



TRANSPORTATION – EMEDNY 000201 CLAIM FORM INSTRUCTIONS

The following guide gives instructions for proper claim form completion when submitting claims for Transportation Services using the eMedNY 000201 claim form. A field-by-field description is provided to indicate what entries are required when submitting claims to the eMedNY system. Please refer to your MMIS Transportation Provider Manual if further information is required.

FIELD BY FIELD INSTRUCTIONS

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

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

2. **BILLING DATE** – Leave blank.

4. **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.

6. **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.

6A. **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 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 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 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 Implementation, enter the 16-digit TCN in this field. Submitting a void will void the entire claim.

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

8. **DATE OF BIRTH** – Enter the Client's date of birth in MMDDYYYY format. The full date of birth is now required rather than just the year.

8A. **SEX** – Place an X on M for Male or on F for Female to indicate the Client's sex.

9. **RECIPIENT NAME – FIRST** - Enter the Client's First Name.

9A. **RECIPIENT NAME – LAST** - Enter the Client's Last Name.



10. **OFFICE 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 appear on your remittance statement.

13. **EMERGENCY** - Place an X on Y for Yes to indicate that the service is related to an emergency or urgent situation. This field may be left blank if the answer is No.

14. **ACCIDENT CODE** – If applicable, enter the appropriate Accident Code.

Code Description

0/Blank Not Applicable

1 Auto Accident

2 Employment

3 Another Party Responsible

4 Other Accident

19. **PRIOR APPROVAL NUMBER** - Enter the Prior Approval Number in this field if applicable.

21. **SERVICE PROVIDER** – Ambulette Providers only – the vehicle license plate number used for the service should be entered in this field.

22. **OTHER REFERRING/ORDERING PROVIDER** – Ambulette Providers only – Enter the individual's driver license number in this field.

23. **ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER**

Ambulance, Ambulette, and Livery

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

Instructions for Entering a License Number

If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to end of this document for the Post Office state abbreviations.

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

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

Taxi and Day Program

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

23A. **PROF CODE** - Enter the 3-digit profession code when a license number is entered in field 23 – Ordering/Referring Provider ID/License Number. The profession code identifies the profession assigned to the license number and is completed only when the Ordering/Referring Provider's License Number is used. If an MMIS Provider ID Number is entered in field 23, the Prof Cd field must be blank.



25. **DATE OF SERVICE** - Enter the date of service using 6 digits – MMDDYY format.
26. **PROCEDURE CODE** - Enter the 5-character procedure code assigned to the service you are billing.
27. **TIMES PERFORMED** – This field indicates either the number of times a service (trip) was performed or the number of miles associated with a transportation service.
30. **AMOUNT CHARGED** – Enter the amount charged for the procedure.
31. **MEDICARE CO INSURANCE** – If Medicare is involved and a claim is being submitted for the balance, enter the co-insurance amount.
- 31A. **MEDICARE DEDUCTIBLE** – If Medicare is involved enter the amount (if any) that was put towards the deductible.
- 31B. **MEDICARE CO PAY** - If Medicare is involved enter the amount of the Medicare co-pay.
- 31C. **MEDICARE PAID** - If Medicare is involved enter the amount Medicare paid.
32. **OTHER INSURANCE PAID** – If Third Party Insurance is involved in the claim, enter the amount they paid in this field. If they denied the claim, enter zeros. This field is also used to show the amount paid by the client to meet a spend-down (patient participation).
37. **SIGNATURE** - The provider of transportation services or an authorized representative 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.
- 37A. **COUNTY** – This field may be left blank if the Provider address on the claim form is within the county that the form is being signed in. If for some reason, the form is being signed in a different county, enter the county code assigned to that county.
38. **DATE** – Enter the date the claim form was signed using 6 digits – MMDDYY format.

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

Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
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.