

**DENTAL – EMEDNY 000201 CLAIM FORM INSTRUCTIONS**

The following guide gives instructions for proper claim form completion when submitting claims for Dental Services using the eMedNY 000201 claim form. A field-by-field description is provided to indicate what entries are required when submitting claims to the eMedNY system. Please refer to your MMIS Dental Provider Manual if further information is required.

FIELD BY FIELD INSTRUCTIONS

1. **PROVIDER ID** – Enter the 8-digit MMIS Provider ID Number assigned to you at the time of enrollment. On a Group claim form this field must be completed with the individual Provider ID of the Dentist who performed the service.

PROVIDER NAME AND ADDRESS – Enter the Provider's name and correspondence address as it appears on their eMedNY Provider file. For Group practice forms, enter the Group's name and correspondence address.

2. **BILLING DATE** – Leave this field blank.

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

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

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

Dental Schools and Orthodontic Clinics: Leave this field blank.

4. **LOCATOR CODE** – Enter the appropriate locator code that was assigned at the time of enrollment. Entries in the locator code field are 003 or higher. Add a zero in front of a 2-digit locator code.

6. **CODE A/V** – This field is only used to adjust or void a previously paid claim. Place an X over the A if submitting an Adjustment or an X over the V if submitting a Void.

6A. **ORIGINAL TRANSACTION CONTROL NUMBER** – This field is only used to adjust or void a previously paid claim. Enter the Transaction Control Number (TCN) of the claim that previously processed. This field has been expanded to 16 spaces to accommodate the 16-digit TCN that replaces the 15-digit CRN.

- If you are submitting an adjustment or void to a claim that was processed prior to Phase II Implementation, enter the 15-digit CRN in the first 15 spaces and leave the last space blank.
- If you are submitting an adjustment to a claim that was processed after Phase II Implementation, enter the 16-digit TCN in this field. You must enter ALL claim lines that were submitted on the original claim. If you want to void a single line of a claim that processed with 2 or more lines, you must submit an adjustment and omit the line you want to void.



- If you are submitting a void to a claim that was processed after Phase II Implementation, enter the 16-digit TCN in this field. Submitting a void will void the entire claim.

7. **RECIPIENT ID NUMBER** – Enter the Client ID Number. Format must be 2 alpha-5 numeric-1 alpha.

8. **DATE OF BIRTH** – Enter the Client's date of birth in MMDDYYYY format.

8A. **SEX** – Place an X on M for Male or on F for Female to indicate the Client's sex.

9. **RECIPIENT NAME – FIRST** - Enter the Client's First Name.

9A. **RECIPIENT NAME – LAST** - Enter the Client's Last Name.

10. **OFFICE ACCOUNT NUMBER** – This is an optional field. You may enter up to 20 characters in this field to identify a client. Information entered here will appear on your remittance statement.

13. **EMERGENCY** - Place an X on Y for Yes to indicate that the service is related to an emergency or urgent situation. This field may be left blank if the answer is No.

14. **ACCIDENT CODE** – If applicable, enter the appropriate Accident Code.

Accident Codes

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

15. **PATIENT STATUS CODE** – You may enter the appropriate code to indicate the status of the patient as of the last date of service on the claim or you may leave this field blank.

19. **PRIOR APPROVAL NUMBER** - Enter the Prior Approval Number in this field if applicable.

20. **PLACE OF SERVICE CODE** - Enter the 2-digit Place of Service code that indicates the type of location where the service was rendered. The Place of Service code for services rendered in the Dental Office is 11. Refer to the end of this document for a complete list of Place of Service codes.

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

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

Instructions for Entering a License Number

If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. Please refer to list at the end of this document for Post Office state abbreviations.



23A. **PROF CODE** - Enter the 3-digit profession code when a license number is entered in field 23 – Ordering/Referring Provider ID/License Number. The profession code identifies the profession assigned to the license number and is completed only when the Ordering/Referring Provider's License Number is used. If an MMIS Provider ID Number is entered in field 23, the Prof Cd field must be blank.

25. **DATE OF SERVICE** - Enter the date of service using 6 digits – MMDDYY format.

26. **PROCEDURE CODE** - Enter the 5-character procedure code assigned to the service you are billing.

27. **TIMES PERFORMED** – An entry must be made in this field. If the same procedure is performed more than one time on the same date of service, enter the number of times in this field.

28. **ORAL CAVITY** - When appropriate, enter the oral cavity identification. The procedure code section of the MMIS Provider Manual will indicate in the description of the procedure if oral cavity identification is required. Identification will be shown in the following manner:

Quadrant Identification:

- 10 = Upper Right Teeth 1-8
- 20 = Upper Left Teeth 9-16
- 30 = Lower Left Teeth 17-24
- 40 = Lower Right Teeth 25-32

Arch Identification

- 01 = Arch Upper
- 02 = Arch Lower
- 00 = Entire Oral Cavity

29. **TOOTH** - When appropriate, enter the tooth identification. The procedure code section of the MMIS Provider Manual indicates in the description of the procedure if tooth identification is required. Identification is shown in the following manner:

- Permanent teeth are identified by the appropriate number
- Primary teeth are identified by the appropriate letter

29A. **SURFACE** - If the procedure requires surface identification, place the appropriate letter in the box that indicates the surface(s) being restored. Surface Identification is as follows:

- M = Mesial
- I/O = Incisal/Occlusal
- D = Distal
- F/B = Facial/Buccal
- L = Lingual

30. **AMOUNT CHARGED** – Enter the amount charged for the procedure.

31. **MEDICARE CO INSURANCE** – If Medicare is involved and a claim is being submitted for the balance, enter the co-insurance amount.

31A. **MEDICARE DEDUCTIBLE** – If Medicare is involved enter the amount (if any) that was put towards the deductible.

31B. **MEDICARE CO PAY** - If Medicare is involved enter the amount of the Medicare co-pay.

31C. **MEDICARE PAID** - If Medicare is involved enter the amount Medicare paid.



32. **OTHER INSURANCE PAID** – If Third Party Insurance is involved in the claim, enter the amount they paid in this field. If they denied the claim, enter zeros. This field is also used to show the amount paid by the client to meet a spend-down (patient participation).

37. **SIGNATURE** - The Dentist must sign the claim form. The signature must be original. Copies and rubber stamps will not be accepted. Please note that the certification statement is on the back of the claim form.

37A. **COUNTY** – This field may be left blank if the Provider’s address is within the county that the form is being signed in. If for some reason, the form is signed in a different county, enter the county code assigned to that county.

38. **DATE** – Enter the date the claim form was signed using 6 digits – MMDDYY format.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER				2. BILLING DATE			3. GROUP ID NUMBER				4. LOCATOR CODE		5. SA EXCP CODE		ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM														
				MO	DAY		YR									6. CODE		6A. ORIGINAL TRANSACTION CONTROL NUMBER											
																A	V												
				7. RECIPIENT ID NUMBER				8. DATE OF BIRTH				8A. SEX		9. RECIPIENT NAME - FIRST						10. OFFICE ACCOUNT NUMBER (OPTIONAL)						11 OFFICE USE ONLY			
												M	F	9A. RECIPIENT NAME - LAST															
				DIAGNOSIS CODE				EMERGENCY?	POSSIBLE DISABILITY?		FAMILY PLANNING?	ACCIDENT CODE	PATIENT STATUS CODE	EPSDT/ C/THP	RECIPIENT OTHER INSURANCE CODE	ABORT STER CODE	19. PRIOR APPROVAL NUMBER												
				12. PRIMARY		12A. SECONDARY		13. Y N	13A. Y N		13B. Y N	14.	15.	16. Y N	17.	18.													
PLACE OF SERVICE				21. SERVICE PROVIDER ID/LICENSE NUMBER				21A. PROF CD		21B. NAME						23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER				23A. PROF CD		23B. NAME							
20. CODE	20A. ADDRESS																												
				22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER				22A. PROF CD		22B. NAME						24. SHARED HEALTH FACILITY ONLY		24A. SIGNATURE						24B. DIAGNOSIS					
LINE	25. DATE OF SERVICE			26. PROCEDURE CODE				27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL					30. AMOUNT CHARGED				MEDICARE				32. OTHER INSURANCE PAID						
	MO	DAY		YR							29. TOOTH	29A SURFACE								31. CO-INSURANCE	31A. DEDUCTIBLE	31B. CO-PAY	31C. PAID						
												M	I/O	D	F/B	L													
1																													
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9																													
				33. CASE MGR				TOTALS		34.				35.				35A.	35B.	35C.		36.							

DO NOT STAPLE IN BARCODE AREA

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

37. SIGNATURE		37A. COUNTY*		38. DATE		
				MO	DAY	YR

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

**Appendix A – Code Sets****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
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance-land
42	Ambulance-air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
60	Mass immunization center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

**UNITED STATES STANDARD POST OFFICE ABBREVIATIONS****Standard Post Office Abbreviations for States**

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

American Territories

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

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