New York State Medicaid General Billing Guidelines

PROFESSIONAL

Version 2022 - 01

8/15/2022

eMedNY is the name of the electronic New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and the eMedNY fiscal agent. More information about eMedNY can be found at www.emedny.org.

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

1. Purpose Statement

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

This document is intended to serve as an instructional reference tool for providers who submit claims using either the 837 Professional or paper 150003 form. For providers new to NYS Medicaid, it is required to read the the Trading Partner Information Companion Guide available at www.emedny.org by clicking on the link to the webpage as follows: Trading Partner Information Companion Guide.

2. Claims Submission

Professional service providers may submit their claims to NYS Medicaid using electronic or paper formats.

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

Providers are asked to update their Certification Statement on an annual basis. Providers are sent renewal information when their Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide.

2.1 Electronic Claims

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

Professional providers who submit claims electronically are required to use the HIPAA 837 Professional (837P) transaction.

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837P standards and other program specifications. These documents are available at store.X12.org.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

Further information on the 5010 transaction is available at www.emedny.org by clicking on the link to the web page as follows: eMedNYHIPAASupport.

Further information about electronic claim prerequisites is available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide.

2.2 Paper Claims

Professional services providers who submit their claims on paper forms must use the New York State eMedNY-150003 claim form.

To view a sample eMedNY - 150003 claim form, see Appendix A below. The displayed claim form is a sample and is for illustration purposes only.

An Electronic/Paper Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide..

2.2.1 General Instructions for Completing Paper Claims

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

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2

Written As	Intended As	Interpreted As
6. 0 0	6.00	6. 6 0 → Zero interpreted as six

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

Exhibit 2.2.1-3

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

- Characters should not touch each other as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

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

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

The address for submitting claim forms is:

eMedNY
P.O. Box 4601
Rensselaer, NY 12144-4601

Expedited / Priority Shipping:
eMedNY
327 Columbia Turnpike
ATTN: Box 4601
Rensselaer, NY 12144

2.3 eMedNY – 150003 Claim Form

To order New York State Medicaid 150003 forms, please contact the eMedNY call center at 1-800-343-9000.

To view a sample Physician eMedNY - 150003 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.4 General Billing Instructions

This subsection of the Billing Guidelines covers general billing requirements for professional claims. Although the instructions that follow are based on the eMedNY - 150003 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims. For reference purposes, the related electronic fields are provided. For further electronic claim submission information, refer to eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12

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

2.4.1 Instructions for the Submission of Medicare Crossover Claims

This subsection is intended to familiarize the provider with the submission of crossover claims. Providers can bill claims for Medicare/Medicaid members to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid. ***Medicare Part-C*** (Medicare Managed Care) and ***Medicare Part-D*** claims are ***not*** part of this process.

Providers must review their Medicare remittances for crossover information to determine whether their claims have been crossed over to Medicaid for processing. Any claim that was indicated by Medicare as a crossover should not be submitted to Medicaid as a separate claim. If the Medicare remittance does not indicate that the claim has been crossed over to Medicaid, the provider should submit the claim directly to Medicaid. Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows.

If a separate claim is submitted directly by the provider to Medicaid for a dual eligible recipient and the claim is paid before the Medicare crossover claim, both claims will be paid. The eMedNY system will then automatically void the provider submitted claim. Providers may submit adjustments to Medicaid for their crossover claims.

Electronic remittances from Medicaid for crossover claims will be sent to the default ETIN when the default is set to electronic. If there is no default ETIN, the crossover claims will be reported on a paper remittance. The ETIN application is available at www.emedny.org by clicking on the link to the webpage as follows: Default Electronic Transmitter Identification Number (ETIN) Selection Form.

2.4.2 eMedNY - 150003 Claim Form Field Instructions

Header Section: Fields 1 through 23B

The information entered in the Header Section of the claim form (fields 1 through 23B) applies to all claim lines entered in the Encounter Section of the form.

The following two unnumbered fields should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

Adjustment/Void Code (Upper Right Corner of Form)

837P Ref: Loop 2300 CLM05-3

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' in the 'A' box.
- If submitting a ***void*** to a previously paid claim, enter 'X' in the 'V' box.

Original Claim Reference Number (Upper Right Corner of Form)

837P Ref: Loop2300 REF02 where REF01 = F8

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)***. 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.

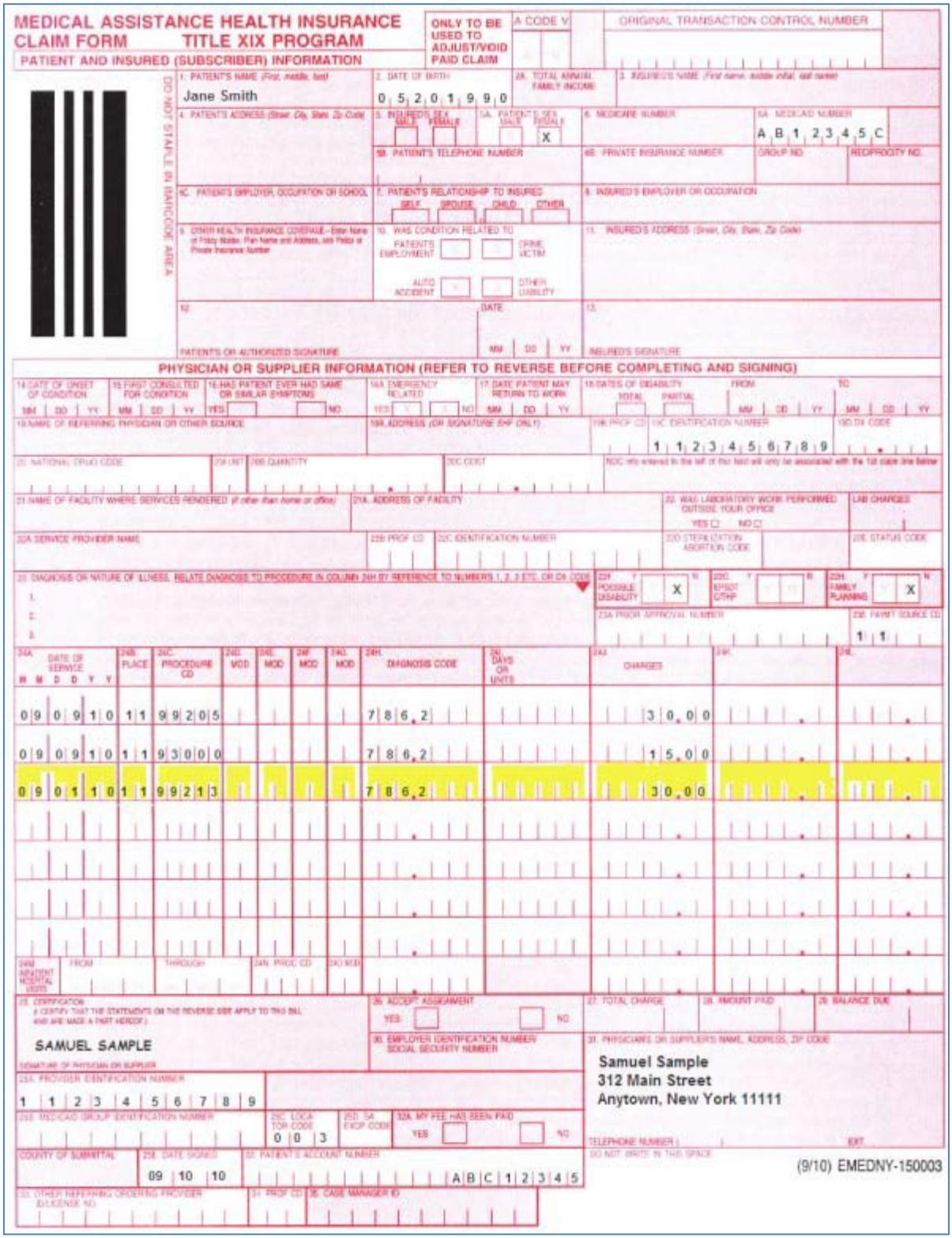
2.4.2.1 Adjustment

An adjustment may be submitted to correct any information on a previously paid claim other than:

- Billing Provider ID
- Group Provider ID
- Member ID.

Exhibit 2.4.2.1-1 and Exhibit 2.4.2.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 1026501234567890 is shared by three individual claim lines. This TCN was paid on September 22, 2010. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.2.1-1



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): Jane Smith

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

2A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. INSURED'S SEX: MALE / FEMALE

5A. PATIENT'S SEX: MALE / FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: A B 1 2 3 4 5 C

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

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: PATIENTS EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE: MM DD YY

13. 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 / NO

16A. EMERGENCY RELATED: YES / NO

17. DATE PATIENT MAY RETURN TO WORK: MM DD YY

18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM: MM DD YY — TO: MM DD YY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19A. ADDRESS (OR SIGNATURE ENP ONLY)

19B. PROV CD

19C. IDENTIFICATION NUMBER: 1 1 2 3 4 5 6 7 8 9

19D. DX CODE

20. NATIONAL DRUG CODE

20A. UNIT

20B. QUANTITY

20C. COST

NDC info entered to the left of this field will only be associated with the 1st claim line below

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 / NO

LAB CHARGES

23A. SERVICE PROVIDER NAME

23B. PROF CD

23C. IDENTIFICATION NUMBER

23D. STERILIZATION ABORTION CODE

23E. 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

1.

2.

3.

22F. POSSIBLE DISABILITY: X

22G. EPSDT/CHF

22H. FAMILY PLANNING: X

23A. PRIOR APPROVAL NUMBER

23B. PAMT SOURCE CD: 1 1

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.	24L.
0 9 0 9 1 0	1 1	9 9 2 0 5					7 8 6 2		3 0 0 0		
0 9 0 9 1 0	1 1	9 3 0 0 0					7 8 6 2		1 5 0 0		
0 9 0 1 1 0	1 1	9 9 2 1 3					7 8 6 2		3 0 0 0		

24M. INPATIENT HOSPITAL VISITS — FROM — THROUGH — 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.)

SAMUEL SAMPLE

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER

31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE

Samuel Sample
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 1 1 2 3 4 5 6 7 8 9

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATION CODE: 0 0 3

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID: YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 10 10

27. PATIENT'S ACCOUNT NUMBER: A B C 1 2 3 4 5

DO NOT WRITE IN THIS SPACE

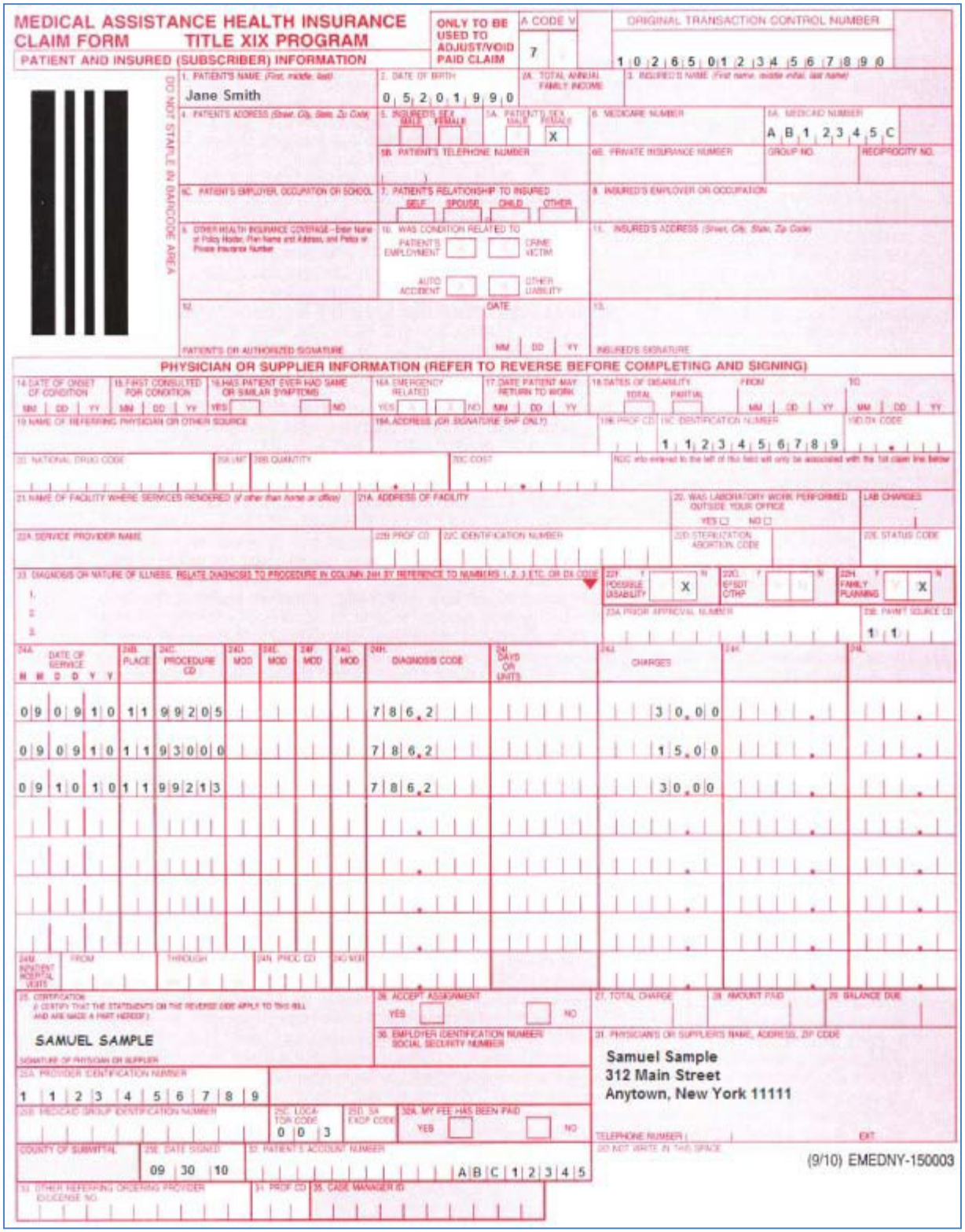
(9/10) EMEDNY-150003

33. OTHER REFERRING ORDERING PROVIDER (LICENSE NO.)

34. PROF CD

35. CASE MANAGER ID

Exhibit 2.4.2.1-2



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM: A CODE V: 7

ORIGINAL TRANSACTION CONTROL NUMBER: 1026501234567890

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME: Jane Smith

2. DATE OF BIRTH: 05 20 1990

4. PATIENT'S ADDRESS

5. INSURED'S SEX: MALE / FEMALE

5A. PATIENT'S SEX: MALE / FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: AB12345C

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

6C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

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 / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. 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 / NO

16A. EMERGENCY RELATED? YES / NO

17. DATE PATIENT MAY RETURN TO WORK MM DD YY

18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM MM DD YY — TO MM DD YY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19A. ADDRESS (OR SIGNATURE SHP ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 1123456789

19D. DX CODE

20. NATIONAL DRUG CODE

20A. UP

20B. QUANTITY

20C. COST

NDC info entered to the left of this field will only be associated with the 1st claim line below

21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

21A. ADDRESS OF FACILITY

20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐

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

1.
2.
3.

22I. POSSIBLE DISABILITY: X

22G. EPSDT CHP

22H. FAMILY PLANNING: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

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.	24L.
09 09 10	11	99205					786.2		300.00		
09 09 10	11	93000					786.2		150.00		
09 10 10	11	99213					786.2		300.00		

24M. INPATIENT HOSPITAL DATES — FROM — THROUGH — 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.)

SAMUEL SAMPLE

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

Samuel Sample
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER — EXT

25A. PROVIDER IDENTIFICATION NUMBER: 1123456789

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATION CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID: YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 30 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

(9/10) EMEDNY-150003

33. OTHER REFERRING/ORDERING PROVIDER (LICENSE NO.)

34. PROF CD

35. CASE MANAGER ID

2.4.2.2 Void

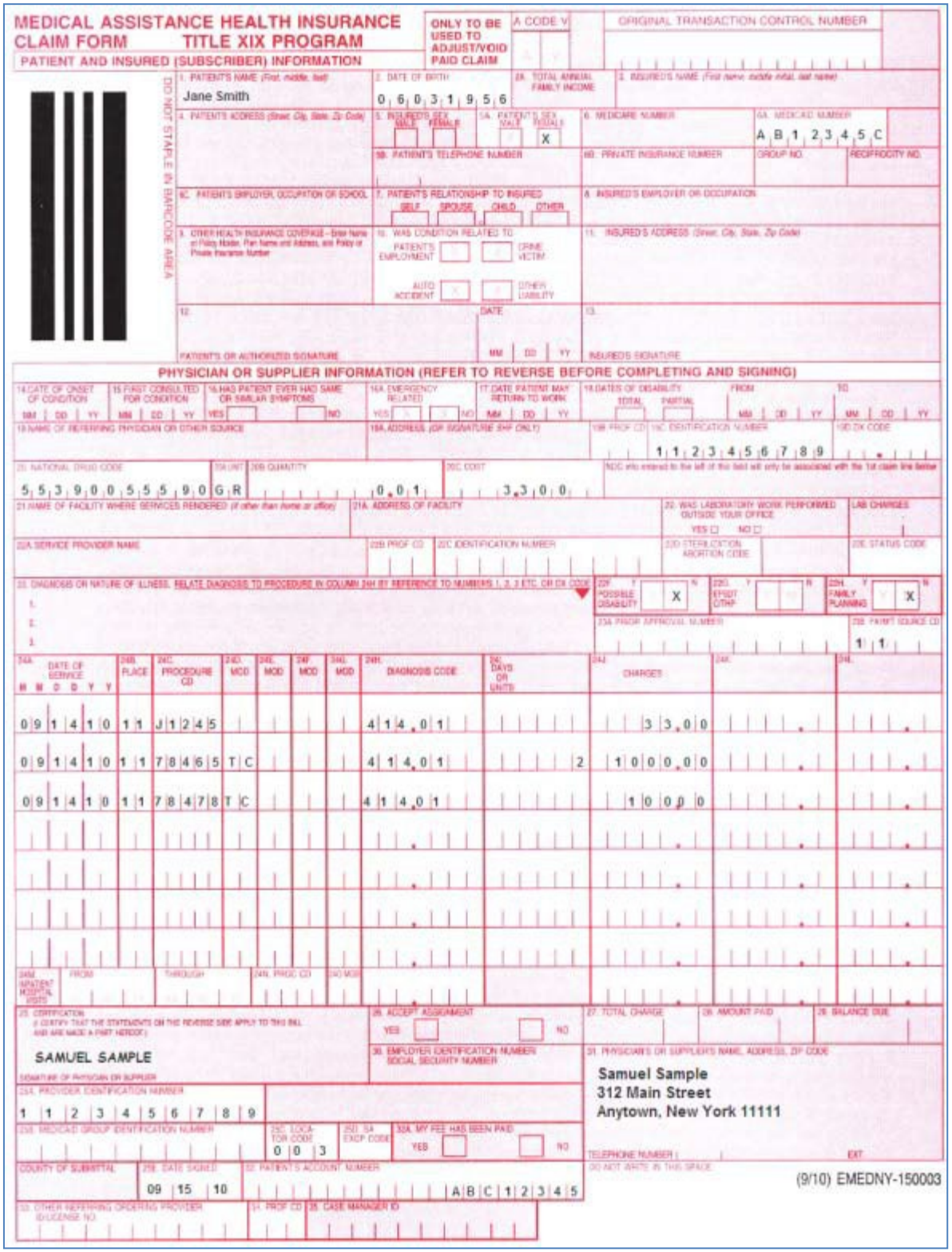
A void is submitted to nullify the original claim in its entirety.

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 the TCN and the originally submitted Group ID, Billing Provider ID, and Member ID.

Exhibit 2.4.2.2-1 and Exhibit 2.4.2.2-2 illustrate an example of a claim being voided. TCN 1026301234567890 contained two claim lines, which were paid on September 20, 2010. Later, the provider became aware that the member had other insurance coverage. The other insurance was billed and the provider was paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Exhibit 2.4.2.2-1 shows the claim as it was originally submitted and Exhibit 2.4.2.2-2 shows the claim being submitted as voided.

Exhibit 2.4.2.2-1



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME: Jane Smith

2. DATE OF BIRTH: 06 03 1956

6A. MEDICAID NUMBER: AB12345C

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

24A DATE OF SERVICE	24B PLACE	24C PROCEDURE CD	24D MOD	24E MOD	24F MOD	24G MOD	24H DIAGNOSIS CODE	24I DAYS OR UNITS	24J CHARGES
09 14 10	11	J1245					414.01		33.00
09 14 10	11	78465	TC				414.01	2	100.00
09 14 10	11	78478	TC				414.01		100.00

25. CERTIFICATION: SAMUEL SAMPLE

26. ACCEPT ASSIGNMENT: YES

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE:
Samuel Sample
312 Main Street
Anytown, New York 11111

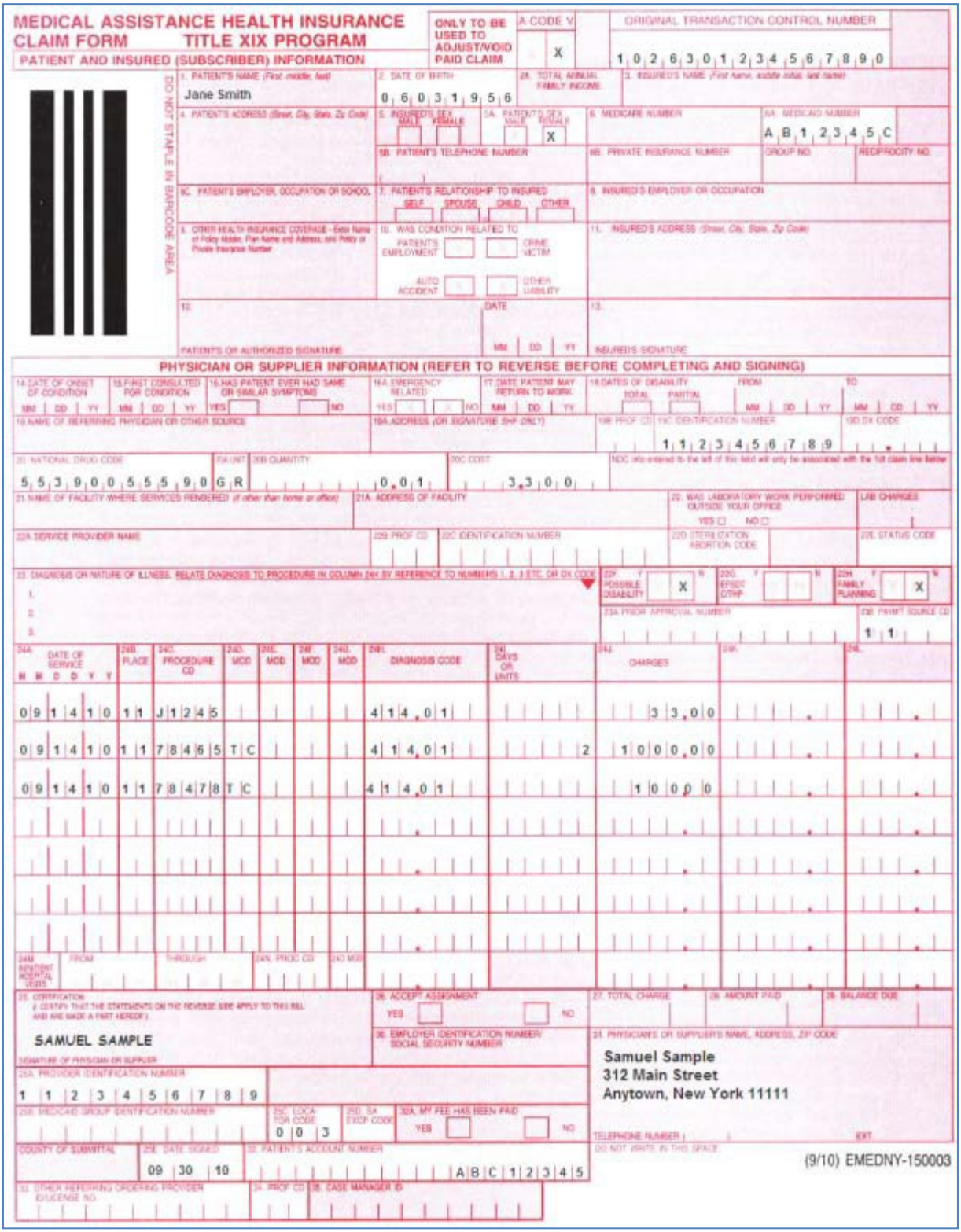
23A. PROVIDER IDENTIFICATION NUMBER: 1123456789

32A. MY FEE HAS BEEN PAID: YES

32. PATIENT'S ACCOUNT NUMBER: ABC12345

(9/10) EMEDNY-150003

Exhibit 2.4.2.2-2



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM — A CODE: X

ORIGINAL TRANSACTION CONTROL NUMBER: 1026301234567890

1. PATIENT'S NAME: Jane Smith

2. DATE OF BIRTH: 06 03 1956

A. TOTAL ANNUAL FAMILY INCOME

3. INSURED'S NAME

4. PATIENT'S ADDRESS

5. INSURED'S SEX: MALE / FEMALE

5A. PATIENT'S SEX: MALE / FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: AB12345C

5B. PATIENT'S TELEPHONE NUMBER

6B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

7C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

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 / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. INSURED'S SIGNATURE

DO NOT STAPLE IN BARCODE AREA

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 / NO

16A. EMERGENCY RELATED? YES / NO

17. DATE PATIENT MAY RETURN TO WORK MM DD YY

18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM MM DD YY — TO MM DD YY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19A. ADDRESS (OR SIGNATURE SHP ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 1123456789

19D. DX CODE

20. NATIONAL DRUG CODE: 53900555 90 GR

20A. UNIT

20B. QUANTITY: 0001

20C. COST: 3300

NDC info entered to the left of this field will only be associated with the 1st claim line below

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 / NO

LAB CHARGES

22A. SERVICE PROVIDER NAME

22B. PROF CD

22C. IDENTIFICATION NUMBER

22D. CERTIFICATION/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

1.

2.

3.

22F. POSSIBLE DISABILITY: X

22G. EPSDT/CHP

22H. FAMILY PLANNING: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

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.	24L.
09 14 10	11	J1245					414.01		33.00		
09 14 10	11	78465	TC				414.01	2	1000.00		
09 14 10	11	78478	TC				414.01		1000		

24G. EMERGENCY — 24H. FAMILY PLAN — 24I. IDTNTFY QUAL — 24J. RENDERING PROVIDER ID #

24K. FROM — THROUGH — 24L. PROC CD — 24M. MOD

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

SAMUEL SAMPLE

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

Samuel Sample
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER — EXT

32. PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

32A. NPI

32B. OTHER ID #

33. PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, PHONE #

33A. NPI

33B. OTHER ID #

33. PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, PHONE #

33A. NPI

33B. OTHER ID #

25A. PROVIDER IDENTIFICATION NUMBER: 1123456789

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATION CODE: 003

25D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID: YES / NO

COUNTY OF SUBMITTAL

25E. DATE SIGNED: 09 30 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

(9/10) EMEDNY-150003

33. OTHER REFERRING/ORDERING PROVIDER (LICENSE NO.)

34. PROF CD

35. CASE MANAGER ID

Patient's Name (Field 1)

837P Ref: Loop 2010BA NM1

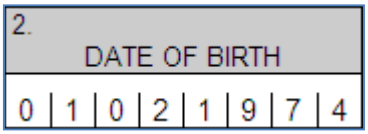
Enter the member's first name, followed by the last name. This information may be obtained from the member's Common Benefit ID Card (CBIC).

Date of Birth (Field 2)

837P Ref: Loop 2010BA DMG02

Enter the member's birth date. This information may be obtained from the CBIC. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.2-1.

Exhibit 2.4.2-1



Patient's Sex (Field 5A)

837P Ref: Loop 2010BA DMG03

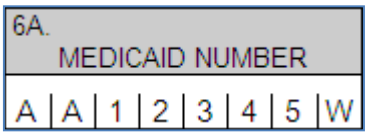
Place an 'X' in the appropriate box to indicate the member's sex. This information may be obtained from the CBIC.

Medicaid Number (Field 6A)

837P Ref: Loop 2010BA NM109

Enter the Member ID. This information may be obtained from the CBIC. Member IDs are assigned by NYS Medicaid and are composed of 8 characters in the format AANNNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.2-2.

Exhibit 2.4.2-2



Was Condition Related To (Field 10)

837P Ref: Loop 2300 CLM11

If applicable, place an 'X' in the appropriate box to indicate whether the service rendered to the member was work related or for a condition resulting from an accident or a crime. Select the boxes in accordance with the following:

- Member's Employment

  If the claim is covered by Worker's Compensation, place an X in the box.

- Crime Victim

  Use this box to indicate that the condition treated was the result of an assault or crime.

- Auto Accident

  Use this box to indicate Automobile No-Fault. Leave this box blank if condition is related to an auto accident other than no-fault or if no-fault benefits are exhausted.

- Other Liability

  Use this box to indicate that the condition was related to an accident-related injury of a different nature from those indicated above.

If the condition being treated is not related to any of these situations, leave these boxes blank.

Emergency Related (Field 16A)

837P Ref: Loop 2400 SV109

Enter an 'X' in the Yes box only when the condition being treated is related to an emergency; otherwise leave this field blank.

Name of Referring Physician or Other Source (Field 19)

837P Ref: Loop 2310A NM1

This field should be completed when claiming the following:

- Ordered Procedure
- Referred Service

Ordered Procedures

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

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

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

Referred Service

If the member was referred by another provider enter the name of the referring provider.

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

Leave this field blank.

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

Leave this field blank.

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

837P Ref: Loop 2310A NM109

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

- Ordered Procedure
- Referred Service

Ordered Procedures

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

Referred Service

If the member was referred for treatment by another physician, enter the referring provider's NPI.

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

When providing services to a member who is restricted to a primary physician or facility, the NPI of the referring professional must be entered. ***If a member is restricted to a facility, the NPI of the facility's referring professional must be entered. The ID of the facility cannot be used.***

DX Code (Field 19D)

837P Ref: Loop 2300 HI01-2

If applicable, enter the secondary diagnosis.

Drug Claims Section: Fields 20 to 20C

The following instructions apply to claims for physician administered drugs:

- The NDC in field 20 and the associated information in fields 20A through 20C must correspond directly to the drug related procedure code reported in the first line of fields 24A through 24L.
- Only one drug code claim may be submitted per 150003 claim form; however, other procedures may be billed on the same claim.

NDC [National Drug Code] (Field 20)

837P Ref: Loop 2410 LIN03

National Drug Code is a unique code that identifies a drug labeler/vendor, product and trade package size.

Enter the NDC as an 11-digit number. Do not use spaces, hyphens or other punctuation marks.

See Exhibit 2.4.2-3 for examples of the NDC and leading zero placement.

Exhibit 2.4.2-3

Package NDC Number Configuration	Correct Leading Zero Placement for 5-4-2 = 11	NDC Field Example:
XXXX-XXXX-XX 4 + 4 + 2 = 10	**0**XXXX-XXXX-XX 5 + 4 + 2 = 11	20. NATIONAL DRUG CODE **0** | x | x | x | x | x | x | x | x | x | x
XXXXX-XXX-XX 5 + 3 + 2 = 10	XXXXX-**0**XXX-XX 5 + 4 + 2 = 11	20. NATIONAL DRUG CODE x¤ | x¤ | x¤ | x¤ | x¤ | **0¤** | x¤ | x¤ | x¤ | x¤ | x¤
XXXXX-XXXX-X 5 + 4 + 1 = 10	XXXXX-XXXX-**0**X 5 + 4 + 2 = 11	20. NATIONAL DRUG CODE x | x | x | x | x | x | x | x | x | **0** | x

Unit (Field 20A)

837P Ref: Loop 2400 SV103

Use one of the following when completing this entry:

- UN = Unit
- F2 = International Unit
- GR = Gram
- ML = Milliliter

Quantity (Field 20B)

837P Ref: Loop 2400 SV104

Enter the numeric quantity administered to the member. Report the quantity in relation to the decimal point as shown in Exhibit 2.4.2-4.

NOTE: The preprinted decimal point must be rewritten in blue or black ink when entering a value. The claim will not process correctly if the decimal is not entered in blue or black ink.

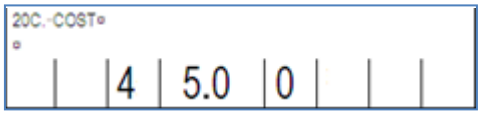
Exhibit 2.4.2-4

Cost (Field 20C)

837P Ref: Loop 2400 SV102

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

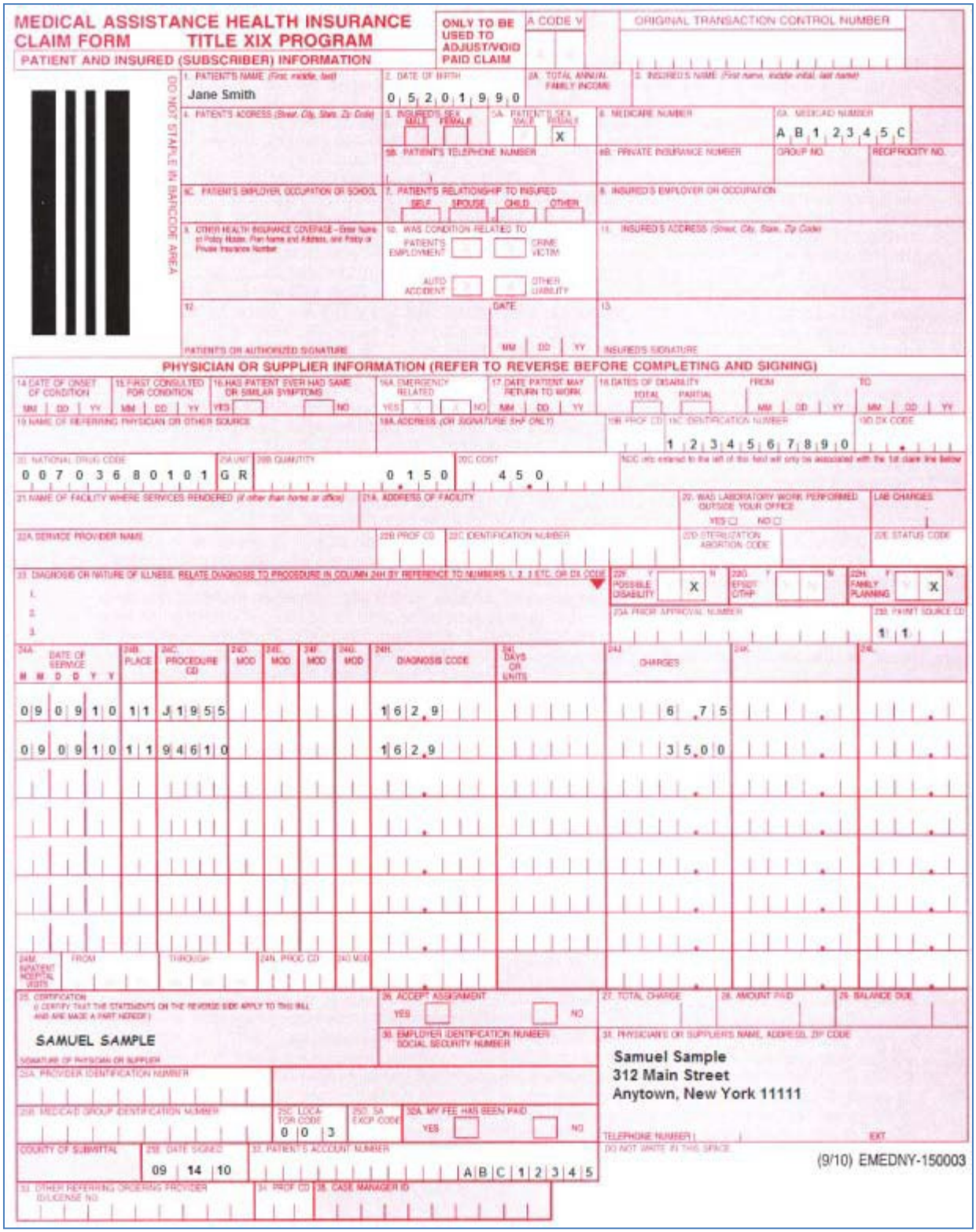
Exhibit 2.4.2-5



NOTE: The preprinted decimal point must be rewritten in blue or black ink when entering a value. The claim will not process correctly if the decimal is not entered in blue or black ink.

Exhibit 2.4.2-6 contains a sample of how a drug code would be submitted along with another service provided on the same day.

Exhibit 2.4.2-6



MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

A CODE V

ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last): Jane Smith

2. DATE OF BIRTH: 05 20 1990

3. INSURED'S SEX: MALE / FEMALE

5A. PATIENT'S SEX: MALE / FEMALE: X

6. MEDICARE NUMBER

6A. MEDICAID NUMBER: AB12345C

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5B. PATIENT'S TELEPHONE NUMBER

8B. PRIVATE INSURANCE NUMBER

GROUP NO.

RECIPROCITY NO.

8C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL

7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

8. INSURED'S EMPLOYER OR OCCUPATION

9. OTHER HEALTH INSURANCE COVERAGE – Enter Name or Policy Nbr, Plan Name and Address, and Policy or Private Insurance Number

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE MM DD YY

13. 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 / NO

16A. EMERGENCY RELATED? YES / NO

17. DATE PATIENT MAY RETURN TO WORK MM DD YY

18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM MM DD YY — TO MM DD YY

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19A. ADDRESS (OR SIGNATURE SHP ONLY)

19B. PROF CD

19C. IDENTIFICATION NUMBER: 1234567890

19D. DX CODE

20. NATIONAL DRUG CODE: 00703680101

20A. UNIT: GR

20B. QUANTITY: 0150

20C. COST: 450

NDC info entered to the left of this field will only be associated with the 1st claim line below

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 / NO

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

1.
2.
3.

22F. POSSIBLE DISABILITY: X

22G. EPSDT/CHP

22H. FAMILY PLANNING: X

23A. PRIOR APPROVAL NUMBER

23B. PAYMT SOURCE CD: 11

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.	24L.
090910	11	J1955					1629		675		
090910	11	94610					1629		350		

24M. INPATIENT HOSPITAL DATES: FROM / THROUGH

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.)

SAMUEL SAMPLE

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT? YES / NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

Samuel Sample
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT

32A. PROVIDER IDENTIFICATION NUMBER

32B. MEDICAID GROUP IDENTIFICATION NUMBER

32C. LOCATION CODE: 003

32D. SA EXCP CODE

32A. MY FEE HAS BEEN PAID? YES / NO

COUNTY OF SUBMITTAL

33. DATE SIGNED: 09 14 10

32. PATIENT'S ACCOUNT NUMBER: ABC12345

DO NOT WRITE IN THIS SPACE

(9/10) EMEDNY-150003

33. OTHER REFERRING ORDERING PROVIDER (LICENSE NO.)

34. PROF CD

35. CASE MANAGER ID

Name of Facility Where Services Rendered (Field 21)

837P Ref: Loop 2010AA NM1 or 2310C NM1

This field should be completed when the Service Location is other than the address the payments are to be remitted.

Address of Facility (Field 21A)

837P Ref: Loop 2010AA N3 and N4 OR 2310C N3 and N4

This field should be completed when the Service Location is other than the address the payments are to be remitted.

NOTE:This is the address where the service was rendered.

Service Provider Name (Field 22A)

837P Ref: Loop 2310B NM1

If the service was provided by a physician's assistant, certified diabetes educator, certified asthma educator, social worker, or a private duty nurse, enter the name. Otherwise, leave this field blank.

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

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

837P Ref: Loop 2310B NM1

If the service was provided by a physician’s assistant, certified diabetes educator, certified asthma educator, social worker, or a private duty nurse, enter the service provider’s NPI. Otherwise, leave this field blank.

Sterilization/Abortion Code (Field 22D)

837P Ref: Loop 2300 HI01-2

If applicable, enter the appropriate code to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in Appendix B – Code Sets.

If the procedure is unrelated to abortion/sterilization, leave this field blank.

When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, ***LDSS-3134***, is required and must be attached to the paper claim form (See Appendix C - Sterilization Consent Form LDSS-3134).

NOTES:

- *The following medical procedures are not induced abortions; therefore when billing for these procedures, leave this field blank.*
  - *Spontaneous abortion (miscarriage);*
  - *Termination of ectopic pregnancy;*
  - *Drugs or devices to prevent implantation of the fertilized ovum;*
  - *Menstrual extraction.*
- *Medicaid does not reimburse providers for hysterectomies performed for the purpose of sterilization. Please refer to the Policy Guidelines on the web page for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows:* Policy Guidelines.

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

837P Ref: Loop 2300 CLM12

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

EPSDT C/THP (Field 22G)

837P Ref: Loop 2400 SV111

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

Family Planning (Field 22H)

837P Ref: Loop 2400 SV112

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

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

- Sterilization procedures.

This field must always be completed. Place an 'X' in the YES box if ***all*** services being claimed are family planning services. Place an 'X' in the NO box if ***at least one*** of the services being claimed is not a family planning service.

If some of the services being claimed, but not all, are related to Family Planning, ***place the modifier FP*** in the two-digit space following the procedure code in Field 24D to designate those specific procedures which are family planning services.

Prior Approval Number (Field 23A)

837P Ref: Loop 2300 REF02 when REF01 = G1

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

NOTES:

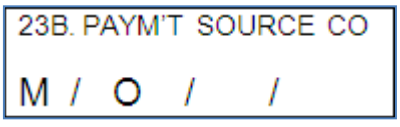
- ***For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to Information for All Providers, Inquiry section on the web page for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Inquiry.
-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

Payment Source Code [Box M and Box O] (Field 23B)

837P Ref: No Map

This field has two components: Box M and Box O as shown in Exhibit 2.4.2-7 below:

Exhibit 2.4.2-7



Both boxes need to be filled as follows:

Box M

The values entered in this box define the nature of the amounts entered in fields 24J and 24K. Box M is used to indicate whether the member is covered by Medicare and whether Medicare approved or denied payment. Enter the appropriate numeric indicator from the following list.

- No Medicare involvement – Source Code Indicator = 1

  This code indicates that the member does not have Medicare coverage.

- Member has Medicare Part B; Medicare approved the service – Source Code Indicator = 2

  This code indicates that the service is covered by Medicare and that Medicare approved the service and ***either made a payment or paid 0.00 due to a deductible.*** Medicaid is responsible for reimbursing the Medicare deductible and /or (full or partial) coinsurance.

- Member has Medicare Part B; Medicare denied payment – Source Code Indicator = 3

  This code indicates that Medicare denied payment or did not cover the service billed.

Box O

Box O is used to indicate whether the member has insurance coverage other than Medicare or Medicaid or whether the member is responsible for a pre-determined amount of his/her medical expenses. The values entered in this box define the nature of the amount entered in field 24L. Enter the appropriate indicator from the following list.

- No Other Insurance involvement – Source Code Indicator = 1

  This code indicates that the member does not have other insurance coverage.

- Member has Other Insurance coverage – Source Code Indicator = 2

  This code indicates that the member has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value ***2*** is entered in Box 'O', the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount.

- Member Participation – Source Code Indicator = 3

  This code indicates that the member has incurred a pre-determined amount of medical expenses, which qualify him/her to become eligible for Medicaid.

Exhibit 2.4.2-8 provides a full illustration of how to complete field 23B and the relationship between this field and fields 24J, 24K, and 24L.

Exhibit 2.4.2-8

	BOX M	BOX O
23B. PAYM'T SOURCE CO 11 M / C / /	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 1 – **No Other Insurance involvement.** Field 24L must be left blank.
23B. PAYM'T SOURCE CO 12 M / C / * / *	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 13 M / C / * / *	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO 21 M / C / /	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 1 – **No Other Insurance involvement**. Field 24L must be left blank.
23B. PAYM'T SOURCE CO 22 M / C / * / *	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 23 M / C / * / *	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO 31 M / C / /	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 1 – **No Other Insurance involvement**. Field 24L must be left blank.
23B. PAYM'T SOURCE CO 32 M / C / * / *	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO 33 M / C / * / *	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 3 – **Indicates patient's participation**. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit insurance code.

Procedure Section: Fields 24A to 24O

The claim form can accommodate up to seven procedures with a single member, plus a block of proceduresin a hospital setting, if all the information in the Header Section of the claim (Fields 1–23B) applies to all the procedures.

Date of Service (Field 24A)

837P Ref: Loop 2400 DTP03 when DTP01 = 472

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

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

Place [of Service] (Field 24B)

837P Ref: Loop 2300 CLM05-1

This two-digit code indicates the type of location where the service was rendered. Please note that place of service code is different from locator code. Place of Service Codes may be found in the NUBC UB-04 Man

Procedure Code (Field 24C)

837P Ref: Loop 2400 SV101-2

Enter the appropriate five-character procedure code.

NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org in the applicable provider manual.

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

837P Ref: Loop 2400 SV101-3, 4, 5, 6, and 7

If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

Special Instructions for Claiming Medicare Deductible

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

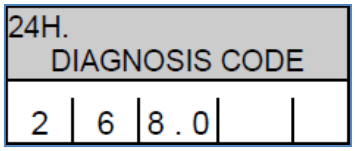
NOTE: Modifier values and their definitions can be found on the web page for this manual under Procedure Codes and Fee Schedule, which can be found at www.emedny.org in the applicable provider manual.

Diagnosis Code (Field 24H)

837P Ref: Loop 2400 SV107 (Diagnosis Pointers)

Enter an ICD-10-CM Diagnosis Code as shown in Exhibit 2.4.2-9.

Exhibit 2.4.2-9



Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

Enter the appropriate number of units.

Charges (Field 24J)

837P Ref: Loop 2400 SV102

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

Amount Charged

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

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

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

NOTES:

- ***The entries in field 23B, Payment Source Code, determine the entries in field's 24J, 24K, and 24L.***
- ***Field 24J must never be left blank or contain zeroes.***
- ***It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.***

Unlabeled (Field 24K)

837P Ref: No Map

This field is used to indicate the Medicare Paid Amount and must be completed if Box M in field 23B has an entry value of ***2*** or ***3***.

Box M=2

- When billing for the Medicare ***deductible***, enter 0.00.
- When billing for the Medicare ***coinsurance***, enter the Medicare Paid amount as the sum of the Medicare paid amount and the Medicare deductible, if any.

Box M=3

Enter 0.00 to indicate that Medicare denied payment or did not cover the service.

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

Unlabeled (Field 24L)

837P Ref: No Map

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

- When Box O has an entry value of ***2***,
  - If there is only one insurance carrier, enter the other insurance payment.
  - If more than one insurance carrier contributes to payment of the claim, enter the total amount paid by all other insurance carriers.
- When Box O has an entry value of ***3***,
  - Enter the amount the member paid.
  - If the member is covered by other insurance and the member made payment, enter the sum.

If the other insurance carrier denied payment, enter 0.00 in field 24L. Proof of denial of payment must be maintained in the member's billing record.

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

NOTES:

- ***It is the responsibility of the provider to determine whether the member's Other Insurance carrier covers the service being billed for, as Medicaid is always the payer of last resort.***
- ***Leave the last row of Fields 24H, 24J, 24K, and 24L blank.***

Consecutive Billing Section: Fields 24M to 24O

This section must be completed only by the following provided types:

- ***Midwife***
- ***Nurse Practitioner***
- ***Physician***
- ***Podiatry***

This section is used for block-billing consecutive daily visits within the ***SAME MONTH/YEAR*** made to a member in a hospital inpatient status.

Inpatient Hospital Visit [From/Through Dates] (Field 24M)

837P Ref: Loop 2400 DTP03 when DTP01 = 472

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

Proc Code [Procedure Code] (Field 24N)

837P Ref: Loop 2400 SV101-2

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

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

MOD [Modifier] (Field 24O)

837P Ref: Loop 2400 SV101-3, 4, 5, 6, and 7

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

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

Trailer Section: Fields 25 through 34

The information entered in the Trailer Section of the claim form (fields 25 through 34) must apply to all claim lines entered in the Procedure Section of the form.

Certification [Signature of Physician or Supplier] (Field 25)

837P Ref: Loop 2300 CLM06

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

Provider Identification Number (Field 25A)

837P Ref: Loop 2010AA NM109 OR Loop 2310B NM109

Enter the provider's 10-digit National Provider Identifier (NPI).

Medicaid Group Identification Number (Field 25B)

837P Ref: 837P Ref: Loop 2010AA NM109

For a Group Practice, enter the NPI assigned to the group.

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

Locator Code (Field 25C)

837P Ref: No Map

Enter the locator code assigned by NYS Medicaid 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 located at www.emedny.org by clicking on the link to the webpage as follows: Inquiry.

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

837P Ref: Loop 2300 REF03 when REF01 = 4N

If required, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix B - Code Sets.

NOTE: If the services being claimed has enhanced or special pricing, the value '7' must be entered.

General Policy. If not applicable leave this field blank.

County of Submittal (Unnumbered Field)

837P Ref: No Map

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

Date Signed (Field 25E)

837P Ref: No Map

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

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

Physician's or Supplier's Name, Address, Zip Code (Field 31)

837P Ref: Loop 2010AA NM1, N3, and N4

Enter the provider's name and correspondence address, using the 5 digit ZIP code or the ZIP plus four.

NOTE: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests please refer to Information for All Providers, Inquiry section which can be found at www.emedny.org by clicking on the link to the webpage as follows: General Inquiry.

Patient's Account Number (Field 32)

837P Ref: Loop 2300 CLM01

This field can accommodate up to 20 alphanumeric characters and will be returned on the Remittance Advice.

Other Referring/Ordering Provider ID/License Number (Field 33)

837P Ref: Loop 2310A NM109

Leave this field blank.

Prof CD [Profession Code – Other Referring/Ordering Provider] (Field 34)

Leave this field blank.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals (by category, status and member ID) and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

APPENDIX A
CODE SETS

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

Service Authorization Exception Codes

Code	Description
1	Immediate/Urgent Care
2	Services rendered in retroactive period
3	Emergency Care
4	Client has temporary Medicaid
5	Request from count for second opinion to determine if recipient can work
6	Request for override pending
7	Special Handling

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

Specialty Codes Exempted from Utilization Thresholds

Code	Description
020	Anesthesiology
150	Pediatrics
151	Pediatrics: Cardiology
152	Pediatrics: Hematology-Oncology
153	Pediatrics: Surgery
154	Pediatrics: Nephrology
155	Pediatrics: Neonatal-Perinatal Medicine
156	Pediatrics: Endocrinology
157	Pediatrics: Pulmonology
158	PPAC: Preferred Physicians and Children Program
159	Moms: Medicaid Obstetrical & Maternal Service Program
161	Pediatrics: Pediatric Critical Care
169	Moms: Health Supportive Services

186 T.B. Directly Observed Therapy/Physician

191 Child Psychology

192 Psychiatry

193 Child Neurology

195 Psychiatry and Neurology

196 Clozapine Case Manager

205 Therapeutic Radiology

247 Managed Care – Physician Enhanced Fee

249 HIV Primary Care Services

270 CHAP: Child Health Assurance Program

Sterilization Abortion Codes

Code	Description
A	Induced Abortion – Danger to the woman's life
B	Induced Abortion – Physical health damage to the woman
C	Induced Abortion—victim of rape or incest
D	Induced Abortion – Medically necessary
E	Induced Abortion – Elective (i.e., Not considered medically necessary by the attending physician. Provision of elective abortions is restricted to New York City members.
F	Procedure performed for the purpose of sterilization

APPENDIX B
STERILIZATION CONSENT FORM – LDSS-3134

A Sterilization Consent Form, LDSS-3134, must be completed for each sterilization procedure. A supply of these forms, available in English and in Spanish [LDSS-3134(S)], can be obtained from the NYS DOH website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

Claims for sterilization procedures must be submitted on paper, and a copy of the completed and signed Sterilization Consent Form, LDSS-3134 [or LDSS-3134(S)] must be attached to the claim.

When completing the LDSS-3134, please follow the guidelines below:

- An illegible or altered form is unacceptable and will cause a paper claim to deny
- Ensure that all five copies are legible.
- Each required field must be completed in order to ensure payment.
- If a woman is not Medicaid eligible at the time she signs the LDSS-3134 [or LDSS-3134(S)] form but becomes eligible prior to the procedure and is 21 years of age when the form was signed, the 30 day waiting period starts from the date the LDSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

LDSS-3134 (2/01)

STERILIZATION CONSENT FORM

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

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from 2. (doctor or clinic). When I asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a 3. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 4. (Month Day Year)

I, 5., hereby consent of my own free will to be sterilized by 6. (Doctor)

by a method called 7.. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

8. (Signature) Date: 9. (Month Day Year)

You are requested to supply the following information, but it is not required: 10.

Race and ethnicity designation (please check)

- ☐ 1 American Indian or Alaska Native
- ☐ 2 Asian or Pacific Islander
- ☐ 3 Black (not of Hispanic origin)
- ☐ 4 Hispanic
- ☐ 5 White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 11. language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

12. (Interpreter) (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

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

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

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

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

15. (Signature of person obtaining consent) (Date)

16. (Facility)

17. (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18. (Name of individual to be sterilized) on 19. (Date of sterilization)

19. (Operation), I explained to him/her the nature of the sterilization operation 20. (Specify type of operation), the fact that it is intended to be a final irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date sterilization was performed.

(2) This sterilization was preformed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable and fill in information requested):

21.
- ☐ 1. Premature delivery
  Individual's expected date of delivery: 22.
- ☐ 2. Emergency abdominal surgery: 23.

(describe circumstances): 23.

24. (Physician) 24. (Date)

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION

I, 25., do certify that on 26., I was present while the counselor read and explained the consent form to 27. (patient's name) and saw the patient sign the consent form in his/her handwriting.

SIGNATURE OF WITNESS	TITLE	DATE
x 28.	29.	30.

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE
x 31.	32.	x 33.	34.

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

STERILIZATION CONSENT FORM – LDSS-3134 AND 3134(S) INSTRUCTIONS

Patient Identification

Field 1

Enter the member's name, Medicaid ID number, and chart number.

The hospital or clinic name is optional.

Consent to Sterilization

Field 2

Enter the name of the individual doctor or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (24) cannot obtain the consent.

Field 3

Enter the name of sterilization procedure to be performed.

Field 4

Enter the member's date of birth. Check to see that the member is at least 21 years old. If the member is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

Field 5

Enter the member's name.

Field 6

Enter the name of the doctor expected to perform the sterilization. It is understood this may not be the doctor who eventually performs the sterilization (24).

Field 7

Enter the name of sterilization procedure.

Field 8

The member must sign the form.

Field 9

Enter the date of member's signature. This is the date on which the consent was obtained.

The sterilization procedure must be performed no less than 30 days, nor more than 180 days, from this date.

Exceptions to the 30 day rule include instances of premature delivery (22), or emergency abdominal surgery (23) when at least 72 hours (three days) must have elapsed.

Field 10

Completion of the race and ethnicity designation is optional.

Interpreter's Statement

Field 11

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

Field 12

The interpreter must sign and date the form.

Statement of Person Obtaining Consent

Field 13

Enter the member's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the member must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (24).

Field 16

Enter the name of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

Field 17

Enter the address of the facility.

Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

Field 18

Enter the member’s name.

Field 19

Enter the date the sterilization operation was performed.

Field 20

Enter the name of the sterilization procedure.

Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), cross out the second paragraph and sign (24) and date the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, complete the folowing fields:

Field 21

Select one of the check boxes as necessary.

Field 22

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one (21) and enter the expected date of delivery (22).

Field 23

If the member was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two (21) and describe the circumstances(23).

Field 24

The physician who performed the sterilization must sign and date the form.

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to the sterilization.

For Sterilizations Performed In New York City

New York City local law requires the presence of a witness chosen by the member when the member consents to sterilization. In addition, upon admission for sterilization, the member is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 25

Enter the name of the witness.

Field 26

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

Field 27

Enter the member's name.

Field 28

The witness must sign the form.

Field 29

Enter the title, if any, of the witness.

Field 30

Enter the date of witness's signature.

Reaffirmation

Field 31

The member must sign the form.

Field 32

Enter the date of the member's signature. This date should be shortly prior to or same as date of sterilization in field 19.

Field 33

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 28.

Field 34

Enter the date of witness's signature.

APPENDIX C
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113, must be completed for each hysterectomy procedure. A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

Claims for hysterectomy procedures must be submitted on paper forms, and a copy of the completed and signed LDSS-3113 must be attached to the claim.

When completing the LDSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable (will cause a paper claim to deny).
- Each required field must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

DSS-3113 (Rev. 4/84)

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
(NYS MEDICAID PROGRAM)

1. RECIPIENT ID NO.	2. SURGEON'S NAME

EITHER PART I OR PART II MUST BE COMPLETED

Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, 3. _____ (RECIPIENT NAME), that the hysterectomy to be performed on me will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

4. RECIPIENT OR REPRESENTATIVE SIGNATURE	5. DATE	6. INTERPRETER'S SIGNATURE (If required)	7. DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

8. SURGEON'S SIGNATURE	9. DATE
X	

Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on 10. _____ (RECIPIENT NAME) was solely for medical reasons. The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

11 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility)_____

_____

12 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

_____

_____

13 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

14. SURGEON'S SIGNATURE	15. DATE
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

Acknowledgement Receipt of Hysterectomy Information Form – LDSS-3113 Instructions

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

Field 1

Enter the recipient's Medicaid ID number.

Field 2

Enter the surgeon's name.

Part I: Recipient's Acknowledgement Statement and Surgeon's Certification

This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The member was not a Medicaid recipient on the day the hysterectomy was performed.

Field 3

Enter the recipient's name.

Field 4

The recipient or her representative must sign the form.

Field 5

Enter the date of signature.

Field 6

If applicable, the interpreter must sign the form.

Field 7

If applicable, enter the date of interpreter's signature.

Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

Field 9

Enter the date of the surgeon's signature.

Part II: Waiver of Acknowledgement

The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the recipient's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

Field 10

Enter the recipient's name.

Field 11

If the recipient's acknowledgment was ***not*** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 12

If the recipient's acknowledgment was ***not*** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 13

If the member's Acknowledgment was ***not*** obtained because she was not a Medicaid recipient at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

Field 14

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

Field 15

Enter the date of the surgeon's signature.