODE		22E. STATUS CODE			
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE										22F. POSSIBLE DISABILITY Y <input type="checkbox"/> N <input type="checkbox"/>		22G. EPSDT C/THP Y <input type="checkbox"/> N <input type="checkbox"/>		22H. FAMILY PLANNING Y <input type="checkbox"/> N <input type="checkbox"/>			
										23A. PRIOR APPROVAL NUMBER				23B. PAYMT SOURCE CODE M   O			
24A. DATE OF SERVICE M   M   D   D   Y   Y		24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES		24K. DIAGNOSIS CODE		24L.			
24M. INPATIENT HOSPITAL VISITS		FROM MM   DD   YY		THROUGH MM   DD   YY		24N. PROC CD		24O. MOD									
25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)						26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>				27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE			
SIGNATURE OF PHYSICIAN OR SUPPLIER						30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER				31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE							
25A. PROVIDER IDENTIFICATION NUMBER																	
25B. MEDICAID GROUP IDENTIFICATION NUMBER						25C. LOCATOR CODE		25D. SA EXCP CODE		32A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>		TELEPHONE NUMBER ( ) EXT.					
COUNTY OF SUBMITTAL		25E. DATE SIGNED MM   DD   YY		32. PATIENT'S ACCOUNT NUMBER						DO NOT WRITE IN THIS SPACE							
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER						34. PROF CD		35. CASE MANAGER ID				EMEDNY - 150001 ((1/04))					

**Appendix A – Code Sets****PLACE OF SERVICE**

<b>Code</b>	<b>Description</b>
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
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



**UNITED STATES STANDARD POST OFFICE ABBREVIATIONS**

**Standard Post Office Abbreviations for States**

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**

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

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