

# New York State Electronic Medicaid System 150003 Billing Guidelines



11/18/2010

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

# 1. Purpose Statement

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

- Billing and submitting claims.
- 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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-150003 claim form.

To view a sample Midwife eMedNY - 150003 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	2	$7 \rightarrow$	Two interpreted as seven
_ <del></del>	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



The 150003 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 - 150003 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-150003 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims, 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 - 150003 Claim Form Field Instructions

## Header Section: Fields 1 through 23B

The information entered in the Header Section of the claim form (fields 1 through 23B) 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 1029119876543200 is shared by three individual claim lines. This TCN was paid on October 18, 2010. After receiving payment, the provider realized that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.



Exhibit 2.4.2.1-1
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MEDICAL ASSISTANCE HEALTH INSURAN CLAIM FORM TITLE XIX PROGRAM	ICE ONLY TO BE A CODE V	ORIGINAL TRANSACTION CONTROL NUMBER
CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	ADJUST/VOID	
1. PATIENT'S NAME (First, middle, last)	2. DATE OF BIRTH 2A. TOTAL ANNU FAMILY INCO	AL 3. INSURED'S NAME (First name, middle initial, last name) ME
SUSAN SAMPLE 4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	0 5 2 0 1 9 9 0 5. INSURED'S SEX 54. PATIENT'S SEX	6. MEDICARE NUMBER 6A. MEDICAID NUMBER
	5. INSURED'S SEX MALE FEMALE 5A. PATIENT'S SEX MALE FEMALE	X  X   1   2   3   4   5   X
STAPLE		6B. PRIVATE INSURANCE NUMBER GROUP NO. RECIPROCITY NO.
Z	( )	
EC. PATIENTS EMPLOYER, OCCUPATION OR SCHOOL	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name	10. WAS CONDITION RELATED TO	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number	PATIENT'S CRIME EMPLOYMENT CRIME	
	AUTO OTHER	
12.	ACCIDENT LIABILITY	13.
PATIENT'S OR AUTHORIZED SIGNATURE	MM DD YY	INSURED'S SIGNATURE
PHYSICIAN OR SUPPLIER INFORM 14.DATE OF ONSET 15.FIRST CONSULTED 16.HAS PATIENT EVER HAD SAME	IGA. EMERGENCY 17. DATE PATIENT MAY	ORE COMPLETING AND SIGNING) 18.DATES OF DISABILITY FROM TO
OF CONDITION FOR CONDITION OR SIMILAR SYMPTOMS	RELATED RETURN TO WORK	TOTAL PARTIAL MM   DD   YY MM   DD   YY
MM DD YY MM DD YY YES NO 19.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	19A.ADDRESS (OR SIGNATURE SHF ONLY)	19B.PROF CD 19C.IDENTIFICATION NUMBER 19D.DX CODE
		1 1 2 3 4 5 6 7 8 9
20. NATIONAL DRUG CODE 20A.UNIT 20B.QUANTITY	20C.COST	NDC into entered to the left of this field will only be associated with the 1st claim line below
21.NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) 21A.	ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES
		VES NO
22A.SERVICE PROVIDER NAME	22B. PROF CD 22C. IDENTIFICATION NUMBER	22D. STERILIZATION ABORTION CODE 22E. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24	H BY REFERENCE TO NUMBERS 1 2 3 ETC. OR DX COD	
1.		POSSIBLE X EPSDT FAMILY PLANNING X
2		23A. PRIOR APPROVAL NUMBER 23B. PAYMIT SOURCE CD
3. 24A auto at 24B, 24C, 24D, 24E, 24F, 24G, 2	4H. 241.	
24A. DATE OF 24B. 24C. 24D. 24E. 24F. 24G. 2 SERVICE PLACE PROCEDURE MOD MOD MOD MOD MOD CD V V	DIAGNOSIS CODE DAYS OR UNITS	CHARGES CHARGES
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0 9 1 5 1 0 1 1 9 9 2 1 1	/ 7 2 3 1	1 7.5 0       .   .   .
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	11.111 1111	
24M. FROM THROUGH 24N. PROC CD 240.MOD INFATIENT CONTRACT OF CONTR		
25. CERTIFICATION () CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)	26. ACCEPT ASSIGNMENT	27. TOTAL CHARGE 28. AMOUNT PAID 29. BALANCE DUE
Sally Forth	30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
SIGNATURE OF PHYSICIAN OR SUPPLIER 25A. PROVIDER IDENTIFICATION NUMBER		Sally Forth
		312 Main Street Anytown, New York 11111
25B. MEDICAID GROUP IDENTIFICATION NUMBER 25C. LOCA- TOR CODE 25D. S.	A 32A. MY FEE HAS BEEN PAID	
COUNTY OF SUBMITTAL 25E. DATE SIGNED 32. PATIENT'S ACCOUNT. NUMBE		TELEPHONE NUMBER ( ) EXT. DO NOT WRITE IN THIS SPACE. (0(10) EMEDNIX 150003
09 16 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	GER ID	(9/10) EMEDNY-150003
ID/LICENSE NO.		



Exhibit 2.4.2.1-2

MEDICAL ASSISTANCE HEALTH INSURA		ORIGINAL TRANSACTION CONTROL NUMBER
CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	USED TO ADJUST/VOID PAID CLAIM 7	1   0   2   9   1   1   9 8   7   6 5   4   3   2   0   0
ATTENT AND INSORED (SUBSCRIDER) INFORMATION     1. PATIENTS NAME (First, middle, last)     CLISAN SAME F	2. DATE OF BIRTH 2A. TOTAL ANNU FAMILY INCO	UAL 3. INSURED'S NAME (First name, middle initial, last name)
SUSAN SAMPLE 4. PATIENTS ADDRESS (Street, City, State, Zip Code)	0 5 2 0 1 9 9 0	I6A, MEDICARE NUMBER
	5. INSURED'S SEX MALE FEMALE	X  X   1   2   3   4   5   X
STAPLE	58. PATIENT'S TELEPHONE NUMBER	68. PRIVATE INSURANCE NUMBER GROUP NO. RECIPROCITY NO.
	( ) 7. PATIENT'S RELATIONSHIP TO INSURED	8. INSURED'S EMPLOYER OR OCCUPATION
B. OTHER HEALTH INSURANCE COVERAGE - Ferrer Name     OFHER HEALTH INSURANCE COVERAGE - Ferrer Name     OTHER HEALTH INSURANCE COVERAGE - Ferrer Name     OTHER HEALTH INSURANCE COVERAGE - Ferrer Name	SELF SPOUSE CHILD OTHER	
	10. WAS CONDITION RELATED TO PATIENT'S CRIME	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
Private Insurance Number		
	AUTO OTHER ACCIDENT ACCIDENT LIABILITY	
12.	DATE	13.
PATIENT'S OR AUTHORIZED SIGNATURE	MM DD YY	INSURED'S SIGNATURE
PHYSICIAN OR SUPPLIER INFOR	MATION (REFER TO REVERSE BER 16A. EMERGENCY 17. DATE PATIENT MAY	FORE COMPLETING AND SIGNING) 18.DATES OF DISABILITY FROM TO
14.DATE OF ONSET 15.FIRST CONSULTED 16.HAS PATIENT EVER HAD SAME OF CONDITION OR SMILLAR SYMPTOMS MM   DD   YY   YES   NO	RELATED RETURN TO WORK	
19.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	19A.ADDRESS (OR SIGNATURE SHF ONLY)	19B.PROF CD 19C.IDENTIFICATION NUMBER 19D.DX CODE
20. NATIONAL DRUG CODE 20A.UNIT 20B.QUANTITY	20C.COST	NDC info entered to the left of this field will only be associated with the 1st claim line be
21.NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) 214	ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES OUTSIDE YOUR OFFICE
22A.SERVICE PROVIDER NAME	22B. PROF CD 22C. IDENTIFICATION NUMBER	YES NO 22D.STERILIZATION 22E.STATUS CODI
		ABORTION CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 2	IH BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CO	DE 22F, Y N 22G, Y N 22H, Y POSSIBLE DISABILITY X CTHP P ANILY
2		23A. PRIOR APPROVAL NUMBER 23B. PAYMT SOURC
3. 24A. DATE DE 24B. 24C. 24D. 24E. 24F. 24G.	24H. 24I.	1 1 1 124J 124K 124L
ANTE OF PLACE PROCEDURE MOD MOD MOD MOD MOD MOD	24H. DIAGNOSIS CODE UNITS	CHARGES
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0 9 1 5 1 0 1 1 8 5 0 0 7	V 7 2,3 1	
	11.111.111	
		+
	11.11.11.11	
24M. FROM THROUGH 24N. PROC CD 240.MOD		
HOSPITAL VISITS 25. CERTIFICATION II CER	26. ACCEPT ASSIGNMENT	27. TOTAL CHARGE 28. AMOUNT PAID 29. BALANCE DUE
AND ARE MADE A PART HEREOF.)		
Sally FortA SIGNATURE OF PHYSICIAN OR SUPPLIER	30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
SIGNATURE OF PHYSICIAN OR SUPPLIER 25A. PROVIDER IDENTIFICATION NUMBER		Sally Forth 312 Main Street
1         2         3         4         5         6         7         8         9           25B. MEDICAID GROUP IDENTIFICATION NUMBER         25C. LOCA-         25D.         25D. <td>A 32A. MY FEE HAS BEEN PAID</td> <td>Anytown, New York 11111</td>	A 32A. MY FEE HAS BEEN PAID	Anytown, New York 11111
25B. MEDICAID GROUP IDENTIFICATION NUMBER         25C. LOCA- TOR CODE         25D. EXCP           1         1         0         0         3		TELEPHONE NUMBER ( ) EXT.
COUNTY OF SUBMITTAL 25E. DATE SIGNED 32. PATIENT'S ACCOUNT. NUM	A second s	DO NOT WRITE IN THIS SPACE.
		(9/10) EMEDNY-1500
10         22         10         1         1         1           33. OTHER REFERRING ORDERING PROVIDER IDLICENSE NO.         34. PROF CD         35. CASE MAN	A B C 1 2 3 4 5	(9/10) EMEDNY-1500

#### 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 submitted on the claim. TCN 1028718765432100 contained three individual claim lines, which were paid on October 14, 2010. Later it was determined that one of the claims was billed unintentionally, 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.



Exhibit 2.4.2.1-3	Exł	hibit	2.4	.2.1	L-3
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MEDICAL ASSISTANCE HEALTH INSURA CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	UDED TO	ORIGINAL TRANSACTION CONTROL NUMBER
1. PATIENT'S NAME (First, middle, last)	2. DATE OF BIRTH 2A. TOTAL ANNUA FAMILY INCO	AL 3. INSURED'S NAME (First name, middle initial, last name)
Z SUSAN SAMPLE	0 5 2 0 1 9 9 0	
	MALE FEMALE MALE FEMALE	6. MEDICARE NUMBER 6A. MEDICAID NUMBER
STAPLE		X   X   1   2   3   4   5   X           6B. PRIVATE INSURANCE NUMBER         GROUP NO.         RECIPROCITY NO.
	5B. PATIENT'S TELEPHONE NUMBER	68. PHIVATE INSURANCE NUMBER GROUP NO. HECIPROCITY NO.
	( ) L 7. PATIENT'S RELATIONSHIP TO INSURED	8. INSURED'S EMPLOYER OR OCCUPATION
C. PATENTS EMPLOYER, OCCUPATION OR SCHOO     CONTRACT OF THE NUMBER	SELF SPOUSE CHILD OTHER	
9. OTHER HEALTH INSURANCE COVERAGE - Enter Nam		11. INSURED'S ADDRESS (Street, City, State, Zip Code)
of Policy Holder. Plan Name and Address, and Policy or Private Insurance Number	PATIENT'S CRIME EMPLOYMENT CRIME	
E A A A A A A A A A A A A A A A A A A A		
12.	ACCIDENT LIABILITY	13.
12.	DATE	10.
PATIENT'S OR AUTHORIZED SIGNATURE	MM DD YY	INSURED'S SIGNATURE
	MATION (REFER TO REVERSE BEF	
14.DATE OF ONSET OF CONDITION FOR CONDITION OR SIMILAR SYMPTOMS	16A. EMERGENCY RELATED 17. DATE PATIENT MAY RETURN TO WORK	18.DATES OF DISABILITY FROM TO TOTAL PARTIAL
MM DD YY MM DD YY YES NO	YES X X NO MM DD YY	MM DD YY MM DD YY
19.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	19A. ADDRESS (OR SIGNATURE SHF ONLY)	19B.PROF CD 19C.IDENTIFICATION NUMBER 19D.DX CODE
20. NATIONAL DRUG CODE 20A.UNIT 20B.QUANTITY	20C.COST	NDC info entered to the left of this field will only be associated with the 1st claim line below
21.NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office) 21/	A. ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES OUTSIDE YOUR OFFICE
		YES NO D
22A. SERVICE PROVIDER NAME	22B. PROF CD 22C. IDENTIFICATION NUMBER	22D.STERILIZATION 22E.STATUS CODE
44 DIADNOSIS OF MATURE OF MANESS, RELATE DIADNOSIS TO PROSEDURE IN COMMUN.		DE 22F. Y N 22G. Y N 22H. Y N
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 2 1.	24h BT REPERENCE TO NUMBERS 1, 2, 3 ETC. ON DX COL	POSSIBLE X EPSOT FAMILY X FAMILY V X
2		23A. PRIOR APPROVAL NUMBER 23B. PAYMT SOURCE CD
3.		
24A. DATE OF 24B. 24C. 24D. 24E. 24F. 24G. SERVICE PLACE PROCEDURE MOD MOD MOD MOD MOD	24H. 24I. DAYS DAYS	24J. 24K. 24L. 24L.
M M D D Y Y CD MOD MOD MOD MOD MOD	OR UNITS	UNINGEO
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0   9 1   5 1   0 1   1 9 9 2 1 1	V 7 2,3 1	1 7,50
0 9 1 6 1 0 1 1 9 9 2 1 1	V 7 2.3 1	1 7,5 0       .   .   .
		<u>┤└╵└╹╸╎</u> ┨╵└╵╵╸╎┨╵╵╵╸┼
	11.11.1	
	11.11111111	
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Exhibit 2.4.2.1-4

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		8. INSURED'S EMPLOYER OR OCCUPATION
8	CONDITION RELATED TO	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
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#### 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 1028701234567890 contained two claim lines, both of which were paid on October 14, 2010. 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.



	Exhi	bit	2.4	.2.2	2-1
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Exhibit 2.4.2.2-2

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## 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.							
DATE OF BIRTH							
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 150003 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.



#### Exhibit 2.4.2-3

Package NDC Number Configuration	Correct Leading Zero Placement for 5-4-2 = 11	NDC Field Example:	
$\begin{array}{rcrcr} XXXX-XXX-XX\\ 4 & + & 4 & + & 2 & = & 10 \end{array}$	<b>0</b> XXX-XXX-XX 5 + 4 + 2 = 11	20NATIONAL DRUG CODE= • • • • • • • • • • • • •	
XXXX-XXX-XX 5 + 3 + 2 = 10	5 + 4 + 2 = 11	20NATIONAL DRUG-CODE+ * X¤ X¤	
XXXXX-XXXX-X 5 + 4 + 1 = 10	XXXX-XXX- <b>0</b> X 5 + 4 + 2 = 11	20NATIONAL-DRUG-CODE» ° X X X X X X X X X X 0 X	

## 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.



#### 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.



Exhibit 2.4.2-	6
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MEDICAL ASSISTANCE HEALTH INSURANCE ONLY TO BE A CODE V OFIGINAL TRANSACTION CONTROL NUMBER					
CLAIM FORM TITLE XIX PROGRAM USED TO ADJUST/VOID					
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	2. DATE OF BIRTH 2A. TOTAL ANN				
SUSAN SAMPLE	0   5   2   0   1  9   9   0	CME			
A PATIENT'S ACOPESS (Sever, City, Sam, Zp Code		6. MEDICARE NUMBER 6A. MEDICAD NUMBER			
STA	X	X   X   1   2   3   4   5   X			
E Contraction of the second seco	58. PATIENT'S TELEPHONE NUMBER	68. PRIVATE INSURANCE NUMBER GROUP NO. RECIPROCITY NO.			
2 0. PATENTS BARLOYER, OCCUPATION OR SCHOOL	( ) A. 7. PATIENT'S RELATIONSHIP TO INSURED	8. INSURED'S EMPLOYER OR OCCUPATION			
	SELF SPOUSE CHED OTHER				
OPHER HEALTH INGLAWCE CONTRIAGE-Brain Name     d Racy Noder, Fain Name and Address, and Policy or					
d Psicy Rober, Pan Name and Address, and Poicy in Physics Roundary Rundler					
E S					
	ACCIDENT ACCIDENT				
12.	DATE	a de la constante de la consta			
	w   co   vr				
PATENTS OF AUTHORIZED SIGNATURE PHYSICIAN OR SUPPLIER INFOR		FORE COMPLETING AND SIGNING)			
14.DATE OF ORSET 15.FIRST CONSULTED 16.HAS PATIENT EVER HAD SAME OF CONDITION FOR CONDITION OR SMILAR SYMPTOMS	16A EMERGENCY 17.DATE PATIENT MAY RELATED RETURN TO WORK	18.DATES OF DISABLITY FROM TO			
MN CO YY MN CO YY YES NO	YES X X NO MM DO YY	TOTAL PARTIAL MM CO YY MM CO YY			
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	194. ADDRESS (OR SIGNATURE SHF ONLY)	198 PROF CD 11C IDENTIFICATION NUMBER 190.0X CODE			
The same data which which and a same and a	ac cost	1 1 2 3 4 5 6 7 8 9			
20. NATIONAL DRUG CODE 254.UNT 258 QUANTITY		NDC who entered to the left of this field will only be associated with the 1st claim line below			
0 0 7 0 3 6 8 0 1 0 1 G R	0,1 5 0 4 5,0 0 A ADDRESS OF FACUTY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES			
		OUTSIDE YOUR OFFICE			
22A-SERVICE PROVDER NAME	228 PROF CD 22C IDENTIFICATION NUMBER	220.STERALIZATION 22E.STATUS CODE ADORTION CODE			
23. DIAGNOSIS OR NATURE OF LUNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN.	204 BY REFERENCE TO NUMBERS 1. 2. 3 ETC. OR DX OC	POSSIBLE Y EPISOT FAMILY Y			
2		DISABLITY COTHP PLANNING COTHP 23A PEOR APPROVAL NUMBER 23B PAYMET SOURCE CO			
1		11111			
24A DATE OF 248. 24C. 240. 34E 24F. 24G.	24H Stars	24J. 24K. 24L.			
BERNICE PLACE PROCEDURE MOD MOD MOD MOD MOD	DIAGNOSIS CODE DAYS OR UNITS	CHARGES			
102010111955	1 6 2,9	6,75			
1 0 2 0 1 0 1 1 94 6 1 0	1 6 2,9	3 5 0 0       .       .			
	102,3	3 5,0 0			
	11.111 1111				
		+			
	11.111.1111	lanna bura dana			
	11.11.1				
24M. FROM THROUGH 24M. PROC CD 240 M00					
V973 25. CERTIFICATION	28. ACCEPT ASSIGNMENT	27. TOTAL CHARGE 28. AMOUNT PAID 29. EALANCE DUE			
S CERTIFY THAT THE STATEMENTS ON THE NEVERSE SIDE APPLY TO THIS BAL AND ARE WADE A PART HEREOF )	YES NO				
Sally Forth	30. EMPLOYER DENTIFICATION NUMBER SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE			
Social Security Number Social Security Number Sally Forth					
28A PROVIDER DENTIFICATION NUMBER 312 Main Street					
1 1 2 3 4 5 6 7 8 9 Anytown, New York 11111					
TOR CODE (20)	SA 32A, MY FEE HAS BEEN PAID NO				
COUNTY OF SUBMITTAL 25E DATE SIGNED 32. PATIENT'S ACCOUNT NUM		TELEPHONE NUMBER ( ) EXT.			
10 21 10	ABC12345	(9/10) EMEDNY-150003			
33. OTHER REFERENCE CROERING PROVIDER 34. PROF CD 36. CASE MAN IDLICENSE NO.					
	1 1 1 1 1 1 I I				

## 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.



#### Exhibit 2.4.2-8

	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.	Code 2 – Other Insurance involved.
1 /2 / * / *	Field 24J should contain the amount charged and field 24K must be left blank.	Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO	Code 1 - No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.	Code 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total payments in 24L and ** enter the two-digit
23B. PAYM'T SOURCE CO	Code 2 – <b>Medicare Approved Service</b> . Field 24J should contain the Medicare Approved amount and field 24K should	insurance code. Code 1 – No Other Insurance involvement. Field 24L must be left blank.
21011	contain the Medicare payment amount.	
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 1 * 1 *		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.
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.	Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the
<b>3</b> / <b>2</b> / * / * 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
<b>1</b> / <b>1</b> / * / *		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: <u>Midwife Manual.</u>

#### 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 SYSTEM	DATE: 05/31/2010 REMITTANCE NO: 07080600006 PROVID: 00112233/1123456789
	NO PAYMENT WILL B	E RECEIVED	THIS CYCLE. SEE REMIT	FANCE 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

	MES STRONG	MEDIC		TANCE (TITLE XI)	() PROGR	AM	E				
10	NYTOWN, NEW YORK	(11111	item.				D.R.	ROVID: 001 EMITTANCE	12233/11 NO: 070	123546789 3806000006	
	OFFICE ACCOUNT NUMBER	CLIENT	CLIENT ID	TCN	DATE OF	PROC.	UNITS	CHARGED	PAID	STATUS	ERRORS
-	CP111111 CP222222	DOE SAMPLE		07206-000033667-0-0 07206-000033667-0-0	05/11/10 05/12/10	72072 73010	1.000	14.30	14.30	PAID	
	CP333333	EXAMPLE		07206-000033667-0-0	05/14/10	71035	1,000	52.80	52.80	PAID	
	CP444444	SPECIMEN		07206-000056767-0-0	05/15/10	71130	1.000	66.00	66.00	PAID	
01	CP777777	STANDARD	XX56789X	07206-000067767-0-0	05/05/10	70260	1.000	17,60	17.60-	ADJT	ORIGINAL 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

			VĽ	MANAG	CAIC	IM		PA DA CY		04 05/31/20 1710	10
: JAMES STRONG 100 BROADWAY ANYTOWN, NEW YORK				NCE STA		OORAM	PR	IN: ACTITIONER OVID: 00112 MITTANCE N	2233/112	13456789 10600006	
N. OFFICE ACCOUNT	NAME	CLIENT ID NUMBER		CN	DATE OF SERVICE		UNITS	CHARGED	PAID	STATUS	ERRORS
01 CP112347	EXAMPLE	XX34567X			05/13/10	70100	1.000	69.30	0.00	**PEND	00162
02 CP444444 01 CP112348	SPECIMEN STANDARD	XX45678X XX56789X			05/14/10 05/14/10	72170 71015	1.000	71.04 14.30	0.00	**PEND	00162 00142
01 CP777777	MODEL			033660-0-0	05/12/10	72190	1.000	14.30	0.00	**PEND	
									= PRE = NEV		PENDED CLAIM
TOTAL AMOUNT ORIO	USTMENTS		PEND PEND	168.94 0.00	NUMBER	OF CLAIN	IS	4 0			PENDED CLAIM
	USTMENTS DS				NUMBER NUMBER		IS	4			PENDED CLAIM
NET AMOUNT ADJI NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS	USTMENTS DS DS - ADJUSTS	ER	PEND	0.00 0.00 0.00	NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN	IS IS	4 0 0 0			PENDED CLAIM
NET AMOUNT ADJU NET AMOUNT VOID NET AMOUNT VOID	USTMENTS DS DS - ADJUSTS	ER	PEND	0.00	NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN	IS IS IS	4 0 0			PENDED CLAIM
NET AMOUNT ADJI NET AMOUNT VOIE NET AMOUNT VOIE REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID	USTMENTS DS DS - ADJUSTS	ER	PEND	0.00 0.00 0.00 3.60- 168.94 147.40	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN OF CLAIN		4 0 0 1 4 4			PENDED CLAIM
NET AMOUNT ADJI NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PENDS TOTAL PAID TOTAL DENIED	USTMENTS DS DS - ADJUSTS	ER	PEND	0.00 0.00 0.00 3.60- 168.94 147.40 162.20	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	OF CLAIM OF CLAIM OF CLAIM OF CLAIM OF CLAIM OF CLAIM	IS IS IS IS IS IS IS	4 0 0 1 4 4 4			PENDED CLAIM
NET AMOUNT ADJI NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID	USTMENTS DS DS - ADJUSTS	ER	PEND	0.00 0.00 0.00 3.60- 168.94 147.40	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	4 0 0 1 4 4			PENDED CLAIM
NET AMOUNT ADJI NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PENDS TOTAL PAID TOTAL DENIED NET TOTAL PAID MEMBER ID: 001122	USTMENTS DS DS - ADJUSTS G - PRACTITION	ER	PEND	0.00 0.00 0.00 168.94 147.40 162.20 143.80	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 5			PENDED CLAIM
NET AMOUNT ADJU NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL PAID NET TOTAL PAID NET TOTAL PAID MEMBER ID: 001122 VOIDS – ADJUSTS	USTMENTS DS DS - ADJUSTS G - PRACTITION	ER	PEND	0.00 0.00 168.94 147.40 162.20 143.80 3.60-	NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER	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 1 4 4 5 1			PENDED CLAIM
NET AMOUNT ADU NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL PAID NET TOTAL PAID MEMBER ID: 001122 VOIDS – ADJUSTS TOTAL PENDS	USTMENTS DS DS - ADJUSTS G - PRACTITION	ER	PEND	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	IS IS IS IS IS IS IS IS IS IS IS IS	4 0 0 1 4 4 5			PENDED CLAIM
NET AMOUNT ADJU NET AMOUNT VOID NET AMOUNT VOID REMITTANCE TOTALS VOIDS – ADJUSTS TOTAL PENDS TOTAL PAID TOTAL PAID NET TOTAL PAID NET TOTAL PAID MEMBER ID: 001122 VOIDS – ADJUSTS	USTMENTS DS DS - ADJUSTS G - PRACTITION	ER	PEND	0.00 0.00 0.00 168.94 147.40 162.20 143.80 3.60- 168.94	NUMBER 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	IS IS IS IS IS IS IS IS IS IS IS IS	4 0 0 1 4 4 5 1 4			PENDED CLAIM



**REMITTANCE ADVICE** 

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.

TO: JAMES STRONG 100 BROADWAY ANYTOWN, NEW YORK 11111 MEDICAL ASSISTANCE (TITLE REMITTANCE STATE	ACCOUNTS RECEIVABLE TIX) PROGRAM SMENT PAGE 08 05/31/10 CYCLE 1710 ETIN: ACCOUNTS RECEIVABLE PROVID: 00112233/1123456789 REMITTANCE NO: 07080600006
REASON CODE DESCRIPTION ORIG BAL CURR BAL \$XXX.XX- \$XXX.XX- \$XXX.XX- \$XXX.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
00131 PROVIDER NOT APPROVED 00142 SERVICE CODE NOT EQUA 00162 RECIPIENT INELIGIBLE ON	L TO PA DATE OF SERVICE	OR 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.

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	ORIGINAL TRANSACTION CONTROL NUMBER
1. PATIENT'S NAME Prist, middle, last 2. DATE OF BITTH 2A. TOTAL ANNA	IAL 3. INSURED'S NAME (First name, middle initial, last name)
SUSAN SAMPLE 0 5 2 0 1 9 9 0	ARE INTERNET
A PATIENT'S ACOPIESS (SIMM, Cax, Same, Zo Code) 5. INCLIDED'S SEX	6. MEDICARE NUMBER 64. MEDICAD NUMBER
	X   X   1 2 3 4 5 X
58. PATENTS TELEPHONE NUMBER	BE PRIVATE INSURANCE NUMBER OROUP NO. RECEPTORITY NO.
2 ( C. PATENT'S BIPLOYER, OCCUPATION OR SCHOOL 7, PATIENT'S RELATIONSHIP TO INSURED	8. INSURED'S EMPLOYER OR OCCUPATION
S SUL POISE OND OTHER	
R OTHER HEALTH INSURANCE CONTINUE To WAS CONDITION RELATED TO If Palay Rober, Pan Name and Address, and Palay in PATIENTS	11. INSURED'S ADDRESS (Snwit, City, State, Zip Code)
A rady moder, war have an Added, an holey of PATIENTS CRIME Physics Number	
AUTO CONFIG LUABLITY 12	12
PATIENTS OF AUTHORIZED SIGNATURE MM DO YY	INSURED'S SIGNATURE
PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEI	
14 DATE OF ONSET 15.PRIST CONSULTED 16.HAS PATIENT EVER HAD SAME 16A ENERGENCY 17.DATE PATIENT MAY OF CONDITION OR SMILAR SYMPTOMS RELATED RETURN TO WORK	18.DATES OF DISABILITY FROM TO TOTAL PARTIAL
MU DO YY MM DO YY YES NO YES X X MO MM DO YY	MM DD YY MM DD YY
19.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 154.ADDRESS (OR SROATURE SHF ONLY)	198 PHOF CD 19C DENTIFICATION NUMBER 190 DX CODE
20. NATIONAL DRUG CODE 234.UNIT 288.OUAN/TITY 286.COST	NDC into entered to the left of this field will only be associated with the flat claim line before
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or afficial) 21A. ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED LAB CHARGES
	OUTSIDE YOUR OFFICE
22A SERVICE PROVIDER NAME. 228 PROF C0 22C IDENTIFICATION NUMBER	220 STERILIZATION 22E-STATUS CODE ABORTION CODE
21. DWONDER OR NATURE OF ILLNESS. HELATE DWONDER TO PROCEDURE IN COLUMN 24H BY REFERENCE TO MUMBERS 1, 2, 3 ETC. OR DX CO	POSSIBLE Y EPSOT FAMILY Y
	DISABILITY COTHP PLANNING CO 23A PROR APPROVAL NUMBER 23B PROVI SOURCE CO
	1.1.
24A DATE OF 248, 24C, 240, 34E, 24F, 24G, 24H, 24H, 24H, 24H, 24H, 24H, 24H, 24H	244. 244. 244.
BESINCE PLACE PROCEDURE MOD MOD MOD MOD DIAGNOSIS CODE OR UNITS	CHURGES
10141099201 V7231	6,5 0
1 0 2 0 1 0 1 1 9 9 2 1 1 V 7 2 3 1	5,00
1 0 2 9 1 0 1 1 9 9 2 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5,00
	+
	+
24M, FROM THROUGH 24N, PROC CO 240,MOD	
	127. TOTAL OWPCE 28. AMOUNT PAID 29. BALANCE DUE
25. CERTIFICATION (CERTIFICATION THAT THE TRATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL YES NO. YES NO.	27. TOTAL CHARGE 28. AMOUNT PAID 29. BALANCE DUE
30. EMPLOYER IDENTIFICATION MUNICE/V	31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZP CODE
Safly FortA SOCAL SECURITY NAMER	
25A PROVDER DENTIFICATION NUMBER	Sally Forth 312 Main Street
1 1 2 3 4 5 6 7 8 9	Anytown, New York 11111
256 MEDICKO GROUP DENTIFICATION NUMBER 25C LOCA 250 54 32A MY FEE HAS BEEN PAD TOR CODE 25C PCC YES NO	
COUNTY OF SUBMITTAL ZSE, DATE SIGNED 32, PATIENT'S ACCOUNT NUMBER	TELEPHONE NUMBER ( ) EXT. DO NOT WRITE IN THIS SPACE
	(9/10) EMEDNY-150003
33. OTHER REFERENAL ORDERING PROVIDER 34. PROF CO 36. CASE MANAGER ID	
DUCENSE NO.	



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 Columbi Florida Georgia Hawaii Idaho Illinois Iowa Indiana	Abbrev. AL AK AZ CA CO CT DE DC FL GA HI ID IL ID IL IA IN	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	Abbrev. MO MT NE NV NH NJ NM NC ND OH OH OK OR PA RI SC SD
Kansas Kentucky Louisiana Maine Maryland Massachusetts Michigan Minnesota	KS KY LA ME MD MA MI MN	Tennessee Texas Utah Vermont Virginia Washington West Virginia Wisconsin	TN TX UT VT VA WA WV WI
	American Territories American Samoa Canal Zone Guam Puerto Rico Trust Territories Virgin Islands	AS CZ 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 NAM	E			CHART NO.	RECI	IPIENT ID N	<b>1</b> O.	
STERILIZATION			1.						
CONSENT FORM	HOSPITAL/CLI	NIC							
NOTICE: YOUR DECISION AT AN	Y TIME NOT TO E	BE STERILIZE	ED WILL N	IOT RESULT IN	THE WITHDRAWA	L OR WITH	HOLDING	OF ANY	
BENEFITS PROVIDED B			S RECEIVI				-		
■ CONSENT TO S			from		TEMENT OF PEF				
(doctor or clinic)	When	n I asked for	the	consent form	13. Name	of Individua		of the st	terilization
information, I was told that the de				operation	, I explained to 1 14. irreversible proce	, the	fact that	it is inten	ided to be
up to me. I was told that I could de not to be sterilized, my decision w	ill not affect my	right to futu	ire care	benefits asso	ciated with it.				
or treatment. I will not lose an receiving Federal funds, such as A	A.F.D.C. or Med			of birth contr	d the individual to ol are available v	hich are	temporary		
getting or for which I may become I UNDERSTAND THAT TH	IE ŠSTERILIZA			l informed	different because the individual to b	e sterilizeo	d that his/h		
CONSIDERED <b>PERMANENT</b> AN DECIDED THAT I DO NOT WANT				withdrawn at services or an	any time and t benefits provide	that he/sh ed by Fed	ne will no eral funds.	t lose a	ny healtl
CHILDREN OR FATHER CHILDR I was told about those temporar		irth control t	that are	To the be	st of my knowle at least 21 years	dge and	belief the	e individu	ual to be ompetent
available and could be provided to father a child in the future. I ha	me which will	allow me to l	bear or	He/She know	lingly and volun understand the	tarily requ	uested to	be steri	lized and
chosen to be sterilized.	-			procedure.	understand the	nature	and con	sequence	
I understand that I will be ster	ne discomforts,	risks and b	benefits		15.				
associated with the operation hav questions have been answered to	my satisfaction.			Signatur	e of person obtaining	16.		Date	9
I understand that the operation days after I sign this form. I under	stand that I can	change my i	mind at						
any time and that my decision at a result in the withholding of any be	any time not to I nefits or medica	be sterilized al services pi	will not rovided			Address			
by federally funded programs. I am at least 21 years of age and	d was born on	4.			PHYSICIA	N'S STAT		•	
I am at least 21 years of age and I. <u>5.</u> free will to be sterilized by <u>7.</u> by a method called <u>7.</u>	, hereby o	Month Day Y consent of n	<i>∕ear</i> my own	Shortly bef	ore I performed a	sterilizatio	on operatio	n upon 19.	
ree will to be sterilized by	6. (Doctor)			Name o	of individual to be ste 2.0	erilized		Date of ste	rilization
by a method called									
expires 180 days from the date of	mv signature be	My c	consent		of individual to be ste 20. peration sterilization opera	tion	21.		the
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# 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>.