

New York State Electronic Medicaid System 150002 Billing Guidelines



TABLE OF CONTENTS

1.	Pu	rpc	ose Statement	. 4
2.	Cla	aim	s Submission	. 5
	2.1	E	lectronic Claims	5
	2.2	Ρ	aper Claims	6
	2.2	.1	General Instructions for Completing Paper Claims	6
	2.3	e	MedNY – 150002 Claim Form	8
	2.4	Ν	Aidwife Services Billing Instructions	8
	2.4	.1	Instructions for the Submission of Medicare Crossover Claims	8
	2.4	.2	eMedNY - 150002 Claim Form Field Instructions	9
3.	Exp	pla	nation of Paper Remittance Advice Sections	36
	3.1	S	ection One – Medicaid Check	37
	3.1	.1	Medicaid Check Stub Field Descriptions	38
	3.1	.2	Medicaid Check Field Descriptions	38
	3.2	S	ection One – EFT Notification	39
	3.2	.1	EFT Notification Page Field Descriptions	40
	3.3	S	ection One – Summout (No Payment)	41
	3.3	.1	Summout (No Payment) Field Descriptions	42
	3.4	S	ection Two – Provider Notification	43
	3.4	.1	Provider Notification Field Descriptions	44
	3.5	S	ection Three – Claim Detail	45
	3.5	.1	Claim Detail Page Field Descriptions	49
	3.5	.2	Explanation of Claim Detail Columns	49
	3.5	.3	Subtotals/Totals/Grand Totals	52
	3.6	S	ection Four – Financial Transactions and Accounts Receivable	53
	3.6	.1	Financial Transactions	
	3.6		Accounts Receivable	
	3.7	S	ection Five – Edit (Error) Description	57
Ap	penc	xit	A Claim Samples	58



Appendix B Code Sets	60
Appendix C Sterilization Consent Form – LDSS-3134	63
Sterilization consent Form – LDSS-3134 and 3134(S) Instructions	65

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

1. Purpose Statement

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

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

This document is customized for Midwives and should be used by the provider as an instructional as well as a reference tool. For providers new to NYS Medicaid, it is required to read the All Providers General Billing Guideline Information available at www.emedny.org by clicking on the link to the webpage as follows: <u>Information for All Providers</u>.

2. Claims Submission

Midwives can submit their claims to NYS Medicaid in electronic or paper formats.

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

Providers will be asked to update their Certification Statement on an annual basis. Providers will be provided with renewal information when their Certification Statement is near expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: <u>Information for All Providers</u>.

2.1 Electronic Claims

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

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

- HIPAA 837P Implementation Guide (IG) explains the proper use of the 837P standards and program specifications. This document is available at the web page as follows: <u>www.wpc-edi.com/hipaa</u>.
- NYS Medicaid 837P Companion Guide (CG) is a subset of the IG, which provides specific instructions on the NYS Medicaid requirements for the 837P transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: <u>eMedNY Companion Guides and Sample Files</u>.
- 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. This document is available at www.emedny.org by clicking on the link to the web page as follows: <u>eMedNY Companion Guides and Sample Files</u>.

Further information about electronic claim pre-requirements is available at www.emedny.org by clicking on the link to the webpage as follows: <u>Information for All Providers</u>.

2.2 Paper Claims

Midwives who choose to submit their claims on paper forms must use the New York State eMedNY-150002 claim form.

To view a sample Midwife eMedNY - 150002 claim form, see Appendix A below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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

2.2.1 General Instructions for Completing Paper Claims

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

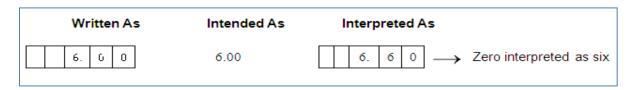
- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1



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

Exhibit 2.2.1-2



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



Exhibit 2.2.1-3

Written As	Intended As	Interpreted As	
	2	$7 \rightarrow$	Two interpreted as seven
_ <u>_</u> 3	3	$_2 \rightarrow$	Three interpreted as two

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





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

The address for submitting claim forms is:

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

2.3 eMedNY - 150002 Claim Form

The 150002 form is a New York State Medicaid form that can be obtained through the financial contractor (CSC). To order the forms, please contact the eMedNY call center at 1-800-343-9000.

To view a sample Midwife eMedNY - 150002 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

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.

2.4 Midwife Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Midwives. Although the instructions that follow are based on the eMedNY-150002 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims, in addition to the HIPAA Companion Guides which are available at www.emedny.org by clicking on the link to the webpage as follows: <u>eMedNY</u> <u>Companion Guides and Sample Files</u>.

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

2.4.1 Instructions for the Submission of Medicare Crossover Claims

This subsection is intended to familiarize the provider with the submission of crossover claims. Providers can bill claims for Medicare/Medicaid patients to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid.

Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows. Also, *Medicare Part-C* (Medicare Managed Care) and *Medicare Part-D* claims are *not* part of this process.

Providers are urged to review their Medicare remittances for crossovers beginning December 1, 2009, to determine whether their claims have been crossed over to Medicaid for processing. Any claim that was indicated by Medicare as a crossover should not be submitted to Medicaid as a separate claim. If the Medicare remittance does not indicate that the claim has been crossed over to Medicaid, the provider should submit the claim directly to Medicaid.

- Claims that are denied by Medicare will not be crossed over.
- Medicaid will deny claims that are crossed over without a Patient Responsibility.

If a separate claim is submitted directly by the provider to Medicaid for a dual eligible recipient and the claim is paid before the Medicare crossover claim, both claims will be paid. The eMedNY system automatically voids the provider submitted claim in this scenario. Providers may submit adjustments to Medicaid for their crossover claims, because they are processed as a regular adjustment.

Electronic remittances from Medicaid for crossover claims will be sent to the default ETIN when the default is set to electronic. If there is no default ETIN, the crossover claims will be reported on a paper remittance. The ETIN application is available at www.emedny.org by clicking on the link to the webpage as follows: <u>Provider Enrollment Forms</u>.

NOTE: For crossover claims, the Locator Code will default to 003 if the submitted ZIP+4 does not match information in the provider's Medicaid file.

2.4.2 eMedNY - 150002 Claim Form Field Instructions

Header Section: Fields 1 through 23B

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

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

Adjustment/Void Code (Upper Right Corner of Form)

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 (Upper Right Corner of Form)

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 combinations 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.

2.4.2.1 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.

Exhibit 2.4.2.1-1 and Exhibit 2.4.2.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 0826019876543200 is shared by three individual claim lines. This TCN was paid on September 16, 2008. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.



		CE HEALTH					NLY TO BE SED TO	A CODE V			ORIGINAL	CLAIM RE	FERENCE NUME	IER		-
CLAIM FORI		TITLE XI			М	A	DJU ST/VOID	A V								
PATIENT AND IN SU		B SCRIBER) INFO	RMATIC	DN			OF BIRTH	2A. TOTAL ANNU FAMILY INCOM	AL 3	INSURED'S N	ANE (First name, middl	intial last nam	w 1			
								FAMILYINCON	IE .							
	4 04703	E SMITH TS ADDRESS (Sheet, City, See	Zip Code)			5. INSUR		. PATIENT'S SEX	đ.	MEDICARE N.	MEER		6A. MEDICAID NUMBI	R		-
	ð					MAL	E FEMALE	MALE FENA					A B 1	2 3 4	5 C	
	ors							XX					GROUP ND.			
	NOT STAPLE					SB. PAT	IENT/8 TELEPHONE NUN	IBER					GROUP NO.	NEU PN	Jul Thu	
	z	NTS EMPLOYER, OCCUPATIO	N OR SCHOOL				ENPS RELATIONSHIP TO SELF SPOUSE O	NNBURED HLD OTHER	8	INSURED/S E	MPLOYER OR OCCUR	ATION				
	BARCO DE AREA															
	Ran Nan	HEALTH INSURANCE COVER, and Address, and Policy or Priva			ider,		CONDITION RELATED T		1	I. INSURED'S /	ADORESS (Street, Oty,	State, Zp Code	=)			
	AR					EMP	OYMENT X	X VICTIM								
	\$					4	AUTO X	X OTHER UABILITY								
	12.						D	ATE	10	L						
	PATIE	1/8 OR AUTHORIZED SIGNA						MM DD		ISURED'S SIG						
	15. FIRST CON	SULTED 16. HAS PA	TIENT EVER	HAD	164, 8	NERGEN	ATION (REFER	7. DATE PATIENT I	AY 18	ORE CO		FROM	IING)	TO		
OF CONDITION	FOR COND		BMLARSYM	_		REATED		RETURN TO WO		TOTAL	PARTIAL		1 1		1	1
MM DD YY 19. NAME OF REFERRINGPHY	MM DE SCIANOROTH			NO			(OR SIGNATURE SHE ON	MM DD	108. P		C. IDENTIFICATION		DD YY	100. DX CC	DD CE	YY
20. NATIONAL DRUG CODE		204	UNIT 208	B. QUANT	ITY			20	0. COST		1 1 2 3	4 5	6 7 8 9			
		1 1 1		1 1	Т	T			1 1	1.1						
21. NAME OF FACILITY WHERE	SERVICES REP	DERED (If other then home or	office)		21A. A	DORESS	OF FACILITY				22. WAS LABORA OUTSIDE YOU	TORY WORK P	ERFORIVED	LAB CHARGES		
											YES	ר ר	NO			
22A. SERVICE PROVIDER NAM	E					B. PROF	CD 22C. IDENTIF	CATIONNUMBER			220. STERIUZ			22E. STATUS	CODE	
						T	1 1	1 1 1	11		ABORTION	CODE				
23. DIAGNOSS OR NATURE OF	FILLNESS <u>Rel</u>	TE DIAGNOSIS TO PROCE	UREINCOLU	VIN 24H BY	REER	NCETO	UMBERS 1, 2, 3, ETC. OF		22F POSSIBLE	Y	N N	229 Y EPSOT	Y N N	22H Y FAMILY	Y X	N
1.									DISABILITY		· · · ·	ртнр	T IN	PLANNING		·
2.									23A. PRIOR	R APPROVAL N	UNEER			238. PAYIMT	SOURCE CODE	
														1	1	
244. DATE OF	248. PLACE	240. PROCEDURE	24D. MOD	24E. MOD	24F. MOD	249. MOD	24H. DIAGNOSIS CODE	24. DAY8 OR	24J.	CHAR	GES	24K.		1 24.	1	
DATE OF SERVICE	248. PLACE Y		240. MOD	24E. MOD	24F. NOD	243. MOD	24H. DIAGNOSIS CODE	24I. DAY8 OR UNITS	24).	CHAR	IDES	24K.			1	
DATE OF SERVICE M M D D Y	Y	PROCEDURE CD		24E. NOD	24F. MOD	243. MOD	DIAGNOSIS CODE	OR UNITS	24,1	CHAR		24K			1	
DATE OF SERVICE 0 9 0 4 0	v 8 111	9 9 2 0	1	24E. MOD	24F. NOD	243. NOD	DIAGNOSIS CODE		24J. 	CHAR	6.5 0	24K			1	•
DATE OF SERVICE M M D D Y	v 8 111	PROCEDURE CD	1	24E. MOD	24F. NOD	243. MOD	DIAGNOSIS CODE		24,1	CHAR		24K.			1 	• •
DATE OF SERVICE 0 9 0 4 0	× 8 1⊥1 8 1⊥1	9 9 2 0	1	24E. MOD	24F. MOD	249. MOD	DIAGNOSIS CODE		24.1.	CHAR	6.5 0	24K			1 	• •
DATE OF SERVICE M M D D Y 0 9 0 4 0 0 9 1 0 0	× 8 1⊥1 8 1⊥1	9 9 2 0 9 9 2 1	1	24E. MOD	24F. NOD	249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1		24).		<u> 6.5 0</u> 5.0 0	24K			1 	·
DATE OF SERVICE M M D D Y 0 9 0 4 0 0 9 1 0 0	× 8 1⊥1 8 1⊥1	PROCEDURE 0 9 9 9 2 1 1 9 9 2 1 1 9 9 2 1 1 9 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1	94E. MOD	24F. NOD	243. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1		24J.	CHAR	1 16.510 1 15.010 1 15.010	24K.			1 	• •
DATE OF SERVICE M M D D Y 0 9 0 4 0 0 9 1 0 0	× 8 1⊥1 8 1⊥1	PROCEDURE 0 9 9 9 2 1 1 9 9 2 1 1 9 9 2 1 1 9 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1	24E. MOD	24F. MOD	249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1			CHAR	1 16.510 1 15.010 1 15.010	26K.				· · · · · · · · · · · · · · · · · · ·
DATE OF SERVICE M M D D Y 0 9 0 4 0 0 9 1 0 0	× 8 1⊥1 8 1⊥1	PROCEDURE 0 9 9 9 2 1 1 9 9 2 1 1 9 9 2 1 1 9 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1	24E. MOD	24F. MOD	249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1		24.1	CHAR	1 16.510 1 15.010 1 15.010	26K				·
DATE OF SERVICE M M D D Y 0 9 0 4 0 0 9 1 0 0	× 8 1⊥1 8 1⊥1	PROCEDURE 0 9 9 9 2 1 1 9 9 2 1 1 9 9 2 1 1 9 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1	24E MOD		249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1		24J.		1 16.510 1 15.010 1 15.010	24K				· · · · · · · · · · · · · · · · · · ·
DATE OF BERVICE M 0 Y 0 9 0 4 0 0 9 1 0 0 0 9 1 0 0 0 9 1 5 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 260 7500 7500 7500	8 1 1 8 1 1 8 1 1 1 1 1	PROCEDURE 0 9 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	24E NOO		243. 1000	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 I I				6.5 0 5.0 0 5.0 0 	24K				· · · · · · · · · · · · · · · · · · ·
DATE OF BERNICE M 0 Y 0 9 0 4 0 0 9 1 0 0 0 9 1 0 0 0 9 1 5 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Y 8 1 1 8 1 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PROCEDURE 0 9 9 9 1 2 1 0 1 9 9 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	24E MOD		248. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 I . I I . I . I . I I . I . I . I I .				1 16.510 1 15.010 1 15.010				1 1	· · · · · · · · · · · · · · · · · · ·
DATE OF BERVICE M 0 Y 0 9 0 4 0 0 9 1 0 0 1 0 9 1 0 0 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 284 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Y	PROCEDURE CD 9 9 2 0 9 9 2 1 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	24E MOD	24F. NOO	249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 I I I I I I I I I I I				6.5 0 5.0 0 5.0 0 					· · · · · · · · · · · · · · · · · · ·
DATE OF BERVICE M M 0 0 V 0 9 0 4 0 0 9 1 0 0 1 9 1 0 0 1	Y	PROCEDURE CD 9 9 2 0 9 9 2 1 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	24E MOD	24F. NOO	243. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 I I I I I I I I I	0R UNTE			6.5 0 5.0 0 5.0 0 					· · · · · · · · · · · · · · · · · · ·
DATE OF BERVICE M 0 Y 0 9 0 4 0 0 9 1 0 0 1 0 9 1 0 0 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 284 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		PROCEDURE CD 9 9 2 0 9 9 2 1 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	AVE. MOD	34F. MOD	249. MOD	V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 I I I I I I I I I I I I I I I I I I I	0R UNTE			6.5 0 5.0 0 5.0 0 - - - - TOTAL CHARGE PHYSICIANS OR BUR					· · · · · · · · · · · · · · · · · · ·
DATE OF DATE OF DAT	Y 8 1 1 8 1 1 8 1 1 1 1	PROCEDURE 0 9 9 2 0 9 9 2 1 9 9 2 1 1 1 THROUGH MM DD EREVERSE SIDE APPLYTO 1 5 6 7	1 1 1 1 1 1 1 1			 	DIAGNOBIE CODE V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 V 7 2. 3 1 1 . 1 1 . 1 1 . 1 1 . 1 21 ACCEPT 4830NU YES 20 ENFLOYERIOSHT SOCIAL SECURITY			 	I I 6.5 0 I I 5.0 0 I					·
DATE OF BERVICE M M 0 0 Y 0 9 0 4 0 0 9 1 0 0 1 9 1 0 0 1 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Y 8 1 1 8 1 1 8 1 1 1 1	PROCEDURE 0 9 9 2 0 9 9 2 1 9 9 2 1 1 1 THROUGH MM DD EREVERSE SIDE APPLYTO 1 5 6 7	1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		 	VIT 2.31 VIT 2.32 VIT 334			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6.5 0 5.0 0 5.0 0 5.0 0 - - - - - PHYBICIANS OR BUR ally Forth 12 Main S			24. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
DATE OF BERVICE M M 0 0 V 0 9 0 4 0 1 0 9 1 0 1 0 1 0 9 1 5 0 1 1 1 1 1 1 1 200 FROM 1 1 1 1 1 1 201 FROM 1 1 1 1 1 1 201 FROM 1 1 1 1 1 1 201 FROM 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		PROCEDURE 0 9 9 2 0 9 9 2 1 9 9 2 1 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 2011 1 2011 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		 	VIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			 	I I 6.5 0 I I 5.0 0 I			24. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
DATE OF BERVICE M M D D V V 0 9 0 4 0 1 0 9 1 0 0 1 0 9 1 0 0 1 1 1 1 1 1 1 1 1 2 0 0 7 FROM 0 0 ERIVINATINE STATUS Sally F Sally F Sally F Sally Control Control	v 8 1 1 8 1 1 8 1 1 9 1 1 1	PROCEDURE CD 9 9 2 0 9 9 2 1 9 9 2 1 9 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		 	VIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			I I	I I 6.5 0 I I 5.0 0 I			24. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		



MEDICAL ASSI	STANC						NLY TO BE A C SED TO	ODEV	<u> </u>	ORIGINAL	CLAIM REP	ERENCE N	IUMBER			_
CLAIM FORM		TITLE XIX F			N	A	DJUST/VOID 7	V				7 10 1	- 14			
PATIENT AND INSURE		CRIBER) INFORM	IATIO	N	2		AID CLAIM	OTAL ANNUAL MILYINCOME		2 6 0 1 DIS NAME (First name, middle			5 4	3 2	0 0	
								MEYINCOME								
	JANE 4. PATIENTS	SIMITH ADDRESS(Sheet, City, Size, Jp C	icde)			INSUR		ENT/8 SEX	6. MEDICAR	RENUMBER		6A. MEDICAID	NUMBER			
DO NO						MALE						AB	1 2	3 4	5 C	
0181					-	B. PATI	ENT/S TELEPHONE NUMBER	^	OB. PRIVAT	TE INSURANCE NUMBER		GROUP NO.		RECIPRO	CITY ND.	
NOT STAPLE IN) NPS RELATIONSHIP TO INSUR			D'S EMPLOYER OR OCCUR						
N BS	D.C.PHILMI	S EMPLOYER, OCCUPATION OR	SCHOOL		ľ			OTHER	a moones		All ON					
BARCODE AREA	9. OTHER HE		Chier name o	o' Policyhold	ier, 1	0. WAS	CONDITION RELATED TO		11. INSURE	ED/S ADDREES (Street, City,	State, Zp Code;)				
DEA	Pan Name ar	d Address, and Policy or Privale. Ins.	rance Numb	ber		PA EMPL	TIENT'S X X	ORIME VICTIM								
REA								OTHER								
	12					A	DATE	UABIUTY	13.							
							MM									
	PATIENT/S		r sup				TION (REFER TO	REVERSE	BEFORE	SIGNATURE COMPLETING A		NG)				
	RET CONBUL				16A. EN Ri			E PATIENT NAY URN TO WORK	18. DATES		FROM		. [0		
MM DD YY MM 19. NAME OF REFERINGPHYSICAL		YY YES		NO	YES 19A, AD	X	X NO MM ORS/BNATURESHF ONLY)	DD YY	198, PROF CD	190. IDENTIFICATION	MM	DD	YY	MM	DD	YY
20. NATIONAL DRUG CODE			IT 208.	QUANT				200. 0		1 1 2 3		6 7 8	9		.	
						1			1 1							
21. NAME OF FACILITY WHERE SERV	ICES RENDE	RED (If other then home or office)	<u> </u>	21A. AD	DRESS (F FACILITY		1.1.	22. WAS LABORAT OUTSIDE YOU	TORY WORK PE	RFORMED	LAB	HARGES		
										YES		NO				
224. SERVICE PROVIDER NAME					228	PROF	CD 220. IDENTIFICATIO	NNUMBER		220. STERIU 24			226	. STATUS C	2006	
										ABORTION	ICODE					
23. DIAGNOSS OR NATURE OF ILLNE	ISS <u>Relate</u>	DAGNOSIS TO PROCEDURE!	NCOLUM	N24H BY	REFEREN	CETON	UMBERS 1, 2, 3, ETC, OR DX CI	20E 22F ▼ POS	Y BIBLE	N N	229 Y SP80T	Y N	N 225 FA	K Y VILY	Y	X
1.								DISA	BIUTY		отнр		PU	NNNG		
3.								234.	PRIOR APPROV	AL NUMBER			236	. PAYMPT SI	OURCE CODE	
244.	248.	240.	240.	24E	24F. [2	9.	244.	24.	244		24K		1		1	
DATE OF SERVICE	248. PLACE	PROCEDURE CD	240. MOD	24E. NOD	NOD N	00	DIAGNOSIS CODE	24I. DAYS OR UNITS	0	CHARGES						
<u>N N D D Y Y</u>					_			0.010								
0 9 0 4 0 8	111	9 9 2 0 1					V 7 2.3 1	1		6.5 0	1.1	1.1.1	• T T	1 1		
019 110 018	111	91912111					V 7 2. 3 1			1 15.010	1.1					
019 116 018	111	9 9 2 1 1					V 7 2. 3 1			5.0 0						
		51512111	· ·	-	-		1 2.5 1			3.0 0			• • •			•••
			1	-	-	1		1		•			• • •			I • I
	1		1	Т	1	1	1.1.1.1.1	1	1.1	1 1 1 • 1	1.1		• 1 1	1 1		• •
	1		1	1	1	1		1	1.1		1.1		. i i	1 1		
								1.1								
24M. FROM NPJ/TENT HOSPITAL		THROUGH	24N, PR	10000	24	омор										
25. CERTIFICATION () CERTIFY THAT THE STATEMEN		MM DD YY				-	20. ACCEPT ASSIGNMENT			27. TOTAL CHARGE		28. AMOUNT P		29. 6	BALANCE DUE	
AND ARE MADE A PART HEREOF)	EVENSE SIDE APPETTICTING	BUL				YES 30. EMPLOYERIDENTIFICAT		10	31. PHYSICIANS OR SUP	PLERSNANE	400#E88.7/P	DODE			
Sally For	rth						SOCIAL SECURITY NUME	ER		Sally Forth						
SIGNATURE OF PHYSICIAN OR SUPP 25A. PROVIDER IDENTIFICATION NU		1 1 1	,							312 Main S						
	4 5	6 7 8	9							Anytown, N	lew Yo	rk 1111				
258. MEDICAID GROUP IDENTIFICAT	ON NUMBER		,	<u>,</u> 0	DCATOR DDE	E	KOP CODE	HAS BEEN FAID		TELEPHONE NUMBER (DO NOT WRITE IN THISS) BRACE		EXT.	(20	(6) EXEDNY-1	50002
COUNTY OF SUBMITTAL 25E. 1	DATE SIGNED	32. PATIENTS ACCOU	NT NUMBE		0 3		YES		NO							
10	06 0	8 34. PROF CC		CASE M	ANADET			C 1 2	3 4 5]						
33. OTHER REFERRING ORDERING P D/LICENSE NUMBER			1	1		1	1 1 1 1									

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.

Exhibit 2.4.2.1-3 and Exhibit 2.4.2.1-4 illustrate an example of a claim with an adjustment being made to cancel a line on submitted on the claim. TCN 0826018765432100 contained three individual claim lines, which were paid on September 16, 2008. 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. Exhibit 2.4.2.1-3 shows the claim as it was originally submitted and Exhibit 2.4.2.1-4 shows the claim as it appears after the adjustment has been made.



		CE HEALTH IN					NLY TO BE SED TO	A COD	EV		ORIGINAL	CLAIM REP	FERENCE NUMB	ER		-
CLAIM FORM					VI		DJU ST/VOID AID CLAIM	Α	V							
PATIENT AND IN SUF		NAIS (Arst middle, last)	ATIO	N				2A. TOT FAMIL	AL ANNUAL VINCOME	3. INSURED	D/S NAME (First name, midd	e intile; lest nem	4			
	JANE	SMITH				0.5	21011191910									
8	4 DATION TO	ADDRESS(Sheet, City, Sale, Jp.C	iode)				ED8 8EX 5A	PATIEN MALE	F/8 8EX FENALE	6. MEDICA/	RENUNBER		6A. MEDICAID NUMBE	R		
N						Γ		Х	X				A B 1 2	2 3 4	1 5 C	;
STA						SB. PAT	IENT'S TELEPHONE NUM	IER		08. PRIVA	TE INSURANCE NUMBER		GROUP NO.	RECIPR	IOCITY NO.	
i i i i i i i i i i i i i i i i i i i	S.C. PATIENT	TS EMPLOYER, OCCUPATION OR	SCHOOL) ENTS RELATIONSHIP TO			8. INSURE	DIS ENFLOYER OR OCCUP	ATION				
BAR							IELF SPOUSE CH									
NOT STAPLE IN BARCODE AREA	9. OTHER HI Flan Name a	EALTH INSURANCE COVERAGE - I Ind Address, and Policy or Privale Ins.	Color name o rance Numb	of Policyhols ber	Cer,		CONDITION RELATED TO	-	INE	11. INSURE	ED/S ADDRESS (Street, Oty	State, Zp Code)			
ARE						EMPL	OYMENT ^	^ VI	CTIM							
×						A	AUTO X	^UA	THER VEILITY							
	12.						DA	I		13.						
	PATIENTS	BORAUTHORIZED SIGNATURE PHYSICIAN O		PLIE	RINF	ORM			EVERSE E		SIGNATURE	ND SIGN	ING)			
14. DATE OF ONBET 15 OF CONDITION	FIRST CONSU FOR CONDITI	LTED 10. HAS PATIEN	T EVER HA	ND D	16A, E	NERGEN		DATE P	ATIENT MAY N TO WORK	18. DATES TOTAL	OF DISABUTY	FROM		то		
MM DD YY N		YY YES] [NO	YE				DD YY	B. PROF CD		MM	DD YY	MM 190. DX CX	DD	YY
20. NATIONAL DRUG CODE				0.000		JUNESS	(un alarix) one ann uno						6 7 8 9			
			IT 208.			ī			200. 004							
21. NAME OF FACILITY WHERE S	ERVICES RENDE	RED (If other then home or office	0		21A. A	DORESS	OF FACILITY				22. WAS LABORA OUTSIDE YO	TORY WORK PE		AB CHARGES		
											YEB	ר ר	NO			
22A. SERVICE PROVIDER NAME					2	B. PROF	CD 22C. IDENTIFI	CATIONN	IMBER		22D. STERIUZ ABORTIO			22E. STATUS	3 CODE	
23. DIAGNOSS OR NATURE OF IL			NCOLINE		-			DX CODE								_
1.								٧	POSS		Y X "	220 Y EP80T	Y N N	22H FAMILY	Y	X
2.									DISAE			DITHP		PLANNING	SOURCE CODE	
3.										1 1		1 1		1	111	
24A. DATE OF	248. PLACE	240. PROCEDURE	240. MOD	24E. NOD	24F. MOD	243. MOD	24H. DIAGNOSIS CODE		24. DAYS	24J.	CHARGES	24K.		24L		
SERVICE	r	co							OR UNTS							
019 014 018	1.1	9 9 2 0 1					V 7 2. 3 1				6.5 0					
019 110 018																
		9 9 2 1 1		-	-		V 7 2.31				5.010					
0 9 1 6 0 8	111	9 9 2 1 1		-	1		V 7 2.3 1				5.0 0		•			· · ·
			1	1	1		1				•		•			· · ·
	1	1111	Т	Т	Т	Т	11.1		1	1.1	1 1 1 • 1	1.1	1 1 1 • 1	<u> </u>		· · ·
1 1 1	1		T	Т	Т	T			1	1.1		1.1		<u> </u>	1 1	
	1		1	1	i.	1			1	1.1		1.1		1 1	і I	· • •
24M, FROM NAUTENT HOSPITAL VIETS MM C		THROUGH	24N, PR	ROCCD		240,000										
25. CERTIFICATION () CERTIFY THAT THE STATE)	ENTSON THE F	REVERSE SIDE APPLY TO THIS	BLL			-	20. ACCEPT ASSIGNUE	INT			27. TOTAL CHARGE	i I	28. AMOUNT PAID	1 20	EALANCE DU	E
Sally Fo							YES 30. EMPLOYERIDENTI SOCIAL SECURITY		NUMBER	,	31. PHYSICIANS OR BU		ADDRESS, ZIP CODE			_
SIGNATURE OF PHYSICIAN OR S	UPRJER										Sally Forth 312 Main S					
25A. PROVIDER DENTIFICATION	1 1										Anytown, I		rk 11111			
1 1 2 3 25B. MEDICAID GROUP IDENTIFIC	4 5 ATION NUMBER		9		OCATO	R	250. 8A 32A. MY	FEE HAS		_	TELEPHONE NUMBER (DO NOT WRITE IN THIS		E			
				0	00E		YES			NO	DO NOT WRITEIN THIS	SHACE		CI	208) ENEONY-	150002
	E DATESIGNE 9 16 0		NTINUMBE	R				BIC	1 2 3	4 5						
33. OTHER REFERRING ORDERIN DILCENSE NUMBER	IG PROVIDER	34. PROF CC	35.	CABE N	ANAGE I											



Exhibit 2	2.4.2.1-4
-----------	-----------

MEDICAL AS	SISTAN	CE HEALT			F	0	NLY TO BE	A 00	DEV			ORIGI	NAL CLAIM	REFER	ENCE N	UMBER	ı		
CLAIM FOR			XIX PRO		_	U	SED TO	~	v										-
PATIENT AND IN S							DJU ST/VOID AID CLAIM	X	V	0	8 2	6 0	1 8 1	7 6	15 14	13	12 11	10 10	
TATELTAD		TS NANE (Rist) mode, last				2 DATE	OF BIRTH	24, TO FAM	TAL ANNUAL ILY INCOME			B NAME (First name,					1- 1.		<u> </u>
	LAND	OUTU																	
	4 DATION	E SMITH	Sinie, Zip Code)			5. INBUR		A. PATIE			6. NEDICARE	ENUMBER		64.1		UNBER			
	8 North					MAL	FEMALE	MALE							B 1	2	3 4	5 0	
	9				L			Х	X							Ľ			<u> </u>
	NOT STAPLE					SB. PAT	ENT/8 TELEPHONE NU	NBER			CE. PRIVATE	E INBURANCE NUM	SER.	GRC	DUP NO.		RECIPRO	CITYNO.	
	E BC.PATE	NTS EMPLOYER, OCCUP	ATION OR SCHOOL		-+	I. 7. PATIE) ENTS RELATIONSHIPTO)		8. INSURED	8 EMPLOYER OR C	OCURATION				-		
						8	ELF SPOUSE (ню											
		HEALTH INSURANCE COV			der,	10. WAS	CONDITION RELATED	то			11. INSURED	VS ADDRESS (Stree	t, Oty, State, Zp	Code)					
		e and Address, and Policy or P				EMPL	OYMENT X	XV	RIME										
	RE						AUTO 🗔		THER										
						A	COIDENT	_	IABILITY										
	12.						C	DATE			13.								
	PATIEN	PS OR AUTHORIZED SIG	BNATURE					мм	DD Y	YY	INSURED'S S	BIGNATURE							
14. DATE OF ONSET	15. FIRST CON		AN OR SU			ORM.	ATION (REFER		REVER S			OMPLETIN F DISABUTY	G AND SI		i)		то		
OF CONDITION	FOR COND		DR BMLAR BYN			BLATED			RN TO WORK		TOTAL	PART				.			
MM DD YY	MM DD		в	NO	YES		X NO	MM	DD Y	YY		190, IDENTIFICA	M	м	DD	YY	MM	00	YY
19. NAME OF REPERRINGPH	SCANOROTHS	R SUURUE			194. 40	JURESS	(UH SIGNATURE ARE U	NLY)		148	PROF CD	1 1 2		5 6	7 8		190. DX COI	.	
20. NATIONAL DRUG CODE			20A. UNIT 20	B. QUANT	ITY				200.	COST									
21. NAME OF FACILITY WHER	E SERVICES REN	DERED (If other then hom	le or office)		21A. AC	ORESS	OF FACILITY					22. WAS LA	BORATORY WOR	K PERFOR	RVED	LAB	CHARGES		
												YES							
224. SERVICE PROVIDER NAM					22	. PROF	CD 22C, IDENTI	REATION	NUMBER			22D STE	RUZATION	<u> </u>		122	E. STATUS	CODE	
						I		I	1 1	1	1.1	ABO	RTIONCODE						
23. DIAGNOSS OR NATURE O	FILINESS <u>Rela</u>	TE DIAGNOSIS TO PROV	CEDURE IN COLU	NN24H BY	REFERE		UNEERS 1, 2, 3, ETC. O	RDXCOD	E 22	F	Y	N N	220	Y		N 22	н ү		N
1.								1		OSSIBL ISABIU		YX	EP80T O/THP	Y	N		AMILY LANNING	Y	X
2.													withe			·			
3.									2	39. PN	IOR APPROVA	LNUMBER				. 2	B. PAYINT 8	JOURGE COL	-
244.	248	240	240	24F	24F [3	243.	244		24	24			245			24	1	1	
DATE OF SERVICE	248. PLACE	PROCEDURE	24D. MOD	NOD	NOD	uop	DIAGNOSIS CODE		241. DAYS OR UNITS			ARGE8				-	-		
M M D D Y	Y								UNITS										
0.0 1.0 0.		0.0.2.0					V.7.2.2.4												
019 110 01	8 111	9 9 1 9 1 2 1 0		-	\vdash		V 7 2, 3 1			-		5.0							<u> </u>
019 116 01	8 111	9 9 2 1	lit i	1	1	1	V 7 2. 3 1	1.1	1	1	1.1	5.0	10	і і.	11.	11	1	<u>і і</u>	1.1
			. .																
						-	1 1 • 1			+									· · ·
	1	1.1.1	Г I	1	1	1	11.1	1.1	1		1.1	1.1.1.	L L	L L	11.	11		<u> </u>	1 • 1
																<u> </u>			
										+									
	1	1.1.1	1 1	1	Т	1	11.1	1.1	1	_	1 1 1	11.		L 1	11.	- 1 1			1 • 1
DAM. FROM		THROUGH	24N.	PROCIO		HOMOD	1 1 • 1										_		
VISITS MM	DD YY	MM DD	YY I	1.1	1	1	20. ACCEPT ASSIGN		1		<u> </u>	27. TOTAL CHARG	ļ				1 22	EALANCE D	<u> </u>
() CERTIFY THAT THE STAT AND ARE MADE A PART H	TEMENTS ON THE	REVERSE SIDE APPLY	TOTHISBL				YES	1		NO		27. TOTALONANO	<u>،</u>			ĩι	"	SALANUE U	Ĩ
							30. EMPLOYERIDEN					31. PHYSICIANS C		ANE, ADD	RESS, ZIP C	ODE			_
Sally F							SOCIAL SECURIT	NUMBER	`			Sally Fo							
254. PROVIDER DENTIFICATI												312 Mair	n Street						
1 1 2 3	4	5 6 7	8 9									Anytown	n, New	York	1111	1			
258. NEDICAID GROUP DENT					OCATOR 200E		250. 8A 32A. N XCP CODE		AS BEEN PAID	0			BER ()			EXT.		OSI ENEONY-	140002
					0 3		YE	8			NO						(0	set analysis.	
COUNTY OF SUBMITTAL	25E. DATE SIGN		5 ACCOUNT NUM						14.10	10	14.15								
3 33. OTHER REFERRING ORDE DILCENSE NUMBER	10 06 RING PROVIDER		PROF CD 3	S. CARE N	IANAGER			BC	1 2	3	4 5								
D'LICENSE NUVESR																			

2.4.2.2 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.

Exhibit 2.4.2.2-1 and Exhibit 2.4.2.2-2 illustrate an example of a claim being voided. TCN 082601234567800 contained two claim lines, both of which were paid on September 16, 2008. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and the provider was paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Exhibit 2.4.2.2-1 shows the claim as it was originally submitted and Exhibit 2.4.2.2-2 shows the claim being submitted as voided.



MEDICAL	ASSI	STANC	E HEALT			CE	0	NLY TO BE	A 000	EV			ORIGINA	L CLAIM R	EFERENCE N	NUMBER		
CLAIM FO			TITLE					SED TO DJU ST/VOID	А	v								
PATIENT AND I	NCIDE			OPMATI	ON			AID CLAIM	M	×	L	1 1	1 1	1 1	1 1 1	1		
CALLENT AND I	HOURE		NAIS (Rist, mode, las)		UN			OF BIRTH	24. TOT	AL ANNUAL VINCOME	3. INBUR	ED'S NAME	E (First name, mit	idie Intile; lest n	ame)			
									P AM									
			SMITH ADDRESS (Short, City)	Sele To Codel				2 0 1 9 9 0 EDS SEX	SA. PATIEN	PRAFY	A MEDIC	ARENUNE	-		6A. MEDICAID	NINGER		
	8						MAL		MALE	FENALE								
	ĝ								Х	X					AB	1 2	3 4 5	C
	NOT STAPLE						SB. PAT	IENT'S TELEPHONE N.	NEER		OB. PRIV	ATE INBUR	RANCE NUMBER		GROUP NO.		RECIPROCITY NO	
	Ē		S ENPLOYER, OCCUP				(7 PATIS) ENTS RELATIONSHIP T			2 INC/ 8		LOVER OR OCCI	RATION				
	NB				-					OTHER								
	BARCODE AREA	0.07477.41	ALTH INSURANCE COV				40.000	CONDITION RELATED			44 INSI		RESS (Street, O	N State 20 Co	via)			
	e e		nd Address, and Policy or R							INE	11. 1110.			.,	~~~			
	Â,						EMPL	OYMENT X	X	CTIM								
	5						<u>م</u>	AUTO X	X UA	THER ABILITY								
		12.							DATE		13.							
									MM									
		PATIENT [®]	PHYSICI	AN OR SI		RIN	FORM	ATION (REFE		EVER SE	INCOME	COM		AND SIG	NING)			
14. DATE OF ONSET OF CONDITION		RST CONSU	TED 16. HAS	PATIENT EVER	RHAD	10A, B	ENERGEN		17. DATE P	ATIENT MAY	18. DAT	S OF DISA	BUTY	FROM		1	ro	
MM DD YY			YY YES			YE		XNO				AL	PARTIAL	MM	DD	YY .	MM L	00 YY
19. NAME OF REFERRIN					~			(OR SIGNATURE SHE C			198. PROF C			NNUMBER		1	ID. DX CODE	
20. NATIONAL DRUG CO	106			204. UNIT 20						200. 0		1	1 2	3 4 5	6 7 8	9	1.1.1	
21. NAME OF FACILITY W	WERE SERV	(CES RENDE	RED //f other than hom	e or office)		214 4	DOBESS .	OF FACILITY				·	22. WAS LABOR OUTSIDE Y	AT DEV WORK	REASORNED	LAB	CHARGES	
												ľ	OUTSIDEY	OUR OFFICE			1	
													YES		NO			
22A. SERVICE PROVIDER	RNAME					2	28. PROF	CD 22C. IDENT	TIRCATIONN	UNBER			220. STERIU	ZATION		228	E. STATUS CODE	
							1	1 1	11		1.1	1	ABORTI	ON CODE				
23. DIAGNOSS OR NATU	URE OF ILLN	ESS <u>relat</u> i	EDIAGNOSIS TO FROM	EDUREINCOU	UVN24H B	YREER	ENCE TO N	UVEERS 1. 2. 3. ETC. C		225	Y		N	223 1	Y L	N 22		N
1.									•		ISIBLE ABILITY	Y	X	EP80T O/THP	Y N		MILY Y	X
2.											PRIOR APPR			-			. PAYINT SOURCE (2005
3.										-						. 1		
244.		248	240	240	245	245	249	244		24	244			246		24		
DATE OF SERVICE		24B. PLACE	PROCEDURE CD	24D. MOC	0 MOD	24F. MOD	243. MOD	DIAGNOSIS CODE		24I. DAYS OR UNITS		CHARGE	8					
M M D D	YY									UNITS								
019 110	0 ₁ 8	111	9 9 2 0	1	+			V 7 2.3 1										1 • 1
019 116	0 8	111	9 9 2 1								1 1		6.5			• • •		
								V 7 2, 3 1	1			<u> </u>				• • • •		
					+-	1	1	V 7 2. 3 1	1 1	I		<u> </u>	15.01			• • •		
	1	1	1 1 1			1		V 7 2. 3 1	1			 				• •		
	-	1						V 7 2. 3 1	1 1							• • •		· · · ·
	1	1						V 7 2.3 1	1 							• • •		· · · · · ·
		1				1	 	V 7 2. 3 1	1 							• • •		· · · · · · · · · · · · · · · · · · ·
		1						V 7 2. 3 1	1 							• • •		· · · · · · · · · · · · · · · · · · ·
		1						V 7 2. 3 1	1 				15.011			• • • • •		
							 	V 7 2. 3 1 . . .	1 				15.011 • • •			• • • • •		
1 1 1 1 2001 FRC MSTRIM MSTRIM				I I I I I I I I Zev			 						5 . 0 					
VSITS MM 25. CERTIFICATION	00		I I I I I I I I I I I I I I I I I I I I				 						5.0 • • •		I I	• • •		
25. CERTIFICATION () CERTIFY THAT THE AND ARE MADE A PA	E STATEMEN	ITSONTHE R	I I I I I I I I I I I I I I I I I I I I				 				I I 27. то	5.0		28. AMOUNT P			· · · · · · · · · · · · · · · · · · ·
25. CERTIFICATION () CERTIFY THAT THE AND ARE MADE A PA	E STATEMEN	ITSONTHE R	I I I I I I I I I I I I I I I I I I I I				 1+0.000			NUNBER		27. TO	5.0 • •					· · · · · · · · · · · · · · · · · · ·
25 CERTIFICATION () CERTIFICATION () CERTIFY THAT THE AND ARE MADE A PA Sally SIGNATURE OF PHYSICI		rsonthe F rth	I I I I I I I I I I I I I I I I I I I I				 	1 1 • 1 1 1 • 1 1 1 • 1 1 1 • 1 20. ACCEPT ABSIGN YES 30. EMPLOYERIDE		NUNBER		27. TO 31. PH Sal	15.01		28. AMOUNT P			
VEITS MAN 25. CERTIFICATION () CERTIFY THAT THE AND ARE MADE A PA Sally BIGNATURE OF PHYSICS 25A. PROVIDER DENTIFI		rtth rth RUBR MEER					 	1 1 • 1 1 1 • 1 1 1 • 1 1 1 • 1 20. ACCEPT ABSIGN YES 30. EMPLOYERIDE		NUNBER		27. то 31. Рн Sal 312	I 5.0 I	0 	1 1 1 28. AMOUNT P NE, ADDRESS, ZIP			
INTERNET MAN 28 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 1 1 2		rth rth								INUNGER		27. TO 31. PH Sal 312 An	I 5.0 II		28. AMOUNT P			
VEITS MAN 25. CERTIFICATION () CERTIFY THAT THE AND ARE MADE A PA Sally BIGNATURE OF PHYSICS 25A. PROVIDER DENTIFI		rth rth			250.		DR			NUNBER	*0	ал. рн 31. рн Sal 312 Ап; тецер	I 5.0 I	0 I	1 1 1 28. AMOUNT P NE, ADDRESS, ZIP			
Vieta CERTIFICATION SI CERTIFICATION CERTIFICATION LO CERTIFICATION CERTIFICATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SIGNATURE OF PHYSIC SECONDALIZATION SIGNATURE OF PHYSIC SECONDALIZATION 1 1 2 SEB. MEDICALD GROUP I SEB. MEDICALD GROUP I		ITS ON THE R TTCh RUER MEER 4 5 TON NUMBER	I I	і і і і і і і і і і 24N тотніваці 8 9	250.	LOCATO	DR			INUNGER		ал. рн 31. рн Sal 312 Ап; тецер	I 5.0 II	0 I	1 1 1 28. AMOUNT P NE, ADDRESS, ZIP			
INTERNET MAN 28 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 0 CERTIFICATION 1 1 2					250.			1			VO	27. ТО 31. РН Sal 312 Ап; тецер DO NO	I 5.0 II	0 I	1 1 1 28. AMOUNT P NE, ADDRESS, ZIP			
Vieta CERTIFICATION SI CERTIFICATION CERTIFICATION LO CERTIFICATION CERTIFICATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SI CERTIFICATION SECONDALIZATION SIGNATURE OF PHYSIC SECONDALIZATION SIGNATURE OF PHYSICAL SECONDALIZATION <t< td=""><td></td><td>ITS ON THE R TTTT RUER LIEER 4 5 TON NULLEER DATE SIGNE 116 0</td><td></td><td></td><td>250.</td><td></td><td>DR E</td><td>1</td><td></td><td></td><td>*0</td><td>27. ТО 31. РН Sal 312 Ап; тецер DO NO</td><td>I 5.0 II</td><td>0 I</td><td>1 1 1 28. AMOUNT P NE, ADDRESS, ZIP</td><td></td><td></td><td></td></t<>		ITS ON THE R TTTT RUER LIEER 4 5 TON NULLEER DATE SIGNE 116 0			250.		DR E	1			*0	27. ТО 31. РН Sal 312 Ап; тецер DO NO	I 5.0 II	0 I	1 1 1 28. AMOUNT P NE, ADDRESS, ZIP			



M	DICA	4661	CTAN/	E HEAL		CUID		<u>۲</u>	0	NLY TO BE	A CO	DEV			ORIGINA	L CLAIM RE	FERENCE NU	JMBER			
			STANC							SED TO											
		ORM		IIIL	e XIX F	PRO	GRA	IM	A	DJU ST/VOID	Α	X									
PATIE	NT AND	INSURE		SCRIBER)		IATIO	N		P	AID CLAIM			0 8	2 6	0 1	1 2	3 4 5	6	7 8	0 0	
			1. PATIENTS	NAME (Rist, middle	o, lezį)				2 DATE	OF BIRTH	2A. TO FAM	LY INCOME	3. INSUR	ED/S NAME	(First name, mid	die Intie, lest ner	na)				
				OLUITU																	
				SMITH ADDRESS (SHORE)	Car Tale Tale					2 0 1 9 9 0 EDS SEX	SA. PATIE	TROCY	A MEDIC	ARENUMB	-		6A. MEDICAIDN	NEC .			
		8		Concernant of the sector					MAL		MALE	FENALE					I			.	1
		NOT STAPLE									Х	X					A B 1	2	3 4	5 C	
		5								IENT/STELEPHONE)			AS PRIV	ATE INSUR	NCE NUMBER		GROUP NO.		RECIPROCIT	(NO	
		E AP							35. PHI	ienino i elerritorie i	WWEER										
		Fi	S.C. PATIENT	S EMPLOYER, OCI	CURATION OR	SCHOOL			7. PATIE) ENTS RELATIONSHIP	TOINBURED	1	8. INSUR	ED'S ENPLI	WER OR OCCI.	JFATION					
		N B								SELF SPOUSE	CHLD	OTHER									
		BARCODE																			
		ğ	9. OTHER HI Flan Name a	ALTH INSURANCE nd Address, and Pole	COVERAGE - 1 syor Private Ins.	Enler name uranze Nur	e of Policyho nber	der,		CONDITION RELATE			11. INSU	RED'S ADDI	RESS (Street, Ct	ly, State, Zp Cod	e)				
		m b							ENPL	ATTENT/8 OYMENT X	X	RIME									
		AREA																			
		-							A 1	AUTO X	XU	THER ABILITY									
			12.						-		DATE		13.								
1																					
⊩			PATIENTS		DEIGNATURE	E D. Club	001.15			ATION (DEC)		DD YI	INCONCL	OS SIGNATI			IN CO.				
14. DATE	OF ONSET	15. F	RST CONSU	TED 16.	HAS PATIEN	(T B/BR H	HAD .		EVERGEN	ATION (REFE		PATIENT MAY		ES OF DISAS		FROM	ING)	TO)		
	NDITION		FOR CONDITI	DN SAI	VE OR SMU	ARSYMP	TONS		RELATED			INTO WORK	тот		PARTIAL						
MM	00 1	Y MM	DD	YY	YES] [NO	YE	x s	X NO	мм	יו סס				MM	DD	YY	MM	DD	YY
19. NAME	OF REFERRI	NOPHYSCIA	NOROTHER	SOURCE				194.	ADDRE88	(OR S/GNATURE SHP	ONLY)		108. PROF C		DENTIFICATIO				D. DX CODE		
-												200. 0		1	1 2	3 4 5	6 7 8	9	<u> </u>		
20. NATIO	DNAL DRUG C	uue .			20A. UN	a 208	QUAN	n IT				206. 0	2061								
										<u> </u>											
21. NAME	OF FACILITY	WHERE BERN	VICES RENDE	RED (If other then	homeoraffice	4)		21A.	ADDRE88	OF FACILITY				2	2 WAS LABOR OUTSIDE Y	AT ORY WORK P	ERFORMED	LAB CH	ARGE8		
															_						
															YES		NO				
22A. SER	ICE PROVIDE	RNAME						<u>'</u>	228. PROF	CD 220. IDEN	TIRCATION	NUNBER			22D. STERIU	ZATION		225	STATUS COD		
									1	1 1 1	1 1				ABORTI	DN CODE					
23. DIAGE	IDSS OR NAT	URE OF ILLN	ESS RELATE	DIAGNOSIS TO P	ROCEDURE	INCOLU	IN 24H B	YREE	RENCE TO A	UNBERS 1. 2. 3. ETC	ORDXCOD	E 22F	Y			220 Y		N 22H	Y		
													88/8LE	Y	X	EPBOT	Y N	FAM	ILY	Y X	N
1.												DIS	ABIUTY			OTHP		PLA	NNG		
2.												234		OVAL NUME	R			238.	PAYINT SOUP	CECODE	
3.																					
244.			240	1000		240	DAR.	DAR.	040	2012		24	24.			244		24			
	DATE OF		248. PLACE	PROCEDURE		24D. MOD	24E. MOD	24F. MOD	243. MOD	DIAGNOSIS CODE		241. DAYS OR UNITS	~	CHARGES		-		-			
	SERVICE			CD								UNITS									
мм	DD	YY				-	-	-	-				-					_			
019	1:0	0 8	1.1	91912	1011					V 7 2.3	1.1			1.1	16.51	0		a la	1.1	1.1	
	1																				-
0 9	1+6	0 8	111	9 9 2	111	1	1	1	1	V 7 2.3	1 1 1	1	1	1 1	15.01	0 1 1	1.1.1.	11	1 1	1 1	• 1
	1																				
								1		1 1 • 1					1 • 1		111.			1.1	• 1
I .									.		1.1		1	1.1	1	1		- h	1.11	1.1	
 	1					-	<u> </u>	+	<u> </u>			-									• 1
1	1	1	1	1.1	1.1	1	1		1	11.1	1.1	1		1.1	1 • 1	1.1			1.1	1.1	
	1																			-	
	1			1.1	L L	1	1	1	1	11.1	1.1	1	1.1	1.1	1 • 1	1.1	1.1.1.	11	1 1	1.1	• 1
I .		Ι.																			
2411		I NOV		THROUGH		24N F	RDCCD		240,000	1 1 • 1					1 • 1		1 1 1 •				•
24M. NPUTIENT HOSPITUL																1 m m		- It	1.11	1.1	
25. CERTI		a DD		MM DD				_		25. ACCEPT ASSIS	INNENT		1 1 1	27. TOT	ALCHARGE		28. AMOUNT PAR	0	29. BAL	ANCE DUE	• 1
() CEP		E STATENEN	ITS ON THE R	EVERSE SIDE AP	PLYTOTHS	BUL				YES			NO								
										30. EMPLOYERID		NUMBER/					E, ADDRESS, ZIP CO	BOE	-		
Sa.	11y	FO.	LCII							SOCIAL SECUR	OTY NUMBER	c .		Sal	y Forti	n					
	REOF PHYS													312	Main §	Street					
	1	1 1	1		1	I I															
	1 2	3	4 5	6 7	8	9											ork 1111				
258. MED		DENTIFICAT	TON NUMBER					LOCAT CODE		250. 8A 32A EXCP CODE	NY FEE H	S BEEN FAID		TELEPH DO NOT	ONE NUMBER			EXT.	1000	MEDNY-1500	
	ICAID GROUP																				
1	ICAID GROUP		1		I	1				Y	'E8	_	NO								
COUNTY		L 25E	DATE SIGNE	0 32. PATIE	ENTR ACCOU	NT NUME	0		3					ł.,							
	OF SUBNITTA	10	06 0	8				0	3			_		;							
		10	06 0	8	ENTRE ACCOUL		0	0	3			_] []1]2	3 4 5	;							

Patient's Name (Field 1)

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

Date of Birth (Field 2)

Enter the patient's birth date. This information may be obtained from the Client's (Patient's) Common Benefit ID Card. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.2-1.

Exhibit 2.4.2-1

2.							
		DAT	ΕO	FΒ	IRTH	ł	
0	1	0	2	1	9	7	4

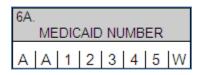
Patient's Sex (Field 5A)

Place an 'X' in the appropriate box to indicate the patient's sex. This information may be obtained from the Client's (Patient's) Common Benefit ID Card.

Medicaid Number (Field 6A)

Enter the patient's ID number (Client ID number). This information may be obtained from the Client's (Patient's) Common Benefit ID Card. Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of 8 characters in the format AANNNNA, where A = alpha character and N = numeric character as shown in Exhibit 2.4.2-2.

Exhibit 2.4.2-2



Was Condition Related To (Field 10)

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

Patient's Employment

Use this box to indicate Worker's Compensation. Leave this box blank if condition is related to patient's employment, but not to Worker's Compensation.

Crime Victim

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

Auto Accident

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

Other Liability

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

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

Emergency Related (Field 16A)

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.

Name of Referring Physician or Other Source (Field 19)

If the service was ordered or the patient was referred by another provider, enter the ordering/referring provider's name in this field.

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

If services were rendered in a *Shared Health Facility* and the patient was referred for treatment or a specialty consultation by another Medicaid provider in the same Shared Health Facility, obtain the referring/ordering provider's signature in this field. If not applicable, leave blank.

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

Leave this field blank.

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

For Ordering Provider

Enter the ordering provider's National Provider Identifier (NPI) in this field.

For Referring Provider

Enter the Referring Provider's NPI.

Restricted Recipients

When providing services to a patient who is restricted to a primary physician, the NPI of the patient's primary physician, must be entered in this field.

If a patient is restricted to a facility, the NPI of the practitioner at the facility the patient is restricted to, must be entered in this field, *the ID of the facility cannot be used*.

NOTE: A facility ID cannot be used for the Ordering/Referring Provider. In those instances where a service was ordered by a facility, the NPI of a practitioner at the facility ordering the service must be entered in this field.

If no referral was involved, leave this field blank.

DX Code (Field 19D)

Leave this field blank.

Drug Claims Section: Fields 20 to 20C

The following instructions apply to drug code claims *only*:

- The NDC in field 20 and the associated information in fields 20A through 20C must correspond directly to information on the first line of fields 24A through 24L.
- Only the first line of fields 24A through 24L may be used for drug code billing.
- Only one drug code claim may be submitted per 150002 claim form; however, other procedures may be billed on the same claim.

NDC [National Drug Code] (Field 20)

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

Enter the NDC as an 11-digit sequence of numbers. Do not use spaces, hyphens or other punctuation marks in this field.

NOTE: Providers must pay particular attention to placement of zeroes because the labeler of a particular drug package may have omitted preceding (leading) zeros in any one of the NDC segments. The provider must enter the required leading zeros within the affected segment.

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



Package NDC Number Configuration	Correct Leading Zero Placement for 5-4-2 = 11	NDC Field Example:
$\begin{array}{rcrcr} XXXX-XXX-XX\\ 4 & + & 4 & + & 2 & = & 10 \end{array}$	0 XXXX-XXX-XX 5 + 4 + 2 = 11	$ \begin{array}{c c} 20. \text{-NATIONAL DRUG CODE}^{\circ} \\ \circ \\ 0 & X & X & X & X & X & X & X & X & X \\ \end{array} $
XXXXX-XXX-XX 5 + 3 + 2 = 10	5 + 4 + 2 = 11	20NATIONAL DRUG-CODE+ * X¤ X¤ X¤ X¤ X¤ X¤ 0¤ X¤ X¤ X¤ X¤ X¤
XXXXX-XXXX-X 5 + 4 + 1 = 10	xxxx-xxx- 0 x 5 + 4 + 2 = 11	$ \begin{array}{c c} 20\text{NATIONAL-DRUG-CODE}_{\circ} \\ \circ \\ x & x & x & x & x & x & x & x & 0 & x \end{array} $

Unit (Field 20A)

Use one of the following when completing this entry:

UN = Unit

F2 = International Unit

GR = Gram

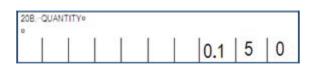
ML = Milliliter

Quantity (Field 20B)

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

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

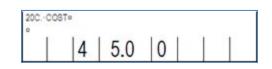




Cost (Field 20C)

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





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

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



MEDICAL ASSISTANCE HEALTH INSURANCE						ONLY TO BE A CODE V					ORIGINAL CLAIM REFERENCE NUMBER						
CLAIM FORM	JIAN	TITLE XIX				U SED TO		N.									
						ADJU ST/VOID PAID CLAIM	A	V			1 1	1 1		1 1	1 1		
PATIENT AND INSURE		SCRIBER) INFORM S NAME (Arst, model, last)	TATION		2	ATE OF BIRTH	24. TOT	AL ANNUAL LY INCOME	3 INSUR	ED/S NAME	E (First name, mist	sia intia; last nan	ne)				
							FAM	LYINCOME									
		SMITH				<u>15 2 0 1 9 9 0</u>											
8	4. PATIENT	S ADORESS (Sheet, City, Sinte, Zip C	(ode)		5.1	NSURED'S SEX MALE FEINALE	SA. PATIEN MALE	FENALE	6. MEDIC	ARENUM	IR		6A. MEDIC	AIDNUMBER			
S S										A B 1 2 3 4 5 C							
I I I I I I I I I I I I I I I I I I I					58						ATE INSURANCE NUMBER GROUP NO. RECIPROCITY NO.						
APL APL					0)											
							ENTS RELATIONSHP TOINSURED 8. INSURE SELF SPOUSE CHLD OTHER			EDS EMPLOYER OR OCCUPATION							
BARCODE AREA																	
8	9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policyholder, Plan Name and Accress and Policy of Phale Insurance Number									RED/8 ADD	ORESS (Street, Ct)	y, State, Zp Cod	e)				
l l l l l l				PATIENT'S X CRIME EMPLOYMENT X X VICTIM													
R R																	
						ACCIDENT X X UABILITY											
	12.						DATE		13.								
	DATIENT	S OR AUTHORIZED SIGNATURS					MM		INSURED	X8 SIGNAT	URF						
		PHYSICIAN O	R SUPP			RMATION (REFE			BEFORE	COM	PLETING /		ling)				
14. DATE OF ONBET 15. F OF CONDITION	FOR CONDIT	ILTED 10. HAS PATIEN ION SAME OR SMIL	T EVER HAD ARSYMPTO	0 N8	10A. ENE RE	RGENCY		PATIENT MAY IN TO WORK	18. DATE TOT	ES OF DISA	BUTY PARTIAL	FROM			то		
MM DD YY MN		YY YES		NO	YES	X X NO	MM	DD YY		٦		MM	DD	YY	MM	DD YY	
19. NAME OF REFERRINGPHYSICA Peter Smith						ESS (OR S/GNATURE SHF			198. PROF C					_	19D. DX CODE	1 1 1	
20. NATIONAL DRUG CODE		204. UN	IT 208. C	QUANTIT	Y			200. 0	рат	1	1 2 3	9 4 3	0 1	0 9			
0 0 17 0 3 6	18 10	1 10 11 G IF		I	I.		5 0		4 5	0 10	1 1						
21. NAME OF FACILITY WHERE SER				_	21A. ADDR	ESS OF FACILITY	13 10	•	14 3		22. WAS LABOR OUTSIDE YO	AT ORY WORK P	ERFORMED	LAB	CHARGES		
											OUTSIDE YO				1		
											YES		NO				
224. SERVICE PROVIDER NAME					228.1	ROF CD 22C. IDEN		NUNBER			220. STERIU2			- 2	E. STATUS CO	OE	
								1 1 1		1	ABORTIC	NCODE					
23. DIAGNOSS OR NATURE OF ILLN	IESS <u>Relat</u>	E DIAGNOSIS TO PROCEDURE	INCOLUMNS	24H BY F	REFERENC	TO NUMBERS 1, 2, 3, ETC.	ORDXCODE	225	Y		N N	220 Y	v	N 22		v v I	
- 1 .									ISIBLE ABILITY	Y	X	EPSOT O/THP	Y N		AMILY LANNING	YX	
2.									PRIOR APPR					_	B. PAYINT SOL		
3.								-	- FRUN HEEN					. 1	S. PATIATION	ALE CODE	
244.	NP	1040	100 In	ME T	we low	2014		241	24.1			246		24		1	
DATE OF SERVICE	248. PLACE	PROCEDURE	240. 2 NOD N	NOD I	24F. 243 MOD MO	DIAGNOSISCODE		24I. DAYS OR UNITS		CHARGE	8			-	~		
M M D D Y Y		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~						ŬNT8									
019 019 019	111	J 1 9 5 5	\vdash			1 6 2.9	1.1	1	1 1	1.1	6.7 5	1.1	1 1 1	• I I	1.1	1.1.	
0 9 0 9 0 9	1.1	9 4 6 1 0	1.1			1 6 2.9			I		815.010						
0 3 0 3 0 3		3 4 0 1 0		-	-	1 0 2.9				1 1	5 5.0 0		1 1 1	• • •			
	1	1.1.1.1		1	1	1.1.1.1	1.1	1	1.1	1.1	1 • 1	1.1	1.1.1	• 11	1.1	1.1.	
			Ι.Τ	.Τ	. Г												
				1	1	1 1 • 1					1 • 1			• 11	1 1	1.1.	
				1	1	1.1.1.1	1.1		1 1	1.1	1.1	1.1		• 11	1 1		
				1	1	1 1 • 1					1 • 1			•		1.1.	
	1					1.1.1.1	1.1	1		1.1	1 • 1	1.1	1.1.1	• III	1.1	1.1.	
24M. FROM NPUTENT NOSPITAL		THROUGH	24N, PRO	0000	240	NCO											
VISITS MM DD 25. CERTIFICATION	YY	MM DD YY				25. ACCEPT ASSIG	NVENT			27. 10	TALCHARGE		28. AMOUN	+	29. 84	LANCE DUE	
() CERTIFY THAT THE STATENEL AND ARE MADE A PART HEREO	NTS ON THE	REVERSE SIDE APPLY TO THIS	BUL			YES	٦		۰O								
30. ENPLOYER IDENTIFICATION NUMBER/ 31. PHYSICIANS CR SUPPLERS NAME, ADDRESS ZIP CODE																	
SALLY FORTE SOCIAL SECURITY NURBER										Sally Forth							
254. PROVIDER IDENTIFICATION N						312 Main Street											
1 1 2 3 4 5 6 7 8 9										Anytown, New York 11111							
258. MEDICAID GROUP DENTIFICA					CATOR		NY FEE HA	8 BEEN FAID		TELEP	HONE NUMBER	() (EXT.			
	I			0 0) 3	EXCP CODE			NO	DO NO	T WRITEIN THIS	SPACE			(12:08)	EVEDNY-150002	
COUNTY OF SUBNITTAL 255	DATE SIGNE	D 32. PATIENTS ACCOU			1 5					-							
						1 1 1 1 4			21410	. 1							
	09						BC	1 2	3 4 5								
33. OTHER REFERENCE ORDERING DUCENSE NUMBER	PROVIDER	09	35.0	CASE MA	NAGER ID		BC	1 2	3 4 5								

Name of Facility Where Services Rendered (Field 21)

This field should be completed *only* when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility.

Address of Facility (Field 21A)

This field should be completed *only* when the Place of Service Code entered in Field 24B is 99 – Other Unlisted Facility.

NOTE: The address listed in this field does not have to be the facility address. It should be the address where the service was rendered.

Service Provider Name (Field 22A)

If the service was provided by a certified diabetes educator or a certified asthma educator, enter his/her name in this field. Otherwise, leave this field blank.

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

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

If the service was provided by a certified diabetes educator or a certified asthma educator, enter the provider's NPI in this field. Otherwise, leave this field blank.

Sterilization/Abortion Code (Field 22D)

Leave this field blank.

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

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

EPSDT C/THP (Field 22G)

Leave this field blank.

Family Planning (Field 22H)

Medical family planning services include diagnosis, treatment, drugs, supplies and related counseling which are furnished or prescribed by, or are under the supervision of a physician or nurse practitioner.

This field must always be completed. Place an 'X' in the YES box if *all* services being claimed are family planning services. Place an 'X' in the NO box if *at least one* of the services being claimed is not a family planning service. If some of the services being claimed, but not all, are related to Family Planning, *place the modifier FP* in the two-digit space following the procedure code in Field 24D to designate those specific procedures which are family planning services.

Prior Approval Number (Field 23A)

If the provider is billing for a service that requires Prior Approval, for example: out-of-state services, 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 claim form has to be submitted for each prior approval.

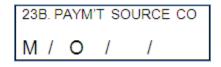
NOTES:

- For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to Information for All Providers, Inquiry section on the web page for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Midwife Manual.
- For information on how to submit a DVS transaction, please refer to the Prior Approval Guidelines, which can be found at www.emedny.org by clicking on the link to the webpage as follows: <u>Midwife Manual.</u>

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

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

Exhibit 2.4.2-7



Both boxes need to be filled as follows:

Box M

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

No Medicare involvement – Source Code Indicator = 1

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

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

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

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

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

Box O

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

No Other Insurance involvement – Source Code Indicator = 1

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

Patient has Other Insurance coverage – Source Code Indicator = 2

This code indicates that the patient has other insurance regardless of the fact that the insurance carrier(s) paid or denied payment or that the service was covered or not by the other insurance. When the value **2** is entered in Box 'O', the two-character code that identifies the other insurance carrier must be entered in the space following Box O. If more than one insurance carrier is involved, enter the code of the insurance carrier who paid the largest amount. For the appropriate Other Insurance codes, refer to Information for All Providers, Third Party Information, which can be found at www.emedny.org by clicking on the link to the webpage as follows: <u>Midwife Manual.</u>

Patient Participation – Source Code Indicator = 3

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

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



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

Encounter Section: Fields 24A to 240

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

Date of Service (Field 24A)

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

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

Place [of Service] (Field 24B)

This two-digit code indicates the type of location where the service was rendered. Please note that place of service code is different from locator code. Select the appropriate codes from Appendix B-Code Sets.

NOTE: If code 99 (Other Unlisted Facility) is entered in this field for any claim line, the exact address where the procedure was performed must be entered in fields 21 and 21A.

Procedure Code (Field 24C)

This code identifies the type of service that was rendered to the patient. Enter the appropriate five-character procedure code in this field.

NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link to the webpage as follows: <u>Midwife Manual.</u>

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

Under certain circumstances, the procedure code must be expanded by a two-digit modifier to further explain or define the nature of the procedure. If the Procedure Code requires the addition of modifiers, enter one or more (up to four) modifiers in these fields.

Special Instructions for Claiming Medicare Deductible

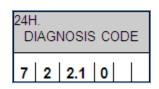
When billing for the Medicare *deductible*, modifier *"U2"* must be used with the Procedure Code for which the deductible is applicable. *Do not enter* the *"U2"* modifier if billing for Medicare *coinsurance*.

Note: Modifier values and their definitions are available at www.emedny.org by clicking on the link to the webpage as follows: Midwife Manual.

Diagnosis Code (Field 24H)

Using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) coding system, enter the appropriate code which describes the main condition or symptom of the patient. The ICD-9-CM code must be entered exactly as it is listed in the manual in the correct spaces of this field and in relation to the decimal point. Proper entry of an IDC-9-CM Diagnosis Code is shown in Exhibit 2.4.2-9.

Exhibit 2.4.2-9



NOTE: A three-digit Diagnosis Code (no entry following the decimal point) will only be accepted when the Diagnosis Code has no subcategories. Otherwise, Diagnosis Codes with subcategories MUST be entered with the subcategories indicated after the decimal point.

Days or Units (Field 24I)

If a procedure was performed and approved by Medicare 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, this field may be left blank.

Charges (Field 24J)

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

Amount Charged

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

Medicare Approved Amount

Box M in field 23B must have an entry value of **2**. Enter the Medicare Approved Amount in field 24J. The Medicare Approved amount is determined as follows:

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

NOTES:

The entries in field 23B, Payment Source Code, determine the entries in field's 24J, 24K, and 24L.

- Field 24J must never be left blank or contain zeroes. If the Medicare Approved amount from the EOMB equals zero, then Medicaid should not be billed.
- It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Unlabeled (Field 24K)

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

Box M = 2

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

Box M = 3

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

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

Unlabeled (Field 24L)

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

- When Box O has an entry value of 2, enter the other insurance payment in this field. If more than one insurance carrier contributes to payment of the claim, add the payment amounts and enter the total amount paid by all other insurance carriers in this field.
- When Box O has an entry value of 3, enter the Patient Participation amount. If the patient is covered by other insurance and the insurance carrier(s) paid for the service, add the Other Insurance payment to the Patient Participation amount and enter the sum in this field.

If the other insurance carrier denied payment, enter 0.00 in field 24L. 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 for 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 the provider to zero-fill other insurance payment for 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 them 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 patient 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 patient or absent parent.
- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

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

NOTES:

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

Consecutive Billing Section: Fields 24M to 240

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

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

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

Proc Code [Procedure Code] (Field 24N)

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

- 99231 through 99233
- 99433

MOD [Modifier] (Field 240)

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

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

Trailer Section: Fields 25 through 34

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

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

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

Provider Identification Number (Field 25A)

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

Medicaid Group Identification Number (Field 25B)

Leave this field blank.

Locator Code (Field 25C)

For electronic claims, leave this field blank. For paper claims, enter the locator code assigned by NYS Medicaid.

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at any time, afterwards, that a new location is added. Enter the locator code that corresponds to the address where the service was performed.

Locator codes 001 and 002 are for administrative use only and are not entered in this field.

If the provider renders services at one location only, enter locator code 003. If the provider renders service to Medicaid patients at more than one location, the entry may be 003 or a higher locator code.

NOTE: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section located at www.emedny.org by clicking on the link to the webpage as follows: Midwife Manual.

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

Providers who are billing Medicaid Obstetric and Maternal Services (MOS) need to indicate a Service Authorization (SA) Exception Code of "7" in this field. Otherwise, leave this field blank.

County of Submittal (Unnumbered Field)

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

Date Signed (Field 25E)

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

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

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

Enter the provider's name and correspondence 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. The Locator Code will default to 003 if the nine digit ZIP code does not match information in the provider's Medicaid file.

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

Patient's Account Number (Field 32)

For record-keeping purposes, the provider may choose to identify a patient 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 patient identification.

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

Leave this field blank.

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

Leave this field blank.



3. Explanation of Paper Remittance Advice Sections

This Section presents samples of each section of the Midwife's remittance advice, 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.

General Remittance Advice Information is available in the All Providers General Billing Guideline Information section available at www.emedny.org by clicking on the link to the webpage as follows: <u>Information for All Providers</u>.

The remittance advice is composed of five sections.

Section One may be one of the following:

- Medicaid Check
- Notice of Electronic Funds Transfer
- Summout (no claims paid)

Section Two: Provider Notification (special messages)

Section Three: Claim Detail

Section Four:

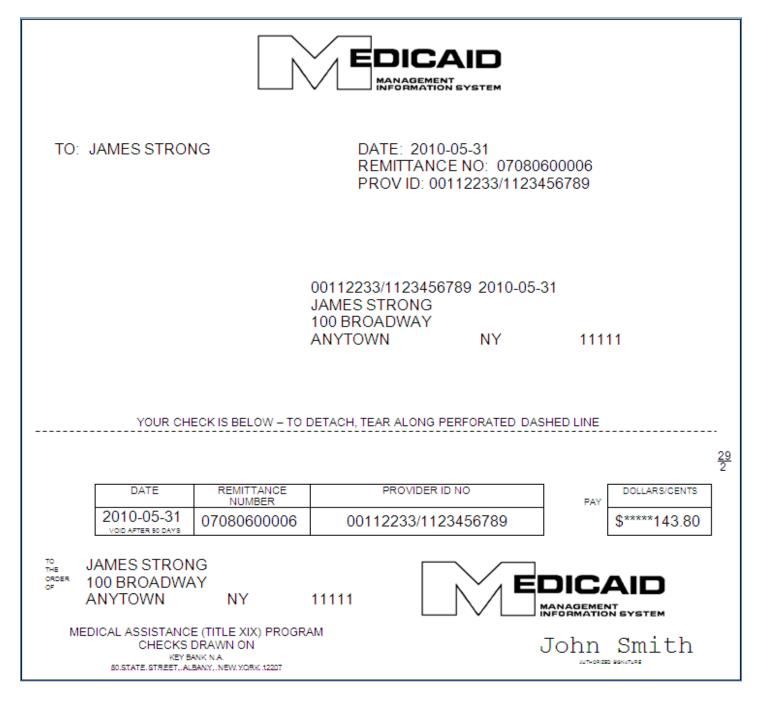
- Financial Transactions (recoupments)
- Accounts Receivable (cumulative financial information)

Section Five: Edit (Error) Description

3.1 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).

Exhibit 3.1-1



3.1.1 Medicaid Check Stub Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/Date

Provider's Name/Address

3.1.2 Medicaid Check Field Descriptions

Left Side

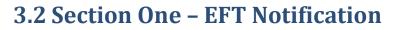
Table

Date: The date on which the check was issued Remittance Number Provider ID No.: This field will contain the Medicaid Provider ID and the NPI

Provider's Name/Address

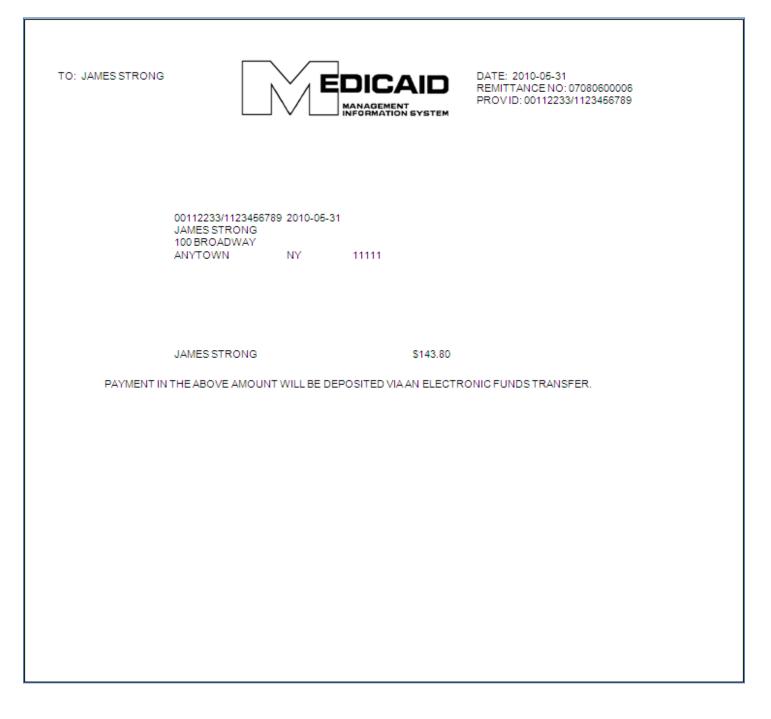
Right Side

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.



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.

Exhibit 3.2-1



3.2.1 EFT Notification Page Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Medicaid Provider ID/NPI/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.

3.3 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.

Exhibit 3.3-1

TO: JAMES STRONG			DICAID MANAGEMENT INFORMATION BYSTEM	DATE: 05/31/2010 REMITTANCE NO: 07080600006 PROVID: 00112233/1123456789
Ν	NO PAYMENT WILL E	BE RECEIVED	THIS CYCLE. SEE REMIT	TANCE FOR DETAILS.
	JAMES STRONG 100 BROADWAY ANYTOWN	NY	11111	

3.3.1 Summout (No Payment) Field Descriptions

Upper Left Corner

Provider's Name (as recorded in the Medicaid files)

Upper Right Corner

Date: The date on which the remittance advice was issued

Remittance Number

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Center

Notification that no payment was made for the cycle (no claims were approved)

Provider's Name/Address

3.4 Section Two – Provider Notification

This section is used to communicate important messages to providers.

Exhibit 3.4-1

Image: Constraint of the second consecond consecond constraint of the second constraint of
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 ACCOUNTFOR 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.
NOTICE: THIS COMMUNICATION AND ANY ATTACHMENTS MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL UNDER STATE AND FEDERAL LAW AND IS INTENDED ONLY FOR THE USE OF THE SPECIFIC INDIVIDUAL(S) TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY ONLY BE USED OR DISCLOSED IN ACCORDANCE WITH LAW, AND YOU MAY BE SUBJECT TO PENALTIES UNDER LAW FOR IMPROPER USE OR FURTHER DISCLOSURE OF INFORMATION IN THIS COMMUNICATION AND ANY ATTACHMENTS. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY NYHIPPADESK@CSC.COM OR CALL 1-800-541-2831. PROVIDERS WHO DO NOT HAVE ACCESS TO E-MAIL SHOULD CONTACT 1-800-343-9000.

3.4.1 Provider Notification Field Descriptions

Upper Left Corner

Provider's Name/Address (as recorded in the Medicaid files)

Upper Right Corner

Remittance Page Number

Date: The 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)

Name of Section: **PROVIDER NOTIFICATION**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

Center

Message Text



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.

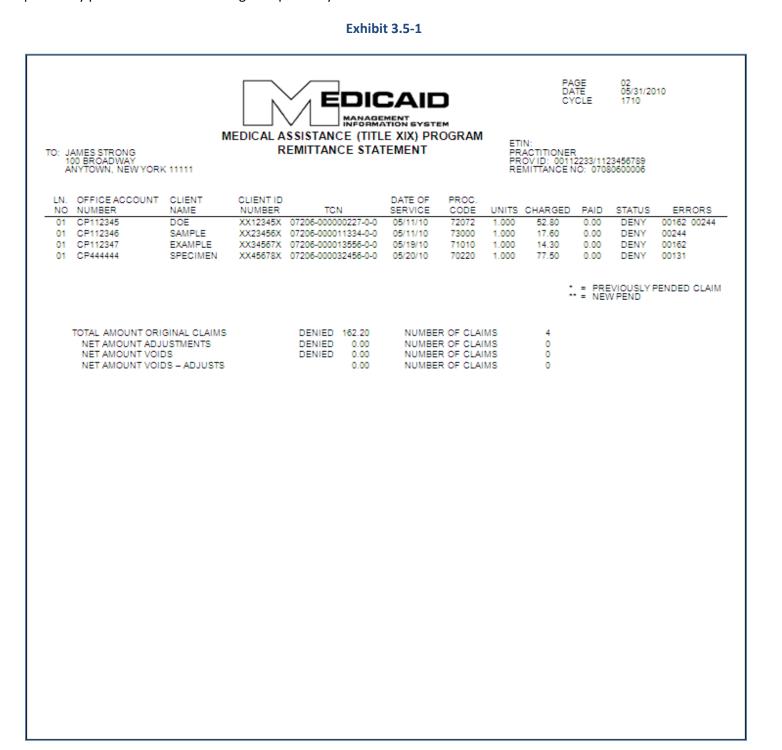






Exhibit 3.5-2

10	AMES STRONG D BROADWAY NYTOWN, NEW YORK			TANCE (TITLE XI)	() PROGR	AM	WA GO	IN: RACTITIONE ROVID: 001 EMITTANCE	R 12233/11 NO: 07/	123546789	
LN.	OFFICE ACCOUNT NUMBER	CLIENT	CLIENT ID	TCN	DATE OF SERVICE	PROC.		CHARGED	PAID		ERRORS
	CP111111	DOE	the second se	07206-000033667-0-0	05/11/10	CODE 72072	1.000	14.30	14.30	PAID	ERRORS
	CP222222	SAMPLE		07206-000033667-0-0	05/12/10	73010	1.000	14.30	14.30	PAID	
-	CP333333 CP44444	EXAMPLE SPECIMEN		07206-000045667-0-0 07206-000056767-0-0	05/14/10 05/15/10	71035	1,000	52.80	52.80 66.00	PAID	
	CP777777	STANDARD		07206-000067767-0-0	05/05/10	70260	1.000	17.60	17.60-	ADJT	CLAIM PAID 05/24/10
01	CP555555	MODEL	XX67890X	07206-000088767-0-0	05/05/10	70328	1.000	14.30	14.30	ADJT	

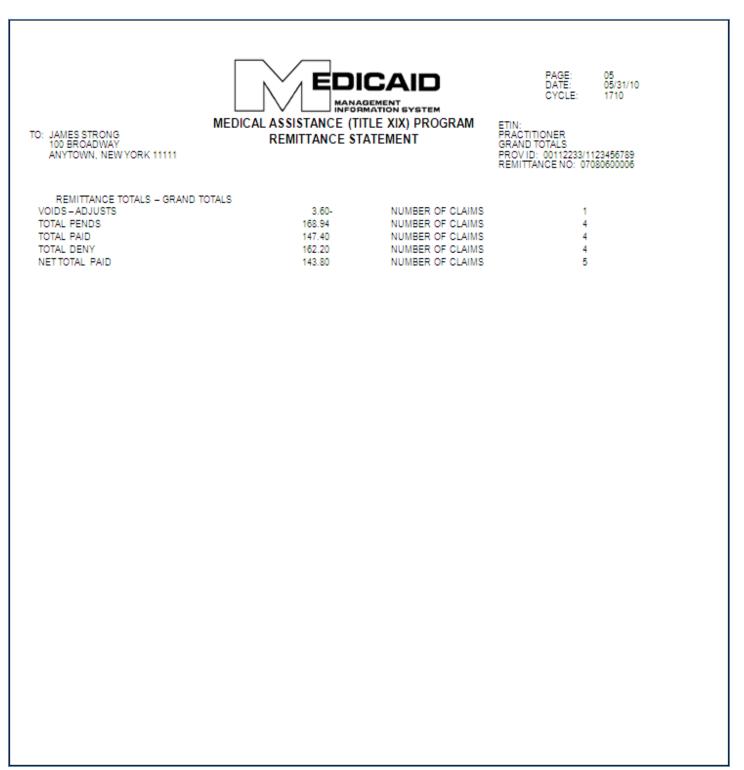


Exhibit 3.5-3

	Λ		VĽ	MANAG	CAIC	IM		PA DA CY		04 05/31/20 1710	10
JAMES STRONG 100 BROADWAY ANYTOWN, NEW YORI				NCE STA			PR	IN: ACTITIONER OVID: 00112 MITTANCE N	2233/112		
LN. OFFICE ACCOUNT NO NUMBER	CLIENT NAME	CLIENT ID NUMBER	т	CN	DATE OF SERVICE	PROC. CODE	UNITS	CHARGED	PAID	STATUS	ERRORS
01 CP112347	EXAMPLE	XX34567X			05/13/10	70100	1.000	69.30	0.00	**PEND	00162
02 CP44444 01 CP112348	SPECIMEN STANDARD	XX45678X XX56789X		0033468-0-0	05/14/10	72170 71015	1.000	71.04 14.30	0.00	**PEND	00162
01 01 112010	OTANDAND		07200-000	1033003-0-0	05/14/10	/1015	1.000	14.30	0.00	FEND	00142
01 CP777777	MODEL			0033660-0-0	05/12/10	72190	1.000	14.30	0.00 = PRE = NEV	**PEND	00131 PENDED CLAIM
TOTAL AMOUNT ORI NET AMOUNT ADJ	GINAL CLAIMS		PEND PEND	168.94 0.00	NUMBER NUMBER	OF CLAIN OF CLAIN	IS	4 0	= PRE	**PEND	
TOTAL AMOUNT ORI	GINAL CLAIMS USTMENTS DS		07206-000 PEND	168.94	NUMBER NUMBER NUMBER	OF CLAIN	IS IS	4	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOI NET AMOUNT VOI REMITTANCE TOTALS	GINAL CLAIMS USTMENTS DS DS – ADJUSTS 8 – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00	NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS	4 0 0	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOI NET AMOUNT VOI	GINAL CLAIMS USTMENTS DS DS – ADJUSTS 8 – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00	NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS	4 0 0	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOI NET AMOUNT VOI REMITTANCE TOTALS VOIDS – ADJUSTS	GINAL CLAIMS USTMENTS DS DS – ADJUSTS 8 – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 3.60-	NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS	4 0 0 0	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOII NET AMOUNT VOII REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL DENIED	GINAL CLAIMS USTMENTS DS DS – ADJUSTS 8 – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 0.00 3.60- 168.94 147.40 162.20	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS IS IS IS	4 0 0 1 4 4 4	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOI NET AMOUNT VOI NET AMOUNT VOI REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL DENIED NET TOTAL PAID	GINAL CLAIMS USTMENTS DS DS - ADJUSTS S - PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 3.60- 168.94 147.40	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS IS IS IS	4 0 0 1 4 4	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT VOI NET AMOUNT VOI NET AMOUNT VOI REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PENDS TOTAL PAID NET TOTAL PAID MEMBER ID: 001122	GINAL CLAIMS USTMENTS DS DS – ADJUSTS S – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 168.94 147.40 162.20 143.80	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS IS IS IS IS	4 0 0 0 1 4 4 5	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOI NET AMOUNT VOI NET AMOUNT VOI REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PENDS TOTAL DENIED NET TOTAL PAID	GINAL CLAIMS USTMENTS DS DS – ADJUSTS S – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 0.00 3.60- 168.94 147.40 162.20	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS IS IS	4 0 0 1 4 4 4	= PRE	**PEND	
TOTAL AMOUNT ORI NET AMOUNT ADJ NET AMOUNT VOII NET AMOUNT VOII REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PAID TOTAL PAID NET TOTAL PAID NET TOTAL PAID MEMBER ID: 001122 VOIDS – ADJUSTS	GINAL CLAIMS USTMENTS DS DS – ADJUSTS S – PRACTITION	XX67890X	PEND PEND	168.94 0.00 0.00 0.00 168.94 147.40 162.20 143.80 3.60-	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN	IS IS IS IS IS IS IS IS IS	4 0 0 0 1 4 4 5 1	= PRE	**PEND	



Exhibit 3.5-4



3.5.1 Claim Detail Page Field Descriptions

Upper Left Corner

Provider's Name/Address (as recorded in the Medicaid files)

Upper Right Corner

Remittance Page Number

Date: The 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: **PRACTITIONER**

PROV ID: This field will contain the Medicaid Provider ID and the NPI

Remittance Number

3.5.2 Explanation of 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 in this column.

Client ID Number

The patient's Medicaid ID number appears under this column.

TCN

The TCN is a unique identifier assigned to each claim 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

The first date of service (From date) entered in the claim appears under this column. If a date different from the From date was entered in the Through date box, that date is not returned in the Remittance Advice.

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 Chiropractors and Portable X-Ray Suppliers 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 was 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: Patient 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 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.

3.5.3 Subtotals/Totals/Grand 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
- Deny
- Net total paid (for the specific service classification)

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)



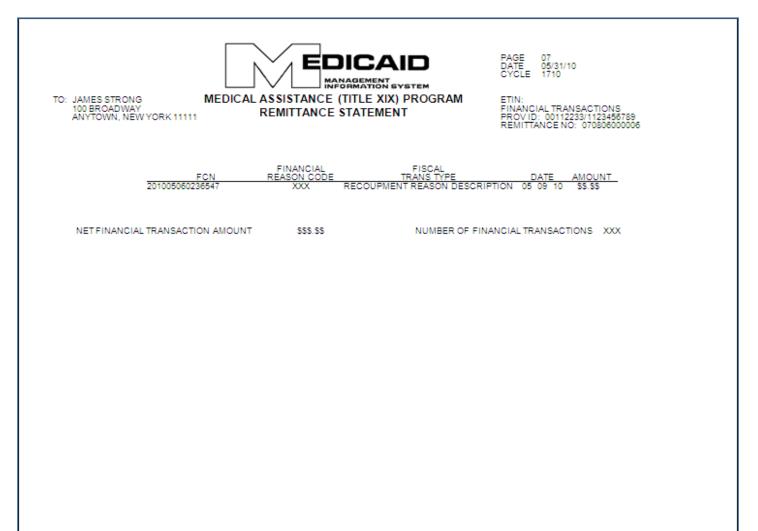
This section has two subsections:

- Financial Transactions
- Accounts Receivable

3.6.1 **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.

Exhibit 3.6.1-1



3.6.1.1 Explanation of Financial Transactions Columns

FCN

The Financial Control Number (FCN) 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.

Financial 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.

3.6.1.2 Explanation of Totals Section

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.

3.6.2 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.

			Exhibit 3.6.2	-1	
TO: JAMES STRONG 100 BROADWAY ANYTOWN, NEW	YORK 11111 M	EDICAL ASSIST REMITT		N SYSTEM	PAGE 08 DATE 05/31/10 CYCLE 1710 ETIN: ACCOUNTS RECEIVABLE PROVID: 00112233/1123456789 REMITTANCE NO: 07080600006
REASON CODE	DESCRIPTION	ORIG BAL SXXX.XX- SXXX.XX-	CURR BAL SXXX.XX- SXXX.XX-	RECOUP %/AMT 999 999	
TOTAL AMOUNT DUE	THE STATE \$XXX.XX				

3.6.2.1 Explanation of 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.



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.

Exhibit 3.7-1

		PAGE 06 DATE 05/31/10 CYCLE 1710
TO: JAMES STRONG 100 BROADWAY ANYTOWN, NEW YORK 11111	MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT	ETIN: PRACTITIONER EDIT DESCRIPTIONS PROVID: 00112233/1123456789 REMITTANCE NO: 07080600006
THE FOLLOWING IS A DESCRIPTION C 00131 PROVIDER NOT APPROVE 00142 SERVICE CODE NOT EQUA 00162 RECIPIENT INELIGIBLE ON	L TO PA	FOR THIS REMITTANCE:
00244 PANOT ON OR REMOVED	FROMFILE	



APPENDIX A CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains an image of a claim with sample data.



M	DICA	4661	CTANC	E HEALTH IN	eup	ANC	_	0	NLY TO BE	A CO	DEV				ORIGI	NALC	CLAIM REF	FERENCI	E NUM	BER				_
			STANC	TITLE XIX				U	SED TO			Ŀ												
									DJU ST/VOID AID CLAIM	A	V												.	
PATIE	NT AND	INSURE	_	SCRIBER) INFORM	IATIO	N				24. 7.0	TAL ANNUAL					-	intia) last nam							
			1.PATIENTS	NANE (Ant) middle, las)				2 DATE	OF BIRTH	FAN	TAL ANNUAL ILY INCOME		3. INSURED	Je nave	: (First name,	mode	inclas, aux nam							
			JANE	SMITH				0.5	2:0:1:9:9:0															
		8	4. PATIENTS	ADDRESS(Shee); City Size, Zip (Code)			5. INBUR	ED/8 SEX	SA. PATIE			6. NEDICAR	RENUME	er.			6A, MEDIC	ALDINUME	ER				_
									E PENALE	MALE	 -	1						AB	11	2	3 4	5	IC	
		9					L			Х	X									-			Ŭ.	
		NOT STAPLE						SB. PAT	IENT'S TELEPHONE N.	UNBER			68. PRIVAT	TE INBUR	ANCE NUME	BER		GROUP N	0.		RECIPRO	DCITYNO		
		Ē		S EMPLOYER, OCCUPATION OR			_	(7. EATIS) ENTS RELATIONSHIPT						OVER OR O		TICH							
		z.	DIL PRIMI	S EPCORE, OCCOPATION OR	SCHOOL				SELF SPOUSE		OTHER		a moune.	US ENFL	LOTEN ON O									
		BARCODE AREA																						
		8		EALTHIN SUR ANCE COVER AGE - nd Address, and Policy or Privale Ins			er,		CONDITION RELATED				11. INSURE	ED/8 ADD	R888 (8tee	t ay,	State, Zp Code	0						
		Ē,						ENPL	ATTENT/8 OYMENT X	X	RIME													
		RE							AUTO 🗸		THER													
		-						A	COLDENT X		ABILITY													
			12.							DATE			13.											
										MM		YY												
<u> </u>			PATIENTS	PHYSICIAN O		PPLIEF	RINF	ORM	ATION (REFE				EFORE (G AI	ND SIGN	ING)						_
14. DATE	OF ONSET		RET CONSUL	TED 10. HAS PATIEN	(T EVER H	AD	16A, E		CY	17. DATE I	PATIENT NA	Y	18. DATES	OF DISA	BUTY		FROM			T	0			
						— I		_	I				TOTAL	-	PARTI	IAL		1	1					
MM 10 NAME		NGPHYRCA	DD	YY YES SOURCE		NO	YE8 104 - 41		IORSIGNATURESHE	MM	DD	YY 10	B. PROF CO	100		TIONS	MM	DD	11		MM D. DX CO		OD	YY
												1.					4 5	6 7	8 9		ĨĨ	. 1		
20. NATIO	INAL DRUG C	3005		204. U	NT 208.	QUANT	TY .				200.	008	т	•		•								
	1 1	1 1				1 1	1	1	.			I	.			I								
21. NAME	OF FACILITY	WHERE SER	ICES RENDE	RED (If other then home or office	U	<u>' '</u>	21A, AI	ORE88	OF FACILITY			-		1	22. VIAS LAS	BORAT E YOU	ORY WORK PE	RFORMED		LAB C	HARGES			
																_								
															YES			NC						
224. SERV	ICE PROVIDE	ERNAME					22	. PROF	CD 22C. IDENT	TIRCATION	NUMBER				220. STE					225	STATUS	CODE		_
								1	1 1		1 1	T		1	ABO	RTION	CODE							
23. DIAGN	1088 OR NAT	TURE OF ILLN	ESS <u>Relate</u>	DAGNOSIS TO PROCEDURE	INCOLUN	N24H BY		NCETON	NUMBERS 1, 2, 3, ETC. (ORDXCOD	E 2	25	Y		N		23 Y		N	22H	1			N
1.												0881		Y	X		PBOT	Y N		FAN		Y	X	
2												IBABI				6	THP				NNNG			_
3.											2	8A. FI	RIOR APPROV	AL NUM	88					238.	PAYMET	SOURCE C	00E	
														1	1	1			1	1		1	l I	
244.	DATE OF		24B. PLACE	240. PROCEDURE	240. MOD	24E. NOD	MOD I	48. 100	24H. DIAGNOSIS CODE		241. DAYS	2	24J.			<u> </u>	24K.			241				
	SERVICE			00							241. DAYS OR UNITS				-									
M M	D D	ΥY										_												
019	0 4	0 8	1.1	9 9 2 0 1					V 7 2. 3	4					6.5					1.				
015	1014			3 3 2 0 1	+	$\left \right $	\rightarrow		V 1 2. J			-			10.3	1.0			•	-				•
019	1 0	0 8	111	9 9 2 1 1	1.1		11	1.1	V 7 2.3	1 i i i	L 1				15.0	10	1.1	1.1.1			1	і I	1	· 1
019	1⊤5	0 8	111	9 9 2 1 1	1		1	1	V 7 2.3	<u>1 </u>	1	_	1.1		15.0	10	1.1		•			<u> </u>		• 1
	L	L													1.	.				1.				
<u> </u>						+ +	-		1			+				-			•	-				• •
1.1								1	1.1.1.1	1.1			1.1	1.1	1.1		1.1	1.1	•		1	<u>і</u> і	1	·
	i																							
					1		1		1.1.1			+		1 1	1.1		1.1		•	1	1			• 1
, I																								
24M. NPLITENT HOSPITAL	1	ROM	1	тнясизн	24N. P	ROCCD	-	HOMOD						1 1		-		1 1	•	-		<u> </u>	1	•
VETE	M	M _ DD	1 11	MM DD YY				1	1.1.1.1	1.1			1.1		1.1		1.1	1.1			1	<u>і і</u>	1	. I
25. CERTI				EVERSE SIDE APPLY TO THIS	BU				26. ACCEPT ASSIGN	MENT				27. TO	TALCHARGE	e		28. AMOUN	TPAID	1	29.	BALANCE	DUE	
ANDA	RE MADE A P	ART HEREOF	9						YES		NN NO	NO		24.000				1000						
Sa.	lly	Fo:	rth						30. EMPLOYERIDE SOCIAL SECURI	TYNUNBER	R				ly Foi		FUERS NAME	, AUURESS,	2P CODE					
SIGNATUR	REOF PHY8(CIAN OR SUP	RUER																					
25A, PRO/	VIDER DENT	FICATION NU	NEER		1										Main									
1	1 2	3	4 5	6 7 8	9									An	ytown	1, N	lew Yo	ork 11	111					
		DENTIFICAT					DCATO			NY FEE H	48 BEEN FAIL	0	_	TELEP	HONE NUME)			EXT.				
I 1	I		Ι		1		DDE) 3		EXCP CODE YE				NO	00 NO	WRITEIN	IHI88	ALCE:				(1	108) EMEDI	vr-15000	2
COUNTY	OF SUBNITTA		DATE SI GNEC		NT NUNB		· ·	,						1										
		09	16 0	8 8					A	BC	1 2	3	4 5											
B 33. OTHER D'UC	rreferring Inde Nuver	R ORDERING F	ROVIDER	34. PROF C	0 35	CASE M	ANAGER	0						-										



APPENDIX B CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of Place of Service codes as well as a list of accepted Unites States Standard Postal Abbreviations.

Place of Service	
Code	Description
03	School
04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
11	Doctor's office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgical center
24	Birthing center
25	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
58	Mass immunization center
59 60	Comprehensive inpatient rehabilitation facility
65	Comprehensive outpatient rehabilitation facility
71	End stage renal disease treatment facility State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	
33	Other unlisted facility



United States Standard Postal Abbreviations

State Alabama Alaska Arizona Arkansas California Colorado Connecticut Delaware District of Columi Florida Georgia Hawaii Idaho Illinois Iowa Indiana Kansas Kentucky Louisiana Maine	Abbrev. AL AK AZ CA CO CT DE DE DE DE GA HI ID IL IL IA IN KS KY LA ME	State Missouri Montana Nebraska Nevada New Hampshire New Jersey New Mexico North Carolina North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas Utah Vermont	Abbrev. MO MT NE NV NH NJ NM NC ND OH OH OH OK OR PA RI SC SD TN TX UT VT
Maine Maryland Massachusetts Michigan Minnesota	ME MD MA MI MN American Territories American Samoa Canal Zone	Vermont Virginia Washington West Virginia Wisconsin <u>Abbrev.</u> AS CZ	VT VA WA WV WI
	Guam Puerto Rico Trust Territories Virgin Islands	GU PR TT VI	

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

APPENDIX C Sterilization Consent Form – LDSS-3134

A Sterilization Consent Form, LDSS-3134, must be completed for each sterilization procedure. No other form can be used in place of the LDSS-3134. A supply of these forms, available in English and in Spanish [LDSS-3134(S)], can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

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

When completing the 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 (will cause a paper claim to deny). 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 LDSS-3134 [or LDSS-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 LDSS form was signed regardless of the date the woman becomes Medicaid eligible.

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

LDSS-3134 (2/01)	PATIENT NAME	CHART NO. REC	IPIENT ID NO.
STERILIZATION	1.		
CONSENT FORM	HOSPITAL/CLINIC		
BENEFITS PROVIDED B	Y TIME NOT TO BE STERILIZED WIL BY PROGRAMS OR PROJECTS RECT STERILIZATION ■	LL NOT RESULT IN THE WITHDRAWAL OR WITH EIVING FEDERAL FUNDS. STATEMENT OF PERSON OB	
		10	
2. (doctor or clinic)	nformation about sterilization from When I asked for the	Before	
information, I was told that the de up to me. I was told that I could d not to be sterilized, my decision v or treatment. I will not lose ar receiving Federal funds, such as getting or for which I may become I UNDERSTAND THAT TH CONSIDERED PERMANENT A DECIDED THAT I DO NOT WAN' CHILDREN OR FATHER CHILDF I was told about those tempora available and could be provided to father a child in the future. I ha chosen to be sterilized. I understand that I will be ste associated with the operation has questions have been answered to I understand that the operation days after I sign this form. I under	HE STERILIZATION MUST B ND NOT REVERSIBLE. I HAV TO BECOME PREGNANT, BEA REN. ary methods of birth control that ar o me which will allow me to bear o we rejected these alternatives ar writized by an operation know as he discomforts, risks and benefi we been explained to me. All m	aly operation 14. , the a final and irreversible procedure and benefits associated with it. I counseled the individual to be sterilized of birth control are available which are sterilization is different because it is permission of birth control are available which are visith control are available which are withdrawn at any time and that he/si visith control are available which are withdrawn at any time and that he/si visith control are available which are withdrawn at any time and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si visith control are available which are and that he/si and appears to understand the nature and that he/si and and and available which are and that he/si and and available which are	e fact that it is intended to b d the discomforts, risks an lized that alternative method temporary. I explained the manent. d that his/her consent can b he will not lose any healt leral funds. belief the individual to b appears mentally competen juested to be sterilized an and consequence of th
result in the withholding of any be by federally funded programs	enefits or medical services provide		
I am at least 21 years of age an	d was born on <u>4</u> . Month Day Year		on operation upon
free will to be sterilized by	Month Day Year , hereby consent of my ow 6. (Doctor) My conse	nt Operation	on19. Date of sterilization
by that Department but only for observed. I have received a copy of this for 8 . Signature	Date:9 . Month Day Yea	re I counseled the individual to be sterili of birth control are available which are sterilization is different because it is pern I informed the individual to be sterilize withdrawn at any time and that he/si ar services or benefits provided by Federal	temporary. I explained that manent. ed that his/her consent can b he will not lose any healt funds.
You are requested to supply th required: 10	e following information, but it is no •	To the best of my knowledge and sterilized is a least 21 years old and a	belief the individual to b appears mentally competen
	lease check)	He/She knowingly and voluntarily req appeared to understand the nature	
Race and ethnicity designation (pl			
□ 1 American Indian or	4 Hispanic	Instructions for use of alternative	
□ 1 American Indian or Alaska Native	 4 Hispanic 5 White (not of Hispanic origin 	Instructions for use of alternative first paragraph below except in the ca	ase of premature delivery of
Alaska Native 2 Asian or Pacific Islander 3 Black (not of Hispanic origin)	□ 5 White (not of Hispanic origin	Instructions for use of alternative first paragraph below except in the ca emergency abdominal surgery where t less than 30 days after the date of the consent form. In those cases, the secon	ase of premature delivery of the sterilization is performe individual's signature on th nd paragraph below must b
 ☐ 1 American Indian or Alaska Native ☐ 2 Asian or Pacific Islander ☐ 3 Black (not of Hispanic origin) ■ INTERPRETER If an interpreter is provided to a: I have translated the information individual to be sterilized by the paralso read 1 him/her 	□ 5 White (not of Hispanic origin R'S STATEMENT ■ ssist the individual to be sterilized: n and advice presented orally to th erson obtaining this consent. I hav the consent form	 Instructions for use of alternative first paragraph below except in the ca emergency abdominal surgery where t less than 30 days after the date of the consent form. In those cases, the secon used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this case sterilization was performed. (2) This sterilization was performed than 72 hours after the date of 	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature o
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a: I have translated the information individual to be sterilized by the pe also read 11. him/her contents to him/her. To the best	5 White (not of Hispanic origin R'S STATEMENT = ssist the individual to be sterilized: n and advice presented oraily to the reson obtaining this consent. I have a sterilized or the steriliz	 Instructions for use of alternative first paragraph below except in the cateria emergency abdominal surgery where the less than 30 days after the date of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passes individual's signature on this case individual's signature on this case in the sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of (check applicable and fill in inform) 	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must be s not used.) ad between the date of the consent form and the dat less than 30 days but more the individual's signature of the following circumstance
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETER If an interpreter is provided to a: I have translated the information individual to be sterilized by the pa also read <u>11</u> . him/her contents to him/her. To the best understood this explanation. 12.	□ 5 White (not of Hispanic origin R'S STATEMENT ■ ssist the individual to be sterilized: n and advice presented orally to the reson obtaining this consent. I have the consent form _ language and explained if of my knowledge and belief he/sh	 Instructions for use of alternative first paragraph below except in the cate of the cate of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passes individual's signature on this case individual's sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of the second than 72 hours after the date of the second than 72 hours after the date of the second than 72 hours after the date of this consent form because of the second than 72 hours after the date of the second the second than 72 hours after the date of the second the seco	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature o the following circumstance hation requested): 22.
 1 American Indian or Alaska Native 2 Asian or Pacific Islander 3 Black (not of Hispanic origin) ■ INTERPRETER If an interpreter is provided to a: I have translated the information individual to be sterilized by the paralso read 11. him/her contents to him/her. To the best understood this explanation. 	□ 5 White (not of Hispanic origin R'S STATEMENT ■ ssist the individual to be sterilized: n and advice presented orally to the erson obtaining this consent. I have the consent form language and explained in	 Instructions for use of alternative first paragraph below except in the cate of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this case individual's signature on this case individual's after the date of this consent form because of (check applicable and fill in inform 1. Premature delivery Individual's expected date of de 2. Emergency abdominal surgery: 	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature of the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETER If an interpreter is provided to a: I have translated the information individual to be sterilized by the pa also read <u>11</u> . him/her contents to him/her. To the best understood this explanation. 12.	□ 5 White (not of Hispanic origin R'S STATEMENT ■ ssist the individual to be sterilized: n and advice presented orally to the reson obtaining this consent. I have the consent form _ language and explained if of my knowledge and belief he/sh	 Instructions for use of alternative first paragraph below except in the cate of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this case sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of (check applicable and fill in inform 1. Premature delivery Individual's expected date of describe circumstances): 	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature o the following circumstance hation requested): 22.
1 American Indian or Alaska Native 2 Asian or Pacific Islander 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a: I have translated the information individual to be sterilized by the paralso read 11. him/her contents to him/her. To the best understood this explanation. 12. Interpreter THE FOLLOWING MUST BE CO	State (not of Hispanic origin State (not of Hispanic origin State (not of Hispanic origin State (not of Hispanic origin) State State (not of Hispanic origin) State State (not of Hispanic origin) State (not origin)	Instructions for use of alternative first paragraph below except in the catering of the set of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this (2) This sterilization was performed. ve (2) This sterilization was performed. (check applicable and fill in inform □ 1. Premature delivery Individual's expected date of degree individual's expected date of degree individual's expected with a sterilization was performed. ve 2. Emergency abdominal surgery: (describe circumstances): 26. Physician Physician I was present while the counselor read	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature o the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a I have translated the information individual to be sterilized by the pa also read <u>11</u> . him/her contents to him/her. To the best understood this explanation. <u>12.</u> Interpreter THE FOLLOWING MUST BE C I, <u>27.</u> do form to <u>29.</u> do	State (not of Hispanic origin State (not origin)) State (not origin State (not origin)) State (not origin) St	Instructions for use of alternative first paragraph below except in the cateristic paragraph below except in the cateristic paragraph below except in the cateristic paragraph when a surgery where the less than 30 days after the date of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this caserilization was performed. (2) This sterilization was performed. (2) This sterilization was performed. (2) This sterilization was performed. (2) The sterilization was performed. (check applicable and fill in inform. 1. Premature delivery Individual's expected date of delivery. (describe circumstances): 26. Physician Physician ONS PERFORMED IN NEW YORK CITY Was and the sterilization was performed.	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature of the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a: I have translated the information individual to be sterilized by the pa also read 11. him/her contents to him/her. To the best understood this explanation. 12. Interpreter THE FOLLOWING MUST BE C (patient's name) SIGNATURE OF WITNESS 3.0	State (not of Hispanic origin State (not of Hispanic origin State (not of Hispanic origin State (not of Hispanic origin) State (not origin) State (not origin) State (not of Hispanic origin) State (not origin) Sta	Instructions for use of alternative first paragraph below except in the catering of the set of the consent form. In those cases, the second used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this (2) This sterilization was performed. ve (2) This sterilization was performed. (check applicable and fill in inform □ 1. Premature delivery Individual's expected date of degree individual's expected date of degree individual's expected with a sterilization was performed. ve 2. Emergency abdominal surgery: (describe circumstances): 26. Physician Physician I was present while the counselor read	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the dat less than 30 days but mor the individual's signature o the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a: I have translated the information individual to be sterilized by the period also read 11. him/her contents to him/her. To the best understood this explanation. 12. Interpreter THE FOLLOWING MUST BE C (patient's name) SIGNATURE OF WITNESS X 30. REAFFIRMATION (to be signed by th	SWhite (not of Hispanic origin SSTATEMENT ssist the individual to be sterilized: n and advice presented orally to th rerson obtaining this consent. I have the consent form I anguage and explained if of my knowledge and belief he/sh Date COMPLETED FOR STERILIZATIO Certify that on 2.8 and saw the patient sign th TITLE e patient on admission for Sterilization	Instructions for use of alternative first paragraph below except in the ca emergency abdominal surgery where the less than 30 days after the date of the consent form. In those cases, the secon used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this co- sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of (check applicable and fill in inform check applicable and fill in inform 1. Premature delivery Individual's expected date of de 2. Emergency abdominal surgery: (describe circumstances): <u>26.</u> Physician DNS PERFORMED IN NEW YORK CITY W I was present while the counselor rea- ne consent form in his/her handwriting. 31.	ase of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must b s not used.) ad between the date of th consent form and the date less than 30 days but mor the individual's signature o the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a I have translated the information individual to be sterilized by the palaso read <u>11</u> . him/her contents to him/her. To the best understood this explanation. <u>12.</u> Interpreter THE FOLLOWING MUST BE C (patient's name) SIGNATURE OF WITNESS X 30. REAFFIRMATION (to be signed by th I certify that I have carefully considere	State (not of Hispanic origin State (not of Hispanic origin) State (not	Instructions for use of alternative first paragraph below except in the ca emergency abdominal surgery where t less than 30 days after the date of the consent form. In those cases, the secon used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this co- sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of (check applicable and fill in inform (check applicable and fill in inform 1. Premature delivery Individual's expected date of de 2. Emergency abdominal surgery: (describe circumstances): <u>26.</u> Physician DNS PERFORMED IN NEW YORK CITY - W In was present while the counselor rea- ne consent form in his/her handwriting. 31.	As a of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must be sonot used.) and between the date of the consent form and the date of the individual's signature of the individual's signature of the following circumstance hation requested): 22.
□ 1 American Indian or Alaska Native □ 2 Asian or Pacific Islander □ 3 Black (not of Hispanic origin) ■ INTERPRETEF If an interpreter is provided to a I have translated the information individual to be sterilized by the palaso read <u>11</u> . him/her contents to him/her. To the best understood this explanation. <u>12.</u> Interpreter THE FOLLOWING MUST BE C (patient's name) SIGNATURE OF WITNESS X 30. REAFFIRMATION (to be signed by th I certify that I have carefully considere	State (not of Hispanic origin State (not of Hispanic origin) State (not	Instructions for use of alternative first paragraph below except in the ca emergency abdominal surgery where t less than 30 days after the date of the consent form. In those cases, the secon used. (Cross out the paragraph which is (1) At least thirty days have passe individual's signature on this c sterilization was performed. (2) This sterilization was performed than 72 hours after the date of this consent form because of (check applicable and fill in inform □ 1. Premature delivery Individual's expected date of de 0 2. Emergency abdominal surgery: (describe circumstances): <u>26.</u> <u>Physician</u> I was present while the counselor rea the consent form in his/her handwriting. 31.	As a of premature delivery of the sterilization is performe individual's signature on the nd paragraph below must be sonot used.) and between the date of the consent form and the date of the individual's signature of the individual's signature of the following circumstance hation requested): 22.



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

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 doctor or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (26) 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 (26).

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 (23), or emergency abdominal surgery (24/25) 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 (26).

Field 16

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

Field 17

Enter the address of the facility.



Physician's Statement

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

Field 18

Enter the patient's name.

Field 19

Enter the date the sterilization procedure was performed.

Field 20

Enter the name of the sterilization procedure.

Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (26) and date the consent form.

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

Field 21

Specify the type of operation.

Field 22

Select one of the check boxes as necessary.

Field 23

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 (22) and enter the expected date of delivery (23).

Field 24

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 (22) and describe the circumstances (25).

Field 25

Describe the circumstances of the emergency abdominal surgery.



Field 26

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

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

For Sterilizations Performed In New York City

New York City local law requires the presence of a witness chosen by the 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 27

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

Field 28

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

Field 29

Enter the patient's name.

Field 30

The witness must sign the form.

Field 31

Enter the title, if any, of the witness.

Field 32

Enter the date of witness's signature.

Reaffirmation

Field 33

The patient must sign the form.



Field 34

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

Field 35

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 30.

Field 36

Enter the date of witness's signature.





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

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

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at <u>www.emedny.org</u>.