MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM | A CODE 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 | 3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code) | 5. INSURED'S SEX MALE FEMALE | 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.

6C. 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 | X CRIME VICTIM | AUTO ACCIDENT X | X OTHER LIABILITY | 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 SHE ONLY) | 19B. PROF CD | 19C. IDENTIFICATION NUMBER | SPEC CODE

20. NATIONAL DRUG CODE | 20A. UNIT | 20B. QUANTITY | 20C. COST | NDC info entered to the left of this field will be printed with this 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 OUTSIDE YOUR OFFICE YES NO | LAB CHARGES

23A. SERVICE PROVIDER NAME | 23B. PROF CD | 23C. IDENTIFICATION NUMBER | 23D. ABORTION CODE | 23E. 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. POSTAGE Y N | 22G. EPSDT OTHP Y N | 22H. FAMILY PLANNING Y N

23F. PRIOR AUTHORIZATION NUMBER | 23G. PAYMT SOURCE CD 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 | 24N. EMERG | 24O. EPSDT PROC CD | 24P. MOD

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) | 26. ACCEPT ASSIGNMENT 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 IDENTIFICATION NUMBER | 25C. LOCATOR CODE | 25D. SA EXCP CODE | 32A. MY FEE HAS BEEN PAID YES NO

TELEPHONE NUMBER ( ) EXT.

CITY OF SUB | 25E. DATE SIGNED MM DD YY | 32. PATIENT'S ACCOUNT NUMBER | DO NOT WRITE IN THIS SPACE.

33. OTHER REFERRING ORDERING PROVIDER ID NO. | 34. PROF CD | 35. CASE MANAGER ID

(9/10) EMEDNY-150003

(PERF) (PERF)

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FACE SCREENS 20 & 30%

2.3 Certification

Provider certifies that: I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the person(s) providing services, care or supplies have the required licensing, certification and training. I have reviewed this form; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and I or the entity make this claim in accordance with applicable federal and state laws and regulations. I certify that the services were rendered at the location listed in the "place of service field" and that such location has been entered on the claim. I HAVE READ THE MEDICAID MANAGEMENT INFORMATION SYSTEMS PROVIDER MANUAL AS IT RELATES TO THE CLAIM FORM, AND ALL REVISIONS AND UPDATES THERETO; ALL CLAIMS ARE MADE IN FULL COMPLIANCE WITH THE PERTINENT PROVISIONS OF THE MANUAL, REVISIONS AND UPDATES; ALL CLAIMS FOR CARE SERVICES AND SUPPLIES PROVIDED AT THE ORDER OF ANOTHER PROFESSIONAL HAVE TO THE BEST OF MY KNOWLEDGE BEEN ORDERED BY THAT PROFESSIONAL IN BONA FIDE COMPLIANCE WITH THE PROCEDURES SET FORTH IN THE MANUAL, REVISIONS, OR UPDATES AND ALL FEDERAL AND STATE LAWS AND REGULATIONS. ALL CARE, SERVICES, AND SUPPLIES FOR WHICH CLAIM IS MADE ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE NAMED RECIPIENT. The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied for error or adjustment, no previous claim for the care, services and supplies itemized has been submitted or is pending. ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefor shall be promptly furnished upon request to the local social services district or the New York State Department of Health, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosure by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all laws, rules, regulations, policies, standards, fee codes and procedures of the United States Department of Health and Human Services, the New York State Department of Health (Department) and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department or any other law, rule, regulation, policy, procedures of any other state agency which governs the provision of or billing for care, services or supplies which are reimbursed under the Medical Assistance Program for the State of New York. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty. I further certify that I have complied with the billing requirements of the United States Department of Health and Human Services and the Department including but not limited to the following: If I am billing as an individual provider (individual practitioner or business entity which is not required to enroll as a group), I certify that the care, services or supplies were provided by me except in situations where care, services or supplies were provided: (a) under a locum tenens agreement or (b) by a physician's assistant or certified social worker who was under my supervision, and that my provider identification number is being used on the claim for payment. If I am required to bill as a group provider, I certify that the care, services or supplies were provided by the group, that the provider identification number of the group is being used on the claim for payment, and that the provider identification number of the individual who provided the service has been entered on the claim.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

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