ORDERED AMB AND LAB – EMEDNY 150001 CLAIM FORM INSTRUCTIONS

The following guide contains instructions for proper claim form completion when submitting claims for Ordered Ambulatory and Laboratory Services using the eMedNY 150001 claim form. The field-by-field description provided indicates which entries are required when submitting claims to the eMedNY system. Refer to the appropriate MMIS Provider Manual if further information is required.

Field by Field Instructions

Note: Instructions are only given for fields used on the claim form.

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.

ORIGINAL CLAIM REFERENCE NUMBER – This field is only used to adjust or void a previously paid claim. Enter the Transaction Control Number (TCN) of the claim that was 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.

1. **PATIENT'S NAME** – Enter the Client's first name followed by the last name.

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

5A. **PATIENT'S SEX** – Place an X on M for Male or on F for Female to indicate the Client's sex.

6A. **RECIPIENT ID NUMBER** – Enter the Client ID Number. Format must be 2 alpha-5 numeric-1 alpha.

10. **WAS CONDITION RELATED TO** – Place an X in the appropriate box to indicate if the condition being treated is related to:

- Patients Employment
- Auto Accident
- Crime Victim
- Other Liability

If one of the above is not involved, this field should be blank.

16A. **EMERGENCY RELATED** – **For Ordered Ambulatory Claims only** - Place an X on Y for Yes to indicate if the service is related to an emergency or urgent situation. This field may be left blank if the answer is No.

19B. **PROF CD** – Enter the 3-digit profession code when a license number is entered in field 19C – Identification Number. The profession code identifies the profession assigned to the license number and is completed only when the Referring/Ordering Provider's License Number is used. If an MMIS Provider ID Number is entered in field 19C – Identification Number - the Prof Cd field must be blank.

19C. **IDENTIFICATION NUMBER** – Enter the ordering provider's Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her 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 the end of this document for a list of Post Office state abbreviations. If the service is ordered by a Physician Assistant or a Nurse Midwife, the supervising licensed practitioner's Medicaid ID number or license number must be entered in this field.

Independent Laboratories (COS 1000) Only
When providing services to a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) who orders laboratory services, enter the Medicaid ID number of the primary provider in this field. **Do not enter the license number of the primary provider.**

If the restricted recipient was referred by his/her primary provider to another provider who orders laboratory services, the laboratory must enter the ordering provider's Medicaid ID number or license number in this field. **If the orderer of the laboratory services is not the recipient's primary provider**, then the primary's provider Medicaid ID number must be entered in field 33.

22D. **STERILIZATION ABORTION CODE** – Enter the appropriate code to indicate if the service rendered is related to an abortion or sterilization. See the MMIS Provider Manual for the appropriate codes. If the service is not related to an abortion or sterilization, leave this field blank.

22H. **FAMILY PLANNING** - Place an X on Y for Yes or on N for No to indicate if the service rendered was related to family planning. You may leave this field blank if the answer is No.

23B. **PAYMENT SOURCE CODE** - There must be an entry of 1, 2 or 3 on both the M and the O boxes to indicate the involvement of Medicare or Other Insurance.

Box M = Medicare - Entries must be consistent with fields 24J and 24K.

1 – No Medicare Involved – This indicates that the Client does not have Medicare. Field 24J will be the amount charged. Field 24K will be blank.

2 – Medicare Approved – This indicates that Medicare has approved the service. Field 24J will be the amount Medicare approved and Field 24K will be the amount Medicare paid.

3 – Medicare Denied – This indicates that Medicare has denied the service. Field 24J will be the amount charged and 24K must have a paid amount of 0.00.

Box O = Other Insurance - Entries must be consistent with fields 24L.

1 – No Other Insurance – This indicates that the Client does not have Other Insurance. Field 24J will be the amount charged. Field 24L will be blank.

2 – Other Insurance Is Involved - This indicates that the Client does have Other Insurance. Field 24J will be the amount charged. Field 24L will be the amount the Other Insurance paid. The 2-character insurance code must be entered in the 2 spaces following box O. This identifies who the Other Insurance carrier is.

3 – Patient Participation - This indicates that the Client has a spend-down. Field 24J will be the amount charged. Field 24L will be the amount the Client paid towards the spend-down. The 2-character insurance code must be completed with 05 – Other.

Note: The attached Payment Source Code chart gives every possible combination of entries that can be made in field 23B and illustrates the relationship between field 23B and fields 24J, 24K and 24L.

24A. **DATE OF SERVICE** - Enter the date of service using 6 digits – MMDDYY format.

24B. **PLACE** – Enter the 2-digit place of service code that indicates the type of location where the service was rendered. Refer to the end of this document for a complete list of place of service codes.

24C. **PROCEDURE CD** – Enter the 5-character procedure code assigned to the service you are billing.

24D. **MOD** – **For Ordered Ambulatory claims only** - If the procedure requires the addition of a 2-character modifier to further define the service, enter it in this field. Only modifiers that are listed in the Procedure Code section of the MMIS Provider Manual are acceptable for billing.

24E. – 24G. **MOD** – These fields can be used to enter up to 3 additional modifiers if necessary. This form can now accommodate up to 4 modifiers to further define a procedure.

24H. **DIAGNOSIS CODE** – Enter the ICD-9-CM code that describes the main condition or symptom of the Client for which the procedure was performed.

24I. **DAYS OR UNITS** – 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 here.

24J. **CHARGES** – This field will contain either the amount charged or the Medicare Approved amount. The entry in this field must correspond with the entry in field 23B.

24K. **(MEDICARE PAID AMOUNT)** - This field will either be blank (if Medicare is not involved) or will contain the Medicare Paid amount. The entry in this field must correspond with the entry in field 23B.

24L. **(OTHER INS PAID AMOUNT)** - This field will either be blank (if Third Party Insurance is not involved) or will contain the Other Insurance Paid amount. The entry in this field must correspond with the entry in field 23B.

25. **CERTIFICATION (SIGNATURE)** – The Provider 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.

25A. **PROVIDER ID** – Enter the 8-digit MMIS Provider ID Number assigned to you at the time of enrollment.

25C. **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.

25D. **SA EXCP CODE** – Enter the appropriate SA exception code if the client has reached their limit under the Utilization Threshold Program but they still require treatment. Examples: the situation is an emergency or there is an increase in services pending.

1 = Immediate/Urgent Care
2 = Services Rendered in a Retroactive Period
3 = Emergency Care
4 = Client has Temporary Medicaid (DSS-2831A)
5 = Request from County for Second Opinion to Determine if Client can work
6 = Request for Override Pending
7 = Special Handling – used to indicate services are exempt from UT

25E. **DATE SIGNED** - Enter the billing date (the date you are completing the claim form) using 6 digits – MMDDYY format.

31. **PROVIDER NAME AND ADDRESS** – Enter the Provider's name and correspondence address as it appears on their eMedNY Provider file.

32. **PATIENT'S 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 also appear on your remittance statement.

PAYMENT SOURCE CODE

23B. PAYM'T SOURCE CO

M / O / /

	BOX M	BOX O
23B. PAYM'T SOURCE CO M / O / 1 / 1	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 M / O / 1 / 2 / * / *	Code 1 – **No Medicare involvement**. Field 24J should contain the amount charged and field 24K must be left blank.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO M / O / 1 / 3 / * / *	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 insurance code.
23B. PAYM'T SOURCE CO M / O / 2 / 1 / /	Code 2 – **Medicare Approved Service**. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 1 – **No Other Insurance involvement**. Field 24L must be left blank.
23B. PAYM'T SOURCE CO M / O / 2 / 2 / * / *	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 service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO M / O / 2 / 3 / * / *	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 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO M / O / 3 / 1 / /	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 M / O / 3 / 2 / * / *	Code 3 – **Medicare denied payment or did not cover the service**. Field 24J should contain the amount charged and field 24K should contain $0.00.	Code 2 – **Other Insurance involved**. Field 24L should contain the amount paid by the other insurance or $0.00 if the other insurance did not cover the service or denied payment. ** You must indicate the two-digit insurance code.
23B. PAYM'T SOURCE CO M / O / 3 / 3 / * / *	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 24L and ** enter the two-digit insurance code.

** - Other Insurance Code

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | CODE: A V | ORIGINAL TRANSACTION CONTROL NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME *(First, middle, last)*	2. DATE OF BIRTH M M D D Y Y Y Y	2A. TOTAL ANNUAL FAMILY INCOME	4. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, City, State, Zip Code)*	5. INSURED'S SEX MALE X FEMALE X	5A. PATIENT'S SEX MALE X FEMALE X	6. MEDICARE NUMBER / 6A. MEDICAID NUMBER
	5B. PATIENT'S TELEPHONE NUMBER ( )		6B. PRIVATE INSURANCE NUMBER / GROUP NO. / RECIPROCITY NO.
6 C. PATIENT'S 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 of Policy Holder, Plan Name and Address and Policy or Private Insurance Number	10. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT X / CRIME VICTIM X; AUTO ACCIDENT X / OTHER LIABILITY X		11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE	DATE MM DD YY		13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION MM DD YY	15. FIRST CONSULTED FOR CONDITION MM DD YY	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES NO	16A. EMERGENCY RELATED YES X X NO	17. DATE PATIENT MAY RETURN TO WORK MM DD YY	18. DATES OF DISABILITY TOTAL PARTIAL	FROM MM DD YY	TO 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. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITIALIZATION DATES ADMITTED MM DD YY	DISCHARGED MM DD YY	20A. NAME OF HOSPITAL	20B. SURGERY DATE MM DD YY	20C. TYPE OF SURGERY

21. NAME OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*	21A. ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES NO	LAB CHARGES

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 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE ▼

1.
2.
3.

22F. POSSIBLE DISABILITY Y N	22G. EPSDT C/THP Y N	22H. FAMILY PLANNING Y N

23A. PRIOR APPROVAL NUMBER	23B. PAYM'T SOURCE CODE M O

24A. DATE OF SERVICE M M D D Y Y	24B. PLACE	24C. PROCEDURE CD	24D. MOD	24E. MOD	24F. MOD	24G. MOD	24H. DIAGNOSIS CODE	24I. DAYS OR UNITS	24J. CHARGES	24K.	24L.

24M. INPATIENT HOSPITAL VISITS	FROM MM DD YY	THROUGH MM DD YY	24N. PROC CD	24O. MOD				

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF)	26. ACCEPT ASSIGNTMENT YES NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNATURE OF PHYSICIAN OR SUPPLIER	30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE		
25A. PROVIDER IDENTIFICATION NUMBER				
25B. MEDICAID GROUP IDENTIFICATION NUMBER	25C. LOCATOR CODE / 25D. SA EXCP CODE	32A. MY FEE HAS BEEN PAID YES NO		
COUNTY OF SUBMITTAL / 25E. DATE SIGNED MM DD YY	32. PATIENT'S ACCOUNT NUMBER	DO NOT WRITE IN THIS SPACE		
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER	34. PROF CD	35. CASE MANAGER ID		

TELEPHONE NUMBER ( ) EXT.

EMEDNY – 150001 ((1/04)

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.