NEW YORK STATE
MEDICAID PROGRAM

INPATIENT HOSPITAL

BILLING GUIDELINES

TABLE OF CONTENTS

Section I - Purpose Statement 2

Section II – Claims Submission 3
Electronic Claims 3

Section III – Remittance Advice 8
Electronic Remittance Advice 8
Paper Remittance Advice 9

Appendix A – Sterilization Consent Form – DSS-3134 32

Appendix B – Acknowledgment of Receipt of Hysterectomy Information Form – DSS-3113 39

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 Inpatient Hospital providers and should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II – Claims Submission

Inpatient Hospital providers can only submit their claims to NYS Medicaid in electronic format.

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.

Inpatient Hospital providers are required to use the HIPAA 837 Institutional (837I) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements.

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

- NYS Medicaid 837I Companion Guide (CG) – A subset of the IG, which provides instructions for the specific requirements of NYS Medicaid for the 837I. This document is available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Phase II HIPAA Transactions**

  ✓ Look for the box labeled "837 Institutional Health Care Claim Transaction" and click on 837 **Institutional Companion Guide PHASE II**

- NYS Medicaid Technical Supplementary Companion Guide – This document 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. The Technical Supplementary CG is available at www.emedny.org.

  ✓ Select **NYHIPAADESK** from the menu

  ✓ Click on **eMedNY Phase II HIPAA Transactions**

  ✓ Look for the box labeled "Technical Guides" and click on the link **TECHNICAL SUPPLEMENTARY Companion Guide**

Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and password
- A Trading Partner Agreement
- Testing

ETIN

This is a four-character submitter identifier, issued by the NYS Medicaid Fiscal Agent, Computer Sciences Corporation (CSC), upon application and must be used in every electronic transaction submitted to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

ETIN applications are available at www.emedny.org.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **Electronic Transmitter Identification Number**

Certification Statement

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

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

The Certification Statement is available at www.emedny.org together with the ETIN application.

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.

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.

- ✓ Select **NYHIPAADESK** from the Menu
- ✓ Click on **Registration Information Trading Partner Resources**
- ✓ Click on **Trading Partner Agreement**

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.

- ✓ Click on **eMedNY Phase II**
- ✓ Click on **eMedNY Provider Testing User Guide**

Communication Methods

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

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

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** www.emedny.org.

Access to the eMedNY eXchange is obtained through an enrollment process. Procedures and instructions regarding how to enroll in the eMedNY eXchange are available at www.emedny.org.

Under **Information**:

- ✓ Click on **eMedNY Phase II**
- ✓ Click on **eMedNY Provider Testing User Guide**
- ✓ On the Table of Contents, click on **Overview**
- ✓ Scroll down to **Access Methods**

FTP
FTP allows for direct or dial-up connection.

CPU to CPU (FTP)
This method consists of an established direct connection between the submitter and the processor and it is most suitable for high volume submitters.

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.

Note: For questions regarding FTP, CPU to CPU or eMedNY Gateway connections, call CSC-Provider Enrollment Support at 800-343-9000.

ePACES

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

To take advantage of ePACES, providers need to follow an enrollment process, which is available at www.emedny.org. Providers who enroll in ePACES will be automatically enrolled in eMedNY eXchange.

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 (except for DVS transactions)
- 837 - Dental, Professional, and Institutional Claims

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, locator code 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 Fiscal Agent 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 must complete the HIPAA 835 Transaction Request form, which is available at www.emedny.org.

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **HIPAA 835 Transaction Request Form**

For additional information, providers may also call CSC-Provider Enrollment Support at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org.

Under the **News and Resources** tab:

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Phase II HIPAA Transaction**
- ✓ Look for the box labeled "835 Health Care Claim Payment Advice Transaction"

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

Providers who choose to receive the 835 electronic remittance advice will receive adjudicated claims (paid/denied) detail for their electronic and paper claim submissions in this format. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transactions for any processing cycle that produces pends.

Paper Remittance Advice

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

Remittance Sorts

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

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

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

To request a sort pattern other than the default, providers must complete the Remittance Sort Request form, available at www.emedny.org

Under **Information**:

✓ Click on **Provider Enrollment Forms**

✓ Click on **Paper Remittance Sort Request**

For additional information, providers may also call CSC-Provider Enrollment Support 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 Inpatient Hospital services followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only.

The following information applies to a remittance advice with the default sort pattern.

Section One – Medicaid Check

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

TO: DOWNTOWN HOSPITAL

DATE: 2005-08-01
REMITTANCE NO: 05080100001
PROVIDER ID: 00234567

05080100001 2005-08-01
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN NY 11111

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

29
2

DATE	REMITTANCE NUMBER	PROVIDER ID NO.
2005-08-01 VOID AFTER 90 DAYS	05080100001	00234567

PAY

DOLLARS/CENTS
$****12000.00

TO THE ORDER OF

05080100001 2005-08-01
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN NY 11111

John

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

Check Stub Information

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID number

CENTER
Remittance number/date
Provider's name/address

Medicaid Check

LEFT SIDE
Table
- Date on which the check was issued
- Remittance number
- Provider ID number

Remittance number/date
Provider's name/address

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

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: DOWNTOWN HOSPITAL

DATE: 08-01-2005
REMITTANCE NO: 05080100001
PROVIDER ID: 00234567

05080100001 08-01-2005
DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN NY 11111

DOWNTOWN HOSPITAL $12000.00

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

Information on the EFT Notification Page

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID number

CENTER
Remittance number/date
Provider's name/address

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

Section One – Summout (No Payment)

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

TO: DOWNTOWN HOSPITAL

DATE: 08/01/2005
REMITTANCE NO: 05080100001
PROVIDER ID: 00234567

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

DOWNTOWN HOSPITAL
123 FIRST ST
ANYTOWN NY 11111

Information on the Summout Page

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

UPPER RIGHT CORNER
Date on which the remittance advice was issued
Remittance number
Provider ID number

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

Section Two – Provider Notification

This section is used to communicate important messages to providers.

PAGE 01
DATE 08/01/05
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID 00234567
REMITTANCE NO 05080100001

REMITTANCE ADVICE MESSAGE TEXT

CSC'S OFFICES WILL BE CLOSED ON MONDAY, SEPTEMBER 5, 2005 IN OBSERVANCE OF LABOR DAY.

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: **PROVIDDER NOTIFICATION**
Provider ID number
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 denied during the specific cycle. This section may also contain claims that pended previously.

PAGE 02
DATE 08/01/05
CYCLE 1458

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
INPATIENT
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001
LOCATOR CD: 003

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC1008432	SMITH	04230-000000315-2-0	05/25/05	0	0	0	4000.00	25.00	0.00	DENY	00805
05/25/05	ZZ22222T	000000585555IH03	05/29/05	2946	C	0122			0.00		00806
											00848
CPIC1088777	TAYLOR	04231-000000441-2-0	05/25/05	0	0	0	4000.00	25.00	0.00	DENY	00162
05/25/05	AB12345C	000000586555IH03	05/30/05	2946	C	0195			0.00		
CPIC1005432	BOWN	04245-000000049-2-0	05/27/05	0	0	0	4000.00	0.00	0.00	DENY	00848
05/27/05	FF33333T	000000587672IH03	05/30/05	2946	C	0127			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	DENIED	12000.00	NUMBER OF CLAIMS	3
NET AMOUT 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

PAGE 03
DATE 08/01/05
CYCLE 1458

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
INPATIENT
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001
LOCATOR CD: 003

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE / PAID	STATUS	ERRORS
CPIC1563324	WAYTKUS	04230-000000315-2-0	05/25/05	2	0	0	4000.00	25.00	0.00	PAID	
05/25/05	SS44444P	000000587672IH03	05/27/05	2946	C	0311			4000.00		
CPIC1768935	GOUGH	04231-000000441-2-0	05/25/05	5	0	0	4000.00	25.00	0.00	PAID	
05/25/05	GG44444L	000000587672IH03	05/30/05	2946	C	0079			4000.00		
CPIC1667792	ABRAHAM	04245-000000049-2-0	05/25/05	5	0	0	4000.00	0.00	0.00	PAID	
05/25/05	BB88888S	000000587672IH03	05/30/05	2946	C	0140			4000.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PAID	12000.00	NUMBER OF CLAIMS	3
NET AMOUT ADJUSTMENTS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS	PAID	0.00	NUMBER OF CLAIMS	0
NET AMOUNT VOIDS – ADJUSTS		0.00	NUMBER OF CLAIMS	0

PAGE 04
DATE 08/01/05
CYCLE 1458

ETIN:
INPATIENT
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001
LOCATOR CD: 003

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PATIENT CONTROL NO / DATE	CLIENT NAME / ID NUMBER	TCN / MEDICAL RECORD NUMBER	SERVICE DATES FROM / THRU	COV'D DAYS / RATE CODE	OUT DAYS / PAY TYPE	TOT DAYS / DRG CODE	COVERAGE BASE	CO-PAY	OTHER INSURANCE PAID	STATUS	ERRORS
CPIC156565633	PROUST	04230-000000315-2-0	05/25/05	0	0	0	4000.00	25.00	0.00	PEND	00162
05/25/05	XX99999V	000000587672IH03	05/26/05	2959	C	0122			0.00		
CPIC196969685	WELBY	04231-000000441-2-0	05/25/05	0	0	0	4000.00	25.00	0.00	PEND	00142
05/25/05	KK99999N	000000587672IH03	05/30/05	2959	C	0088			0.00		
CPIC183211677	SHEEHAN	04245-000000049-2-0	05/25/05	0	0	0	4000.00	0.00	0.00	PEND	00144
05/25/05	WW66666G	000000587672IH03	05/30/05	2959	C	0296			0.00		

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

TOTAL AMOUNT ORIGINAL CLAIMS	PEND	12000.00	NUMBER OF CLAIMS	3
NET AMOUT 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

LOCATOR 003 TOTALS – INPATIENT

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

REMITTANCE TOTALS – INPATIENT

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

MEMBER ID: 00234567

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE: 05
DATE: 08/01/05
CYCLE: 1458

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
GRAND TOTALS
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001

REMITTANCE TOTALS – GRAND TOTALS

VOIDS – ADJUSTS	0.00	NUMBER OF CLAIMS	0
TOTAL PENDS	12000.00	NUMBER OF CLAIMS	3
TOTAL PAID	12000.00	NUMBER OF CLAIMS	3
TOTAL DENY	12000.00	NUMBER OF CLAIMS	3
NET TOTAL PAID	12000.00	NUMBER OF CLAIMS	3

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 CSC with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **INPATIENT**
Provider ID number
Remittance number
Locator Code (providers who have more than one locator code will receive separate Claim Detail sections for each locator code)

Explanation of the Claim Detail Columns

PATIENT CONTROL NUMBER/DATE
This column indicates the Patient Control Number assigned to the patient by the hospital at the time of admission (first line) and the admission date (second line).

CLIENT NAME/ID NUMBER
This column indicates the last name of the patient (first line) and the Medicaid Client ID (second line). 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 in this column.

TCN/MEDICAL RECORD NUMBER
The TCN (first line) is a unique identifier assigned to each claim.

The Medical Record Number will be indicated below the TCN in this column.

SERVICE DATES – FROM/THROUGH
The first date of service covered by the claim (From date) appears on the first line; the last date of service (Through date) appears on the second line.

COV'D (COVERED) DAYS/RATE CODE
The number of full covered days (first line) and the four-digit rate code (second line) that were entered in the claim appear under this column.

OUT DAYS/PAY TYPE
This column will show the number of outlier days, if any, and the type of payment (code) generated by the claim.

TOT (TOTAL) DAYS/DRG CODE
The first line under this column indicates the number of days for which the DRG payment was made. The DRG code assigned to the claim based on pertinent data submitted on the claim will appear below the Total Days.

COVERAGE BASE
For non-DRG hospitals, the coverage base is obtained by multiplying the hospital's rate by the number of covered days.

For DRG hospitals, this column indicates the gross DRG calculation prior to other coverage and other payments.

CO-PAY
The co-pay amount for which the patient is responsible and that is deducted from the claim payment appears in this column.

OTHER INSURANCE/PAID
If applicable, the amount paid by any third party insurance other than Medicare appears on the first line of this column. The second line indicates the amount paid by Medicaid for the specific claim.

STATUS
This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of each 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, or 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 and that 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 a separate page of the remittance advice, at the end of the claim detail section.

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 **service classification/locator code** combination are provided at the end of the claim detail listing for each service classification/locator code combination. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (for the specific combination)

Totals by **service classification** and by **member ID** are provided next to the subtotals for service classification/locator code. These totals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (for the specific service classification)

Grand Totals for the entire provider remittance advice, which include all the provider's service classifications, appear on a separate page following the page containing the **totals** by **service classification.** 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 08/01/05
CYCLE 1458

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001

FCN	FINANCIAL REASON CODE	FISCAL TRANS TYPE	DATE	AMOUNT
200505060236547	XXX	RECOUPMENT REASON DESCRIPTION	08 01 05	$$.$$

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 08/01/05
CYCLE 1458

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001

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 natures (for example, the result of adjustments/voids; the result of retro-adjustments, etc.) or negative balances created at different times, each negative balance will be listed on 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. The codes are listed in ascending numeric order.

PAGE 06
DATE 08/01/05
CYCLE 1458

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

TO: DOWNTOWN HOSPITAL
BUSINESS OFFICE
123 FIRST STREET
ANYTOWN, NEW YORK 11111

ETIN:
INPATIENT
EDIT DESCRIPTIONS
PROVIDER ID: 00234567
REMITTANCE NO: 05080100001

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

00142 RECIPIENT YOB NOT EQUAL TO FILE
00144 RECIPIENT SEX NOT EQUAL TO FILE
00162 RECIPIENT INELIGIBLE ON DATE OF SERVICE
00805 MEDICARE CO-INS / LTR DAYS PRESENT–TOTAL MDCR DAYS BLANK
00806 CO-INSURANCE AND LTR DAYS GREATER THAN PART-A DAYS
00848 THIRD PARTY DAYS NOT EQUAL TO BILLING PERIOD

Appendix A – Sterilization Consent Form – DSS-3134

A Sterilization Consent Form, DSS-3134, must be completed for each sterilization procedure. **No other form can be used in place of the DSS-3134.** A supply of these forms, available in English and in Spanish [DSS-3134(S)], can be obtained from:

New York State Department of Health
Corning Tower - Room 2029
Empire State Plaza
Albany, New York 12237

For electronic claim submissions, the completed and signed DSS-3134 [or DSS-31234(S)] must be kept in the patient's file. If upon audit and examination, it is found that the consent form is not present or is defective, the Department will recoup any and all payments associated with the sterilization procedure.

When completing the DSS-3134, 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. Also, the persons completing the form should check to see that all five copies are legible.

- Each required field or blank must be completed in order to ensure payment.

- If a woman is not currently Medicaid eligible at the time she signs the DSS-3134 [or 3134(S)] form but becomes eligible prior to the procedure and if she is 21 years of age when the form was signed, the 30 day waiting period starts from the date the DSS 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.

DSS-3134 **(Rev.5/82)**

STERILIZATION
CONSENT FORM

PATIENT NAME 1.	CHART NO.	RECIPIENT ID NO.
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 first 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 known 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 the Department but only for determining if Federal laws were observed.
I have received a copy of this form.

____8.____ *Date:*____9.____
Signature *Month Day Year*

10. You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

- ☐1 American Indian or Alaska Native
- ☐2 Asian or Pacific Islander
- ☐3 Blank (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

____16.____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ____17.____ on____18.____
Name of individual to be sterilized *Date of sterilization*
____18. (Con't)____, I explained to him/her the nature of the *operation* sterilization operation____19.____, The fact that
specify type of operation
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 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 appeared to understand the nature and consequences of the pro- cedure.

(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 the sterilization was performed.

(2) This sterilization was performed 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 box and fill in information requested):

☐ 1 Premature delivery 20.
22. Individual's expected date of delivery:____21.____
☐ 2 Emergency abdominal surgery:____23.____
(describe circumstances):____23.(Con't)____

____24.____
Physician
*Date*____25.____

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

I,____26.____do certify that on ____27.____, 19___ I was present while the counselor read and explained the consent form to____28.____ (patient's name) and saw the patient sign the consent form in his/her own handwriting.

SIGNATURE OF WITNESS	TITLE	DATE
X 29.	30.	31.

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 32.	33.	**X** 34.	35.

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

Field-by-Field Instructions for Completing the Sterilization Consent Form – DSS-3134 and 3134(S)

Patient Identification

Field 1

Enter the patient's name, Medicaid ID number, and chart number; name of hospital or clinic is optional.

Consent To Sterilization

Field 2

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

Field 5

Enter the patient's name.

Field 6

Enter the name of doctor who will probably perform the sterilization. It is understood that this might not be the doctor who eventually performs the sterilization (24).

Field 7

Enter the name of sterilization procedure.

Field 8

The patient must sign the form.

Field 9

Enter the date of patient'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, except in instances of premature delivery (20, 21), or emergency abdominal surgery (22, 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 patient's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the patient 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 and address 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.

Physician's Statement

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

Field 17

Enter the patient's name.

Field 18

Enter the date the sterilization procedure was performed.

Field 19

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), then cross out the second paragraph and sign (24) and date (25) 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, proceed as follows:

Field 20

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 and (21) enter the expected date of delivery.

Field 21

If the patient 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 and (23) describe the circumstances.

Field 24

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

Field 25

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 patient when the patient consents to sterilization. In addition, upon admission for sterilization, in New York City, the patient is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 26

Enter the name of the witness to the consent to sterilization.

Field 27

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

Field 28

Enter the patient's name.

Field 29

The witness must sign the form.

Field 30

Enter the title, if any, of the witness.

Field 31

Enter the date of witness's signature.

Reaffirmation

Field 32

The patient must sign the form.

Field 33

Enter the date of the patient's signature. This date should be shortly prior to or same as date of sterilization in field 18.

Field 34

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 29.

Field 35

Enter the date of witness's signature.

Appendix B – Acknowledgment of Receipt of Hysterectomy Information Form – DSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, DSS-3113, must be completed for each hysterectomy procedure. **No other form can be used in place of the DSS-3113.** A supply of these forms, available in English and in Spanish, can be obtained from:

New York State Department of Health
Corning Tower - Room 2029
Empire State Plaza
Albany, New York 12237

For electronic claim submissions, the completed and signed DSS-3113 must be kept in the patient's file. If upon audit and examination, it is found that the acknowledgment of hysterectomy form is not present or is defective, the Department will recoup any and all payments associated with the hysterectomy procedure.

When completing the DSS-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.
- Each required field or blank 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)

EITHER PART I OR PART II MUST BE COMPLETED

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

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

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, 3._______________________, that the hysterectomy to be performed on me will
(RECIPIENT NAME)
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.______________________________ was solely for medical reasons. The
(RECIPIENT NAME)
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

Field-by-Field Instructions for Completing Acknowledgement Receipt of Hysterectomy Information Form – DSS-3113

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 patient 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 Acknowledgment

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 patient'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.