NEW YORK STATE
MEDICAID PROGRAM

DENTAL

BILLING GUIDELINES

TABLE OF CONTENTS

Section I – Purpose Statement

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

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

This document is customized for Dental providers and should be used by the provider as an instructional as well as a reference tool.

Section II – Claims Submission

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

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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis. You will be provided with renewal information when your Certification Statement is near expiration.

Pre-requirements for the Submission of Claims

Before submitting claims to NYS Medicaid, all providers need the following:

- An ETIN
- A Certification Statement

ETIN
This is a submitter identifier issued by the eMedNY Contractor. All providers are required to have an active ETIN on file with the eMedNY Contractor prior to the submission of claims. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

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

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

Electronic Claims

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

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

- **HIPAA 837D Implementation Guide (IG)** explains the proper use of the 837D standards and program specifications. This document is available at www.wpc-edi.com/hipaa.

- **NYS Medicaid 837D Companion Guide (CG)** is a subset of the IG that provides specific instructions on the NYS Medicaid requirements for the 837D transaction.

- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications.

These documents are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Pre-requirements for the Submission of Electronic Claims

In addition to an ETIN and a Certification Statement, providers need the following before submitting electronic claims to NYS Medicaid:

- A User ID and Password

- A Trading Partner Agreement

- Testing

User ID and Password
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a user ID varies depending on the communication method chosen by the provider. For example: An ePACES user ID is assigned systematically via email while an FTP user ID is assigned after the submission of a Security Packet B.

Trading Partner Agreement
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions.

The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Companion Guides and Sample Files

Communication Methods

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

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

ePACES

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

The requirements for using ePACES include:

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

The following transactions can be submitted via ePACES:

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

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

Self Help

eMedNY eXchange

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

The eMedNY eXchange only accepts HIPAA-compliant transactions.

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

FTP

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

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

Provider Enrollment Forms

CPU to CPU

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

eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B can be found at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

Paper Claims

Dental providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A). To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

Dental - Sample Claim

An 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 associated certification qualifies the provider to submit claims in both electronic and paper formats.

General Instructions for Completing Paper Claims

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

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

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0 must be closed.

- Avoid unfinished characters. For example:

Written As	Intended As	Interpreted As
6.0	6.00	6.60 → 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. For example:

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

- Characters should not touch each other. For example:

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

- Do not write in between lines.

- Do not use arrows or quotation marks to duplicate information.

- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.

- If entering information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.

- Do not submit claim forms with corrections (i.e. information written over correction fluid or crossed out information). If mistakes are made, a new form should be used.

- Separate forms using perforations; do not cut the edges.

- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

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

Claim Form A-eMedNY-000201

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

Dental - Sample Claim

General Information About the eMedNY-000201

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

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

		0	2	3	4	5	6	7	8

Billing Instructions for Dental Services

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

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

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

Header Section: Fields 1 through 24B

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

PROVIDER ID NUMBER (Field 1)

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

Enter the provider's ID number and address, using the following rules for submitting the ZIP code.

- **Paper claim submissions:** Enter the 5 digit ZIP code or the ZIP plus four.
- **Electronic claim submissions:** Enter the 9 digit ZIP code.

Note: The planned National Provider Identifier (NPI) implementation date is September 1, 2008. Until NYS Medicaid accepts and processes claims using the National Provider ID/NPI, providers must continue to report their assigned NYS Medicaid Provider ID number. Providers can check www.emedny.org for up-to-date information as the implementation date approaches.

BILLING DATE (Field 2)

Leave this field blank.

GROUP ID NUMBER (Field 3)

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

For a **Group Practice**, enter the Group ID number in this field. A claim should be submitted under the Group ID **only** if payment for the service(s) being claimed is to be made to the group. In such a case, the Medicaid Provider ID number of the group member that rendered the service must be entered in Field 1.

For a **Shared Health Facility**, enter in this field the eight-digit identification number that was assigned to the facility by the New York State Department of Health at the time of enrollment in the Medicaid program. If the provider or the service(s) rendered is not associated with a Group Practice or a Shared Health Facility, leave this field blank.

Note: The planned National Provider Identifier (NPI) implementation date is September 1, 2008. Until NYS Medicaid accepts and processes claims using the National Provider ID/NPI, providers must continue to report their assigned NYS Medicaid Provider ID number. Providers can check www.emedny.org for up-to-date information as the implementation date approaches.

Dental Schools and Orthodontic Clinics
Leave this field blank.

LOCATOR CODE (Field 4)

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

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

Notes:

- **Until NPI implementation by NYS Medicaid, the Locator Code field must be completed on both 837D electronic transactions and on paper claim submissions. After NPI implementation, the Locator Code field is only required for paper claim submissions.**

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

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

For Dental Clinic Claims Only
If it was necessary to provide a service covered under the Utilization Threshold (UT) program and Service Authorization (SA) could not be obtained, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix A - Code Sets.

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

If not applicable, leave this field blank.

Fields 6 and 6A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.

ADJUSTMENT/VOID CODE (Field 6)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

- If submitting an **adjustment** (replacement) to a previously paid claim, enter **X** or the value **7** in the A box.

- If submitting a **void** to a previously paid claim, enter **X** or the value **8** in the V box.

ORIGINAL CLAIM REFERENCE NUMBER (Field 6A)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

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

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

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

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

Adjustment to Change Information

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

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

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

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

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

Example:

TCN 0709819876543200 is shared by three individual claim lines. This TCN was paid on April 18, 2007. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Refer to Figures 1A and 1B for an illustration of this example.

Figure 1A: Original Claim Form
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

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

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

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

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

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11							
		22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY ▶	24A. SIGNATURE	24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D3220			01						87.00					
	04	04	07	D2933			02						130.00					
	04	04	07	D3351			04						67.00					

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

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

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

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

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

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

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

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

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

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1							
		22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY ▶	24A. SIGNATURE	24B. DIAGNOSIS

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 7	D 3 2 2 0			0 1						8 7.0 0					
	0 4	0 4	0 7	D 2 9 3 3			0 2						1 3 0.0 0					
	0 4	0 1	0 7	D 3 3 5 1			0 4						8 7.0 0					
	33. CASE MGR			TOTALS									34.	35.	35A.	35B.	35C.	36.

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[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

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

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

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

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

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

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

Example:

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

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

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

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Anytown, New York 11111-1111

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

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

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11							
		22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	22A. PROF CD	22B. NAME	24.SHARED HEALTH FACILITY ONLY ▶	24A. SIGNATURE	24B. DIAGNOSIS
							.

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D3220			01						87.00					
	04	04	07	D2933			02						130.00					
	04	04	07	D3351			04						67.00					
	33. CASE MGR			TOTALS									34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

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

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

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Figure 2B: Adjustment
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER	2. BILLING DATE MO	DAY	YR	3. GROUP ID NUMBER	4. LOCATOR CODE	5. SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE	6A. ORIGINAL CLAIM REFERENCE NUMBER
01234567					003		7 A V	07098187654321000

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Anytown, New York 11111-1111

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

9A. RECIPIENT NAME – LAST
Smith

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

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
11							

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

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D2933			02						130.00	.	.	.	.	.
	04	04	07	D3351			04						67.00	.	.	.	.	.
													.	.	.	.	.	.
													.	.	.	.	.	.
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				33. CASE MGR			TOTALS						34. .	35. .	35A. .	35B. .	35C. .	36. .

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

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

Void

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

When submitting a void, please follow the instructions below:

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

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

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

Example:

TCN 0709811234567800 contained two claim lines, which were paid on April 18, 2007. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

Figure 3A: Original Claim Form
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

2. BILLING DATE: MO | DAY | YR
3. GROUP ID NUMBER:
4. LOCATOR CODE: 003
5. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A V
6A. ORIGINAL CLAIM REFERENCE NUMBER:

7. RECIPIENT ID NUMBER: AB123456C
8. DATE OF BIRTH: 05/20/1990
8A. SEX: M F X
9. RECIPIENT NAME – FIRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB123456
11. OFFICE USE ONLY

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

PLACE OF SERVICE
20. CODE: 11
20A. ADDRESS:
21. SERVICE PROVIDER ID/LICENSE NUMBER:
21A. PROF CD:
21B. NAME:
22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:
22A. PROF CD:
22B. NAME:
23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER:
23A. PROF CD:
23B. NAME:
24.SHARED HEALTH FACILITY ONLY ▶
24A. SIGNATURE:
24B. DIAGNOSIS:

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	04	04	07	D3220			01						87.00					
	04	04	07	D2933			02						130.00					
	33. CASE MGR			TOTALS									34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

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

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

Version 2008 – 4 (11/11/08)

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

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

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

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

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

PLACE OF SERVICE 20. CODE	20A. ADDRESS	21. SERVICE PROVIDER ID/LICENSE NUMBER	21A. PROF CD	21B. NAME	23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER	23A. PROF CD	23B. NAME
1 1							

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

	25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	I/O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID	32. OTHER INSURANCE PAID
	0 4	0 4	0 7	D 3 2 2 0			0 1						8 7.0 0					
	0 4	0 4	0 7	D 2 9 3 3			0 2						1 3 0.0 0					

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

DO NOT STAPLE IN BARCODE AREA

[redacted]

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

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		06	05	07

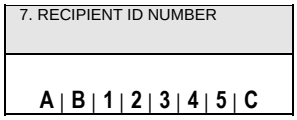
***Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.**

Fields 7-9A require information obtained from the Client's (Recipient's) Medicaid Common Benefit Identification Card.

RECIPIENT ID NUMBER (Field 7)

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

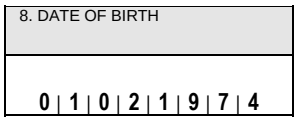
Example:



DATE OF BIRTH (Field 8)

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

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



SEX (Field 8A)

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

RECIPIENT NAME (Fields 9 and 9A)

Enter the patient's first name in Field 9 and the last name in Field 9A.

OFFICE ACCOUNT NUMBER (OPTIONAL) (Field 10)

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

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

Leave this field blank.

EMERGENCY (Field 13)

Enter an X in the Yes box only when the condition being treated is related to an emergency (the patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling condition); otherwise leave this field blank.

POSSIBLE DISABILITY (Field 13A)

Leave this field blank.

FAMILY PLANNING (Field 13B)

Leave this field blank.

ACCIDENT CODE (Field 14)

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

PATIENT STATUS CODE (Field 15)

Leave this field blank.

EPSDT C/THP CODE (Field 16)

Leave this field blank.

RECIPIENT OTHER INSURANCE CODE (Field 17)

Leave this field blank.

ABORTION/STERILIZATION CODE (Field 18)

Leave this field blank.

PRIOR APPROVAL NUMBER (Field 19)

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

Notes:

- **For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section on the web page for this manual.**

- **For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual.**

- **For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual.**

PLACE OF SERVICE CODE (Field 20)

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

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

PLACE OF SERVICE ADDRESS (Field 20A)

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

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

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

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

Dental Practitioners
Leave this field blank.

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

Note: The planned NPI implementation date is September 1, 2008. Until NYS Medicaid accepts and processes claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers can check www.emedny.org for up-to-date information as the implementation date approaches.

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

Orthodontic Clinics and Dental Schools
If a license number is indicated in Field 21, the Profession Code that identifies the service provider's profession must be entered in this field. Profession Codes are available at www.emedny.org by clicking on the link to the web page below:

eMedNY Crosswalks

Dental Practitioners
Leave this field blank.

NAME [Service Provider] (Field 21B)

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

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

Leave this field blank.

PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

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

Leave this field blank.

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

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

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

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

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

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

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

eMedNY Crosswalks

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

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

SHARED HEALTH FACILITY ONLY (Field 24A)

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

Encounter Section: Fields 25 through 32

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

DATE OF SERVICE (Field 25)

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

Example: July 1, 2007 = 07/01/07

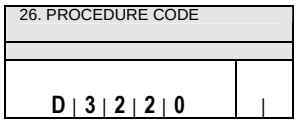
Orthodontists and Orthodontic Clinics
Enter only the last date of service in the quarter for which you are billing.

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

PROCEDURE CODE (Field 26)

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

Example:



Note: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:

Dental Manual

TIMES PERFORMED (Field 27)

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

ORAL CAVITY (Field 28)

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

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

Dental Manual

TOOTH CODE (Field 29)

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

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

Dental Manual

Notes:

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

SURFACE (Field 29A)

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

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

Dental Manual

AMOUNT CHARGED (Field 30)

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

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

Notes:

- **It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.**

- **If the provider knows that the service rendered is not covered by Medicare, enter zero in field 31C.**

MEDICARE CO-INSURANCE (Field 31)

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

MEDICARE DEDUCTIBLE (Field 31A)

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

MEDICARE CO-PAY (Field 31B)

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

MEDICARE PAID (Field 31C)

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

OTHER INSURANCE PAID (Field 32)

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

Note: It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.

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

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

- Prior to billing the insurance company, the provider knows that the service will not be covered because:

  - ► The provider has had a previous denial of payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.

  - ► In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for the same type of service. This communication should be documented in the patient's billing record.

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

  - ► The service is not covered; or

  - ► The deductible has not been met.

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

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

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

Certification Section: Fields 37 through 38

SIGNATURE (Field 37)

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

COUNTY (Field 37A)

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, entered in Field 1, is within the county wherein the claim form is signed.

DATE (Field 38)

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

Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section on the web page for this manual.

Section III – Remittance Advice

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

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

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

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

Remittance advices are available in electronic and paper formats.

Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers may complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

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

eMedNY Companion Guides and Sample Files

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

Note: Providers with only one ETIN who elect to receive an electronic remittance will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.

Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

Remittance Sorts

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

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

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

To request a sort pattern other than the default, providers must complete the Paper Remittance Sort Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

Provider Enrollment Forms

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

Remittance Advice Format

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

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

Explanation of Remittance Advice Sections

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

The information displayed in the remittance advice samples is for illustration purposes only. The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: JAMES STRONG, DDS

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

00112233/0123456789 2007-08-06
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO
2007-08-06 VOID AFTER 90 DAYS	07080600006	0123456789

PAY

DOLLARS/CENTS
$*****143.80

TO THE ORDER OF
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

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

Check Stub Information

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date
Provider's name/Address

Medicaid Check

LEFT SIDE
Table
Date on which the check was issued
Remittance number
*Provider ID No.: This field will contain the NPI **or** the Medicaid Provider ID (if applicable)

Provider's name/Address

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

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

Section One – EFT Notification

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

TO: JAMES STRONG, DDS

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

00112233/0123456789 2007-08-06
JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

JAMES STRONG, DDS $143.80

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

Information on the EFT Notification Page

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

CENTER
*Medicaid Provider ID/NPI/Date: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Provider's name/Address

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

Section One – Summout (No Payment)

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

TO: JAMES STRONG, DDS

MEDICAID MANAGEMENT INFORMATION SYSTEM

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

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

JAMES STRONG, DDS
312 MAIN STREET
ANYTOWN NY 11111

Information on the Summout Page

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 01
DATE 08/06/07
CYCLE 1563

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

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

REMITTANCE ADVICE MESSAGE TEXT

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

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

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

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

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

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

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

Information on the Provider Notification Page

UPPER LEFT CORNER
Provider's name and address

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

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Remittance number

CENTER
Message text

Section Three – Claim Detail

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 02
DATE 08/06/2007
CYCLE 1563

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

ETIN:
DENTAL
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP343444	DAVIS	UU44444R	07206-000000227-0-0	07/11/07	D0120	1.000	52.80	0.00	DENY	00162 00244
01	CP443544	BROWN	PP88888M	07206-000011334-0-0	07/11/07	D0272	1.000	17.60	0.00	DENY	00244
01	CP766578	MALONE	SS99999L	07206-000013556-0-0	07/19/07	D1204	1.000	14.30	0.00	DENY	00162
01	CP999890	SMITH	ZZ22222T	07206-000032456-0-0	07/20/07	D0290	1.000	77.50	0.00	DENY	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
DENTAL
PROV ID: 00112233/0123456879
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP112346	DAVIS	UU44444R	07206-000033667-0-0	07/11/07	D1203	1.000	14.30	14.30	PAID	
02	CP112345	DAVIS	UU44444R	07206-000033667-0-0	07/12/07	D1204	1.000	14.30	14.30	PAID	
01	CP113433	CRUZ	LL11111B	07206-000045667-0-0	07/14/07	D0320	1.000	52.80	52.80	PAID	
01	CP445677	JONES	YY33333S	07206-000056767-0-0	07/15/07	D3220	1.000	66.00	66.00	PAID	
01	CP113487	WAGER	ZZ98765R	07206-000067767-0-0	06/05/07	D0272	1.000	17.60	17.60-	ADJT	ORIGINAL CLAIM PAID 06/24/07
01	CP744495	PARKER	VZ45678P	07206-000088767-0-0	06/05/07	D1204	1.000	14.30	14.00	ADJT	

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 08/06/2007
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
DENTAL
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

LN. NO	OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID NUMBER	TCN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01	CP8765432	CRUZ	LL11111B	07206-000033467-0-0	07/13/07	D3220	1.000	69.30	0.00	**PEND	00162
02	CP4555557	CRUZ	LL11111B	07206-000033468-0-0	07/14/07	D7450	1.000	71.04	0.00	**PEND	00162
01	CP8876543	TAYLOR	GG43210D	07206-000035665-0-0	07/14/07	D1204	1.000	14.30	0.00	**PEND	00142
01	CP0009765	ESPOSITO	FF98765C	07206-000033660-0-0	07/12/07	D1204	1.000	14.30	0.00	**PEND	00131

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	168.94	NUMBER OF CLAIMS	4
NET AMOUNT ADJUSTMENTS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PEND	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0
REMITTANCE TOTALS – DENTAL				
VOIDS – ADJUSTS		3.60-	NUMBER OF CLAIMS	1
TOTAL PENDS		168.94	NUMBER OF CLAIMS	4
TOTAL PAID		147.40	NUMBER OF CLAIMS	4
TOTAL DENIED		162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS	5
MEMBER ID: 00112233				
VOIDS – ADJUSTS		3.60-	NUMBER OF CLAIMS	1
TOTAL PENDS		168.94	NUMBER OF CLAIMS	4
TOTAL PAID		147.40	NUMBER OF CLAIMS	4
TOTAL DENIED		162.20	NUMBER OF CLAIMS	4
NET TOTAL PAID		143.80	NUMBER OF CLAIMS	5

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
DENTAL
GRAND TOTALS

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

PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

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

General Information on the Claim Detail Pages

UPPER LEFT CORNER
Provider's name and address

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

ETIN (not applicable)
Provider Service Classification: **DENTAL**
*PROV ID: This field will contain the Medicaid Provider ID and the NPI (if applicable)
Remittance number

Explanation of the Claim Detail Columns

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

Financial Transactions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 07
DATE 08/06/07
CYCLE 1563

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

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

ETIN:
FINANCIAL TRANSACTIONS
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200705060236547	XXX	RECOUPMENT REASON DESCRIPTION	05 09 07	$$.$$

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

Explanation of the Financial Transactions Columns

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

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

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

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

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

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

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

Accounts Receivable

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

PAGE 08
DATE 08/06/07
CYCLE 1563

MEDICAID MANAGEMENT INFORMATION SYSTEM

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

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROV ID: 00112233/0123456789
REMITTANCE NO: 07080600006

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

TOTAL AMOUNT DUE THE STATE $XXX.XX

Explanation of the Accounts Receivable Columns

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

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

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

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

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

Total Amount Due the State
This amount is the sum of all the **Current Balances** listed above.

Section Five – Edit Descriptions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE 06
DATE 08/06/07
CYCLE 1563

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

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

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

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

Appendix A – Code Sets

Accident Codes

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

Oral Cavity Designations

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

Place of Service Codes

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

SA 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 county for second opinion to determine if recipient can work
6	Request for override pending
7	Special handling

Tooth Codes

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

Tooth Codes (cont.)

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

Tooth Codes (cont.)

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

Surface Codes

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

United States Standard Postal Abbreviations

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

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

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