

New York State Medicaid General Billing Guidelines





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 members.

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

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



1.	Pur	pose Statement	4
2.	Clai	ms Submission	5
	2.1	Electronic Claims	5
	2.2	Paper Claims	6
	2.2.2	1 General Instructions for Completing Paper Claims	6
	2.3	eMedNY – 150003 Claim Form	8
	2.4	General Billing Instructions	8
	2.4.3		
	2.4.2	2 eMedNY - 150003 Claim Form Field Instructions	9
3.	Ren	nittance Advice	33
Aŗ	opend	ix A Code Sets	34
Aŗ	opend	ix B Sterilization Consent Form – LDSS-3134	37
St	eriliza	tion Consent Form – LDSS-3134 and 3134(S) Instructions	39
Aŗ	ppend	ix C Acknowledgment of Receipt of Hysterectomy Information Form – LDSS-3113	44
Ac	know	ledgement Receipt of Hysterectomy Information Form – LDSS-3113 Instructions	46

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.

This document is intended to serve as an instructional reference tool for providers who submit claims using either the 837 Professional or paper 150003 form. For providers new to NYS Medicaid, it is required to read the the Trading Partner Information Companion Guide available at www.emedny.org by clicking on the link to the webpage as follows: Trading Partner Information Companion Guide.

2. Claims Submission

Professional service providers may submit their claims to NYS Medicaid using 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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 are asked to update their Certification Statement on an annual basis. Providers are sent renewal information when their Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: <u>eMedNY Trading Partner Information Companion</u> <u>Guide</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.

Professional providers who submit claims electronically are required to use the HIPAA 837 Professional (837P) transaction.

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837P standards and other program specifications. These documents are available at <u>store.X12.org</u>.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

Further information on the 5010 transaction is available at www.emedny.org by clicking on the link to the web page as follows: <u>eMedNYHIPAASupport</u>.

Further information about electronic claim prerequisites is available at www.emedny.org by clicking on the link to the webpage as follows: <u>eMedNY Trading Partner Information Companion Guide</u>.

2.2 Paper Claims

Professional services providers who submit their claims on paper forms must use the New York State eMedNY-150003 claim form.

To view a sample eMedNY - 150003 claim form, see Appendix A below. The displayed claim form is a sample and is for illustration purposes only.

An Electronic/Paper 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: <u>eMedNY Trading Partner Information Companion Guide</u>..

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

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

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:

eMedNY P.O. Box 4601 Rensselaer, NY 12144-4601 Expedited / Priority Shipping: eMedNY 327 Columbia Turnpike ATTN: Box 4601 Rensselaer, NY 12144

2.3 eMedNY - 150003 Claim Form

To order New York State Medicaid 150003 forms, please contact the eMedNY call center at 1-800-343-9000.

To view a sample Physician eMedNY - 150003 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.4 General Billing Instructions

This subsection of the Billing Guidelines covers general billing requirements for professional claims. 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. For reference purposes, the related electronic fields are provided. For further electronic claim submission information, refer to eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking on the link to the webpage as follows: <u>eMedNY Transaction</u> Information Standard Companion Guide CAQH - CORE CG X12

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 members 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. *Medicare Part-C* (Medicare Managed Care) and *Medicare Part-D* claims are *not* part of this process.

Providers must review their Medicare remittances for crossover information 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 for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows.

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 will then automatically void the provider submitted claim. Providers may submit adjustments to Medicaid for their crossover claims.

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>Default Electronic Transmitter</u> <u>Identification Number (ETIN) Selection Form</u>.



Header Section: Fields 1 through 23B

The information entered in the Header Section of the claim form (fields 1 through 23B) applies 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)

837P Ref: Loop 2300 CLM05-3

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' in the 'A' box.
- If submitting a void to a previously paid claim, enter 'X' in the 'V' box.

Original Claim Reference Number (Upper Right Corner of Form)

837P Ref: Loop2300 REF02 where REF01 = F8

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)*. 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.

2.4.2.1 Adjustment

An adjustment may be submitted to correct any information on a previously paid claim other than:

- Billing Provider ID
- Group Provider ID
- Member ID.

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 1026501234567890 is shared by three individual claim lines. This TCN was paid on September 22, 2010. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.2.1-1 shows the claim as it was originally submitted and Exhibit 2.4.2.1-2 shows the claim as it appears after the adjustment has been made.



MEDICAL ASSISTANCE HEALTH INSURANCE ONLY TO BE A CODE V ORIGINAL TRANSACTION CONTROL NUMBER							
PATIENT AND INSURED (SUBSCRIBER) INFORMATION PAID CLAIM							
Jane Smith 0	5 2 0 1 9 9 0						
AIS		АСОСИНЕ НОМЕЛ А В 1 2 3 4 5 C в РЕМАТЕ НЕЗВАНИСЕ НОМЕЕК ОВОСЯ НО НЕСЕРВОСТУ НО					
2	1						
Ando	SELF SPOUSE CHER CTHER	INDURED'S EMPLOYUR OR OCCUMATION					
of Policy Notice, Plan Name and Address, Ant Police of	PATIENTS CONCENTRATION OF THE SERVE						
12	AUDO DIFERIO ACCOUNT DATE DATE	1					
PATIENTS OF AUTIONZED SCRATINE	MW 10 VV	MBL/RED'S SIGNATURE					
PHYSICIAN OR SUPPLIER INFORMAT 14 CATE OF UNSET 115 FIRST CONSULTED 14 FIAS PATENT EVER HAD SAME 14A	a second design of the second s	DRE COMPLETING AND SIGNING)					
OF CONDITION FOR CONDITION OR SANLAR SMIFTONS	RETURN TO WORK	THE PROPERTY AND THE TRANSPORT OF DEALERS AND THE TRANSPORT OF DEALERS AND THE TRANSPORT OF DEALERS AND A DEALERS					
21 SATIONIL DRUG CDDE	THE CONT	1 1 1 2 3 4 5 6 7 8 9					
21 MARE OF FACULTY WHERE BERKICES RENDERED IF other than forme or affory [21A, ADD	DREESS OF FACILITY	27. HAR LARCENTONY WORK PERFORMED LAR CHARGES OUTSIDE YOUR OFFICE YOU'S CLIND CT					
20A SERVICE PROVIDER NAME 228	PROF CO LUC DENTIFICATION NUMBER	ZIO STEPRIZATION ABORTRON CODE					
23 OWORDER OF NATURE OF LINESE, HELATE DWORDER TO PROCEDURE IN COLUMN 2011 BY	PREFERENCE TO SUMILIAS 1, 2, 2 ETC. OR DI COOP	236 Y N 220 Y N 400 Y N 100 Y					
		23A PROCH APPENDENT LEADERST 22B PARKY SCURE CO					
1 34A GATE (26 34B 24C 24D 24E 24F 34G 24H	8	Ins. 1					
H M D D Y Y PLACE PROCEDURE VOD MOD MOD MOD	DAGNOSIS CODE DAYS	DHANGES					
0 9 0 9 1 0 1 1 9 9 2 0 5 7 8	8 6 2 1 1 1 1 1	30,00					
0 9 0 9 1 0 1 1 9 3 0 0 0 1 1 7 3	8 6,2	15.00 . .					
0 9 0 1 1 0 1 1 9 9 2 1 3	8 6,2	11130.00 1111.1.1					
	1.111 1111	1111.1 111.1.1 111.1					
	1.111 1.111	1111+1 111+1 111+1					
	L.111	1101.1 1111.1 111.1					
and Hard High American Am American American Am American American Ameri American American Ameri America	1.111						
A CENTRY TAAT THE STUTTANTS OF THE SEVERAL SEPARATION AND ARTS AND	ADCEPT ASSIGNMENT IZ	IT. TOTAL CHARGE 28 MAGUNT PAD 20 BALANCE DUE					
	ENPLOYER IDENTIFICATION NUMBER SCILLER	DI. PHYSICLAR'S DH SUPPLEYS NAME, ADDRESS, DP CODE					
1004/148 0F HITSCAN OF KAPURA 534 PROVIDER CENTRICATION NAMERIA 1 1 2 3 4 5 6 7 8 9	Samuel Sample 312 Main Street Anytown, New York 11111						
ZSIL INDEXIG DRUCH DONI PRATION WANNER SIC LOCA FROM COOL TOR COOL 0 0 3	TASA MAY FEE HAS SEEN FAID	TELEPHONE HUMBER EDT					
COUNTY OF SUMMITTAL 275 CATE SOLES 25 INTERVIEW COUNT NUMBER 09 10 10	00 N07 INTE 11 THE SPACE (9/10) EMEDNY-150003						
DATENDE NO.							



Exhibit 2.4.2.1-2

MEDICAL ASSISTANCE HEALTH INSURAN	DRIGINAL TRANSACTION CONTROL NUMBER					
CLAIM FORM TITLE XIX PROGRAM USED TO ADJUIST/VOID 7 PATIENT AND INSURED (SUBSCRIBER) INFORMATION PAID CLAIM 7						
	2. DATE OF BETTHE 24. TOTAL ANNES FAMILY INCO	AL 1 INSURED INVINE (First name, middle er/lai, last name)				
Jane Smith	0 5 2 0 1 9 9 0					
H 4 PATIENTS ADDRESS (Show, CA), Show, Zu CAM, CY	MALE FEMALE LIALS FEDALE	6. MEDICARE NUMBER A. B. 1, 2, 3, 4, 5, C				
TAN	SR. PATIENT'S TELEPHONE NUMBER	DE PRIVATE HISUPANCE NUMBER GROUP NO. RECEPTOCITY NO.				
m 5						
E. MATERIT'S BANLOYER, OCCUPATION OF SCHOOL		& INSURED'S ENFLOYER OR OCCUPATION				
8	SELF SPOUSE CHILD CTHER					
 A. CTHEN HIGH THE PRIMARE CONSTRUCT – Select Name of Policy House, Then Name and Address, and Polics of Policy Residence Transmiss Number 	TE WAS CONDITION RELATED TO PATIENTS CRIME	11. INSURED'S ACORESS (Shiet, City, Shiet, Zip Cook)				
	EWPLOYNENT ACTIM					
	ACCORENT UANE (TY					
12	CATE	12.				
	The second second					
PATIENTS OF AUTHORIZED SCHATURE	MM DD YY	NULRED'S SIGNATURE				
PHYSICIAN OR SUPPLIER INFORM 14 DATE OF OMBET THEFHIST CONSULTED 14 HAS INTENT EVER HAD SAME 1	A EMERGENCY IT DATE PATIENT MAY	INTARTS OF DEALERS AND SPENING)				
OF CONDITION FOR CONDITION OR SMILLAR SYMPTOME	RELATED RETURN TO WORK					
	MA ACCHEER (CH SIGNATURE SHE CALIT)	THE PHOF CD THE DESITIFICATION NUMBER HID DX DODE				
	the second second	1 1 1 2 3 4 5 6 7 8 9 1 1 . 1 1				
21. NATIONAL PRICE CODE 254, ME 288, CAMATTY	mc cos=	NGC who everyships the left of this fails will only be associated with the fail cave line between				
21 NAME OF FACULTY WHERE SETMICES REMOVERED of other than home an office) [21A	ADDRESS OF FADLITY	22. WAS LABORATORY WORK PERFORMED LAB CHWICES				
		VES O NO OFFICE				
22A DERVICE PROVIDER NAME	29 PROF CD 22C IDENTIFICATION NUMBER	22D.STEREIZATION ADDITION CODE 22E.STATUS CODE				
23. DIAGNOORS OF WATCHE OF KLINESS, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 2001	BY HERENKICE TO NUMBERS 1. J. J. ETC. OF DX COL	POENER X " ZAL " ZAL " ZAL " ZAL " ZAL " X POENERE X CTHP RANKY X				
		ZIA PRIOR APPROVAL MAMORIA ZIE PANYY SOURCE C				
A contraction of the second		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
THA DATE OF PLACE PROCEDURE NOD MOD MOD MOD MOD	N DIAGNOSIS CODE DATO	DURGES 144 DR				
н н о о у у со	enver enver					
0 9 0 9 1 0 1 1 9 9 2 0 5	8 6 2 1	3 0, 0 0 . .				
0 9 0 9 1 0 1 1 9 9 2 0 3	00.2	3.0.00				
0 9 0 9 1 0 1 1 9 3 0 0 0 1 7	8 6,2	1 1 5.00				
		The residence of the second				
0 9 1 0 1 0 1 1 9 9 2 1 3 7	8 6.2	30,00				
		<u> </u>				
SHU FROM THROUGH (244 PROC CD (240 WOR)						
25. CONTRACTOR & CERTING THE STATULENTS ON THE REVENUE ONE APRLS TO THIS BUL AND ARE SUCCE A FAST (ACROS)	VE9 NO	21, TOTAL DWPGE IN ANOUNT PAID 29 BALANCE DUE				
SAMUEL SAMPLE 36 EMPLOYER DENTRICATION ROMEEN 31. PHYSICIANS ON SUPPLEYS NAME, ADDRESS, 20 CDDE						
SAMUEL SAMPLE	Samuel Sample					
25A PROVIDER SERVERATION NUMBER		312 Main Street				
1 1 2 3 4 5 6 7 8 9 Set HEDCAD DATAF CONTRACTION NUMBER SET LOCA SET DATA SET AND SET						
DE MEDICAD GROUP DENTRICATION NOMERI DE LOCA ESD SA TOR CODE 0 0 0 13	ODE VEB NO	and the second				
COUNTY OF SUMMITTAL 25E DATE STIMED 12 PATIENT'S ACCOUNT MINEED	TELEPHONE NUMBER EN SPINE					
09 30 10 1 1 1	(9/10) EMEDNY-15000					
31 BITHER HERESPING ORDERING PROVIDER 34 PROF CO 35 CASE WANNE	ABC12345					

2.4.2.2 Void

A void is submitted to nullify the original claim in its entirety.

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 the TCN and the originally submitted Group ID, Billing Provider ID, and Member ID.

Exhibit 2.4.2.2-1 and Exhibit 2.4.2.2-2 illustrate an example of a claim being voided. TCN 1026301234567890 contained two claim lines, which were paid on September 20, 2010. Later, the provider became aware that the member had other 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.



Exhibit	2.4.2.2-1
---------	-----------

MEDICAL ASSISTANCE HEALTH INSURANCE	ORIGINAL TRANSACTION CONTROL NUMBER				
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	ADJUST/VOID PAID CLAIM				
Jane Smith 0, 6, 0	TOTH IN TOTAL ANNUAL I. INSUME IT INVITE (Fill name, while what have) FAMLY INCOME				
G A PATENTI ACCRESS (Street City, State, 2): NOL POT	13(1)9(5)6 19 SEX SA PARTINE SEX 6 MEDICHE NUMER 64 MEDICHE NUMER				
ALC: NOT	X A B 1 2 3 4 5 C				
The second secon	T'S TELEPHONE NUMBER HO. PRIVATE INSURANCE NUMBER OROUP NO. RECIPTOCITY NO.				
2 E ANTEIN'S BINUNEL CODUPTON ON SCHOOL 1. PATENT	S RELATIONSHIP TO INSURED A INSURED S EMPLOYER OF DOCUMATION				
AT CONTRACTOR OF	990.55 OHD 07HER				
PATEN INTERNATION PATEN					
EMPLOYNE S					
ACCEPT	The second				
12	DATE Q				
PATIENTS OF AUTHORIZED SONATURE	MM DD YY INSUREDS EXAMINE				
PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)				
INCAST OF OWNEY IS FIRST CONSILITED SHAMA PARTENT FOR HAD SAME OF CONSTICUT FOR CONSTICUT ON SHAMA SIMPTONS RELATED TAM (DD) YY MIN (20) YY WES NO VOS >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	NOV TO DATE PATTRATI MAY TRUBITS OF DEBAULTY FROM TO PETURAN TO WORK TOTAL PAULTAL PAULTAL DUTY AND DO YY AND DO YY				
THE LEFT THE REAL PROPERTY AND A DESCRIPTION OF THE PROPERTY AND A DESCRIP	L OP INSWITCHE SHE ONLY VIE FROM CD VIE DESITE CATION WARES VIE DO TY OW TOD TY				
20 NATIONAL DISCO CODE THE OWNER DISC CLARITY	1 1 1 2 3 4 1 5 16 17 18 19				
5, 5, 3, 9, 0, 0, 5, 5, 5, 9, 0 G, R	and the second				
21 JUNE OF FACILITY WHERE SERVICED RENDERED (Follow han June at allow) 218. ADDRESS OF					
ZUA SERVICE PROVIDER NAME	YES (2) NO (2) 1 200 STEPLICATION HUMBER 200 STEPLICATION				
	ARCHITCH CODE				
21. DWOHOSES ON NATURE OF ALTEER. HELATE DAGNORS TO PROCEEDING IN COLUMN THE REFERENCE.	NOR TO MUMERS 1, 2, 3 FTC, OH DA COOK 224 7 1 220 7 1 220 7 1 224 7 1 224 7 1 225 1				
	THE PRICE APPROVAL NUMBER OF THE PRICE OF				
1 545 sec. 1505 [200. [200. [200. [200. [200. [200.					
DATE OF EEMVICE FRACE PROCESURE MCD MCD MCD MCD DAGNOD H H O D Y Y	IS CODE DATS CHARGES UNTE				
0 9 1 4 1 0 1 1 J1 2 4 5	0 1				
0 9 1 4 1 0 1 1 7 8 4 6 5 7 C					
0 9 1 4 1 0 1 1 7 8 4 7 8 T C 4 1 4 0					
	111 11111 1111.1 1111.1 111.1				
	m m m m m m m m m m m m m m m m m m m				
and mode tangen in the second					
25 CONTRACTOR 2 CONTRACTOR A CONTRACTOR A CONTRACTOR A CONTRACTOR A CONTRACTOR	KESIGNARENT 27. TOTAL GAVAGE ON ANOUNT PAID 28. BALANCE DUE				
A CERTARY THAT THE REPORTED BIT REPORTED SIDE WHEN TO THIS BALL YES					
SAMUEL SAMPLE SOMETIME SOMETIMES	BE DEPENDENT IN MARKEN BECOMMENDENT AND A STATE OF SUPPLIES NAME, ADDRESS, DF COXE Samuel Sample				
254. PROVIDER IDENTIFICATION MINNER	312 Main Street				
1 1 2 3 4 5 6 7 8 9 ISM_MEDICAD_GROUP DEVERTINGATION NUMBER 355 LOCA BUL 54 X8A, M TOM_MODIL TOM_CODE ENDP_CODE ENDP_CODE ENDP_CODE	Anytown, New York 11111				
TOR CODE EXCP CODE YE	8 TELEPHONE MAREEN EXT				
COUNTY OF SUBRITAL SEE SALED 12 PATENT'S ACCOUNT WAREER	00 A01 AHTE IN THE SPACE (9/10) EMEDNY-150003				
EN CHER REFERENCE OF THE PROVIDER IN THOSE OF THE REPORT O	A B C 1 2 3 4 5				



Exhibit 2.4.2.2-2

MEDICAL AS				A contractor which		ORIGINAL TRANSACTIO	IN CONTROL NUMBER
CLAIM FORM TITLE XIX PROGRAM USED TO ADJUST/VOID ADJUST/VOID XX 1,0,2,6,3,0,1,2,3,4,5,6,7,8,9,0							
	E 1. PATIE	NT'S NAME (First of		2. SATE OF BRITH	2A TOTAL ANNUA FRANCT INCO	AL 1. BULLINED'S KAME Fist Amy	
		Smith	(D) State 7: 0	0,6,0,3,1,9	the first farmer of the second s	6 MEDICARE NUMBER	TRA MEDICAD MUNICH
	5	in a weather paren		W E NEISTOFFE	A PATENT STA	a manager a manager	A B 1 2 3 4 5 C
	NP.			SR. PACTENT'S TELEPHON	the second se	NE PRIVATE NEWFLANCE NUMBER	GROUP NO RECIPROCITY NO.
	-			1			
	PAR PAR	ENT'S ENVICEMENT OF	CUPATION OF SOM	00. 1. PATENTS RELATIONSH	CHED CTHER	A INSURED & EMPLOYER OR OCCUPAT	
	G & OTHER	ICA'S REAR	OTHER ALE - EAN I	IN WAS CONDITION PEL	ATED TO	1. NEURED'S ADDRESS (Smur, Ca)	Ram, Za Caulti
	2 Physics	y Notes, Pan Name et resignes Norter	C ARDELL, Mrs. PORT	FARENTS ENFLOWENT	VICTIM		
	EA			4000	00406		
	12			ACCIDENT	DATE	12	
to constraint a	and the second sec	S OF AUTHORIZED			MM DD YY	NEUREIIS SIGNITURE	
14 SATE OF ONDET	FIRST COMPLETED 11	HAS PATIENT FU	FRI HATI SAME	164 EVERGENCY	17 CART PATENT MAY	ORE COMPLETING AND S INDATES OF DEARLITY FR	
OF CONDITION	MIL DO YY Y	OR SIMLAR SYM	MO	TES NO	METURIN TO MORE	TOTAL PARTIA	
TO MAKE OF REFERENCES			1	TRA.ADDRESS (OR BIOWATS		THE PROFICTION OF THE CATION NO	
20 NATIONAL DRIVE COD	-	TALINET THE CLAR	ID TV	200 000		1 1 2 3 4	5 6 7 8 9
5, 5, 3, 9, 0, 0	Concerns - reside-	100		10.01	3,310,0		
21 NAME OF FACELOTY WH			vie ar affice)	TA ACCHESS OF FACILITY	101010101	22. WAS LABORATO OUTSIDE YOUR	OFFICE
				229 PROF CD 220 0847	PICARCH MUMBER		00 IN STATUS CODE
21A DERVICE PROVIDER I	A AND					ABORTION COL	E
23. EMAGAIOEJS CHI NATLIFE	OF LLNESS. RELATE D	AGNOSE TO PROG	EDURE IN COLUM	A DRY BY REFERENCE TO NUMBER	HS 1. 2. 3 ETC. OF DX CO.	E ZDF. Y X P 220. Pototel.E X EFSCT	T H 22H T N
L					Charles and	POSSEE DISABLITY X EPSC CTHP TLA POSS APPROVA NUMERO	PLANNING X
1						The react Arriston, some	1 1 1 1 1 1 1 1
DATE OF	PLACE PROCEDURE	MCD MCD	HOD MOD	DIAGNOSIS CODE	Stives	244 20%	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
H H D D Y Y	PLACE PROCEDURE	1000 Mar		Straphone occur	UNITS	CHARGES	
0 9 1 4 1 0			1.1.4	4 1 4 . 0 1	11110	3 3,0 0	ILL LILL
021410	11 01 2 7 5			4 1 4 . 0 11		1 3 3.010	
091410	1 1 7 8 4 6	5 T C	1 1	4 1 4 0 1	2	1000.00	
091410	1 1 7 8 4 7 1	TC	1.1	4 1 4 0 1	11111	10000	III.III.I
	1		1 1		11111	111111	111 1 111.1
	1 1 1 1	1 1	11	11.111	11111	1111.1	111.1 111.1
		1 1	1 1	11.111		1111.111	III.I III.I
						1111111	
SHU FROM	THROUGH	224, 216	DC CD 240 M				
APATENT HOERTAL VERTS	In Della	1 11					
35. CERTIFICATION # CONTROL THAT THE STA AND ARE MADE A FIRIT A	TEMENTS ON THE REVERSE EFFORT	SIDE APPLY TO THE	MAL	DE ACCEPT ASSIGNMENT YES	10	27. TOTAL CHARGE 28. AMOUT	AL SWD 26-BALANCE DUE
SAMUEL SA				SE EMPLOYER DERTIFICAT BOCIAL SECURITY NOM	the second se	ST. PHYSICIAN'S ON SUPPLIER'S NAME	AUGHEND, 20 CODE
MOMPH OF ANDIDAL OF REPORT SALE DECIMITION REPORT 1 1 2 3 4 5 6 7 8 9						Samuel Sample	
						312 Main Street	
1 1 2 3 28 MDC46 340.4 6			LOCA 25	SA NY FEE HAS HE	EN PAD	Anytown, New York	
	111	0	0 3	YEB	40	TELEPHONE RABER	617
COUNTY OF SUBWITTAL	24 DATE SKRET		Character conversion	DO NOT VIRUE IN THIS SPACE.	(9/10) EMEDNY-15000		
THE OTHER REPERTING O		10 34. PRIOR	CD IN CASE &		C 1 2 3 4 5		
EDUCENSE NO		1.1.1		11111	121		

Patient's Name (Field 1)

837P Ref: Loop 2010BA NM1

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

Date of Birth (Field 2)

837P Ref: Loop 2010BA DMG02

Enter the member's birth date. This information may be obtained from the CBIC. The birth date must be in the format MMDDYYYY as shown in Exhibit 2.4.2-1.

Exhibit 2.4.2-1



Patient's Sex (Field 5A)

837P Ref: Loop 2010BA DMG03

Place an 'X' in the appropriate box to indicate the member's sex. This information may be obtained from the CBIC.

Medicaid Number (Field 6A)

837P Ref: Loop 2010BA NM109

Enter the Member ID. This information may be obtained from the CBIC. Member IDs 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

6A.						
ME	DIC	:AID	NU	MB	ER	
AA	1	2	2	4	5	W.
	- L	2	5	4	5	V V

NYS Medicaid General Professional Billing Guidelines

Page 15 of 48



837P Ref: Loop 2300 CLM11

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

Member's Employment

If the claim is covered by Worker's Compensation, place an X in the box.

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)

837P Ref: Loop 2400 SV109

Enter an 'X' in the Yes box only when the condition being treated is related to an emergency; otherwise leave this field blank.

Name of Referring Physician or Other Source (Field 19)

837P Ref: Loop 2310A NM1

This field should be completed when claiming the following:

- Ordered Procedure
- Referred Service

Ordered Procedures

If claiming any of the procedures listed below the name of the ordering provider must be entered. If the procedures were performed by the billing physician, the billing physician's name must be entered.

- All Radiology Procedures
- Cardiac Fluoroscopy
- Echocardiography
- Non-invasive Vascular Diagnostic Studies
- Consultations
- Lab Services

Note: Consultation codes must not be claimed for a physician's own member.

Referred Service

If the member was referred by another provider enter the name of the referring provider.

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

Leave this field blank.

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

Leave this field blank.

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

837P Ref: Loop 2310A NM109

This field must be completed when the claim involves any of the following:

- Ordered Procedure
- Referred Service

Ordered Procedures

If the service was ordered by another provider (see field 19 for the list of ordered procedures), enter the ordering provider's National Provider ID (NPI).

Referred Service

If the member was referred for treatment by another physician, enter the referring provider's NPI.

A facility ID cannot be used for the referring/ordering provider. In those instances where an order or referral was made by a facility, the NPI of the practitioner at the facility must be used.

When providing services to a member who is restricted to a primary physician or facility, the NPI of the referring professional must be entered. *If a member is restricted to a facility, the NPI of the facility's referring professional must be entered. The ID of the facility cannot be used.*

DX Code (Field 19D)

837P Ref: Loop 2300 HI01-2

If applicable, enter the secondary diagnosis.

Drug Claims Section: Fields 20 to 20C

The following instructions apply to claims for physician administered drugs:

- The NDC in field 20 and the associated information in fields 20A through 20C must correspond directly to the drug related procedure code reported in the first line of fields 24A through 24L.
- 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)

837P Ref: Loop 2410 LIN03

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 number. Do not use spaces, hyphens or other punctuation marks.

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

Exhibit 2.4.2-3

Package NDC Number Configuration XXXX-XXX-XX	Correct Leading Zero Placement for 5-4-2 = 11 $0 \times \times$	NDC Field Example: 20NATIONAL DRUG CODE-		
4 + 4 + 2 = 10	5 + 4 + 2 = 11	° 0 x x x x x x x x x		
XXXXX-XXX-XX 5 + 3 + 2 = 10	xxxxx- 0 xxx-xx 5 + 4 + 2 = 11	20NATIONAL DRUG-CODE+ * X ^{III} X ^{III}		
$\begin{array}{rcrcrcr} XXXXX-XXXX-X\\ 5 &+ 4 &+ 1 &= & 10 \end{array}$	XXXXX-XXX- 0 X 5 + 4 + 2 = 11	20NATIONAL-DRUG CODE= = X X X X X X X X X X 0 X		



837P Ref: Loop 2400 SV103

Use one of the following when completing this entry:

- 🧶 UN = Unit
- F2 = International Unit
- GR = Gram
- ML = Milliliter

Quantity (Field 20B)

837P Ref: Loop 2400 SV104

Enter the numeric quantity administered to the member. 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. The claim will not process correctly if the decimal is not entered in blue or black ink.

Exhibit 2.4.2-4



Cost (Field 20C)

837P Ref: Loop 2400 SV102

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





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

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



MEDICAL ASSISTANCE HEALTH INSURA CLAIM FORM TITLE XIX PROGRAM PATIENT AND INSURED (SUBSCRIBER) INFORMATION	ADJUST/VOID PAID CLAIM	ORIGINAL TRANSACTION CONTROL NUMBER	
Jane Smith	Z. DATE OF HERTH JA. TOTAL ANNU FAMILY INCO	M. 2. INSCREDIS WINE (First name, include initial, last name) Mile	
4 FATENTS ACCRESS (Blow, Cly, State, Z) Crist	0 5 2 0 1 9 9 0	A MEDICARE NUMBER	
ALL	x	A B 1 2 3 4 5 C	
	SB. INTENTS TELEPHONE MUMBER	HB. PRIVATE INSURANCE MUNIFIER OROUP NO. RECIPROCITY NO.	
22 R. FATENTS BARDYER, OCCUPATION OF SCHO	L A PATIENTS RELATIONSHIP TO INSURED	A INSURED'S ENFLOYER ON OCCUPATION	
2	BELF SPOUSE CHED OTHER		
 CITE(I) HE ALTH BELAMACE COVERAGE - Error Num et Publy Hazes. Fire Name and Address. one Party or 	A TO WAS CONDITION RELATED TO PATIENTS CRIME	11. INSURED & ADDRESS (Sower, City, State, Zip Coder	
Prote transition faither	EMPLOYMENT CENTER VICTIM	and the second se	
>	ALCO DENT		
12	DATE	18	
PATIENTS OF AUTOORZED SONATURE		INSURED'S BIOMATURE	
PHYSICIAN OR SUPPLIER INFOR 14 DATE OF ONSET 11-FIRST CONSULTED 16-MAS PATENT EVER HAD SAME OF CONDITION OR SUBLATED 16-MAS PATENTICAS	MATION (REFER TO REVERSE BEP 17 DATE PATIENT MAY	TRIDATES OF DESABLIEV FROM TO	
CF CONDITION FOR CONDITION OR SAME AN AVAILABLE SYMPTOMS	VES NO MM DO YY		
TO MAKE OF REFERENCE INVISION ON OTHER SOURCE	18A, ADDRESS, (CH SIGNA / LINE SHF CALLY)	VIE PHOP CD INC DENTIFICATION NUMBER OD DK CODE	
20 NATIONAL DRUG CODE 294 UNIT 200 GLAN/TITY	200 0067	1 2 3 4 5 6 7 8 9 0	
00703680101 G R	0 1 5 0 4 5 0		
	A ADDRESS OF FACILITY	27. WAD LARCHATORY WORK PERFORMED LAR CHARGES ISUTSICE YOUR OFFICE	
	Press and the second second second second	MISEL NOC	
32A BERNDE PROVIDER NAME	228 PROF C0 2210 DEMTIFICATION NUMBER	ABORTION CODE	
23. DIAGNOSIS ON WITURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN.	ON BY REPERCICE TO NUMBERS 1, 2, 3 ETC. OF DR OCT		
L	We an and the	DISABLITY OTHER PLANING	
		204 PERCENTROVAL NUMBER 239, PRINT SOURCE CO	
364 Batt of 240 240 240 240 240 240	DARMONE CODE DAYS	244 254 254 254	
M N D D Y Y CD CD MOD MOD MOD MOD	DIAGNOSIS CODE DAYS OR UNITE	DHINGES	
		The second starting and all the	
0909101131955	162,9	6 7 5	
0 9 0 9 1 0 1 1 9 4 6 1 0	162,9	35.00	
	terre de ante l'entrante de	210 122 121 222 222 22 322 22 12	
	FISTER FILLE		
	11.111 11111		
	11 111 11111	TTTT TOTTE TOTTE	
		1 · · · · · · · · · · · · · · · · · · ·	
	II.III IIII	IIIIIIIIIIIIIIIIIIIIIII	
and FROM THROUGH 24b PROC CD DIG MOD NOVYENT MODELS			
VIIIS	IN ACCEPT ASSIGNMENT	21. TOTAL DHARGE 28. AMOUNT PAD 28. BALANCE DUE	
VIIIIS	TEB NO		
VILITS 25. CENTRICATION 25. CENTRICATION 26. CENTRICATION	and the second se	SIL PRATECUARE OR SUPPLIERS NAME, ADDRESS, SP CODE	
USIS SC CENTRATOR © CENTRATOR CONTINUES THE EXISTENCE OF THE REVENUE SEE APRLY TO THE BLL AND ARE USED A WATE TRACETOR SAMUEL SAMPLE SOLUTION OF THE SCHLOP SUPPLIER	TEB NO	34. HWEICHARD OF SUPPLIERS HAVE, ADDRESS, SP CODE Samuel Sample	
S CONTRACTOR CONTRY Text the transferred on the revenue and which to the BL we use which integers SAMUEL SAMPLE	TEB NO	34 Prescuers on suprocess seek, accesso, pr code Samuel Sample 312 Main Street	
Votes 8. CENTROLOGION • CONTRY THAT THE EXAMPLES ON THE REVENUE BDE APRLY TO THE BEL • AND ARE AND A HART REPORT SAMUEL SAMPLE SMARTLER OF PRESCHA OF REPORT SCA. PROVIDER IDENTFRATION REPORT SCA. PROVIDER IDENTFRATION REPORT	1929 AV 36 EMPLOYEN DENTRECATION HUNGER DOCAL DECUNITY HUMBER MODELAL DECUNITY HUMBER MODELAL DECUNITY HUMBER	34. HWECKWITE OF SUPPLIERS HAVE, ADDRESS, SP CODE Samuel Sample	
BL CERTIFICATION 0 CERTIFI	YES NO 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 37 EMPLOYEN DENTFICATION HUNGER 38 EMPLOYEN DENTFICATION HUNGER 39 EMPLOYEN DENTFICATION HUNGER 30 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 37 EMPLOYEN DENTFICATION HUNGER 38 EMPLOYEN DENTFICATION HUNGER 39 EMPLOYEN DENTFICATION HUNGER 30 EMPLOYEN DENTFICATION HUNGER	31 PM/SCARE OF SUPPLIERS NAME, ADDRESS, 29 CODE Samuel Sample 312 Main Street Anytown, New York 11111	
BS. CERTIFICATION 0 CERTIF	YES NO 36 EMPLOYEN UDENTIFICATION NUMBER 36 EMPLOYEN UDENTIFICATION NUMBER 56 DOCAL DECUNITY HAMBER 56 VES 4 VES NO AND	31 PRVISCURE OF SUPPLIERS NAME, ADDRESS, 39 CODE Samuel Sample 312 Main Street Anytown, New York 11111 TELEPHORE HUMBER1 DO NOT WHITE PLANE, SPICE (9(10) EMEDNY-150003	
BL CERTIFICATION 0 CERTIFI	1928 NO 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 36 EMPLOYEN DENTFICATION HUNGER 36 MO 37 CODE 38 EMPLOYEN 40 MO 40 MO 40 MO 40 MO	31 PRVISCURE OF SUPPLIERS NAME, ADDRESS, 39 CODE Samuel Sample 312 Main Street Anytown, New York 11111 TELEPHORE HUMBER1 DO NOT WHITE PLANE, SPICE (9(10) EMEDNY-150003	



837P Ref: Loop 2010AA NM1 or 2310C NM1

This field should be completed when the Service Location is other than the address the payments are to be remitted.

Address of Facility (Field 21A)

837P Ref: Loop 2010AA N3 and N4 OR 2310C N3 and N4

This field should be completed when the Service Location is other than the address the payments are to be remitted.

NOTE: This is the address where the service was rendered.

Service Provider Name (Field 22A)

837P Ref: Loop 2310B NM1

If the service was provided by a physician's assistant, certified diabetes educator, certified asthma educator, social worker, or a private duty nurse, enter the name. Otherwise, leave this field blank.

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

Leave this field blank.

Identification Number [Service Provider] (Field 22C)

837P Ref: Loop 2310B NM1

If the service was provided by a physician's assistant, certified diabetes educator, certified asthma educator, social worker, or a private duty nurse, enter the service provider's NPI. Otherwise, leave this field blank.

Sterilization/Abortion Code (Field 22D)

837P Ref: Loop 2300 HI01-2

If applicable, enter the appropriate code to indicate whether the service being claimed was related to an induced abortion or sterilization. The abortion/sterilization codes can be found in Appendix B – Code Sets.

If the procedure is unrelated to abortion/sterilization, leave this field blank.

When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, *LDSS-3134*, is required and must be attached to the paper claim form (See Appendix C - Sterilization Consent Form LDSS-3134).

NOTES:

NYS Medicaid General Professional Billing Guidelines

Version 2022 - 01

- The following medical procedures are not induced abortions; therefore when billing for these procedures, leave this field blank.
 - Spontaneous abortion (miscarriage);
 - Termination of ectopic pregnancy;
 - Drugs or devices to prevent implantation of the fertilized ovum;
 - Menstrual extraction.
- Medicaid does not reimburse providers for hysterectomies performed for the purpose of sterilization. Please refer to the Policy Guidelines 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: Policy Guidelines.

Status Code (Field 22E)

Leave this field blank.

Possible Disability (Field 22F)

837P Ref: Loop 2300 CLM12

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)

837P Ref: Loop 2400 SV111

This field must be completed if the physician bills for a periodic health supervision (well care) examination for a member under 21 years of age, whether billing a Preventive Medicine Procedure Code or a Visit Code with a well care diagnosis. If applicable, place an 'X' in the Y box for YES.

Family Planning (Field 22H)

837P Ref: Loop 2400 SV112

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. The services include, but are not limited to:

- Physician, clinic or hospital visits during which birth control pills, contraceptive devices or other contraceptive methods are either provided during the visit or prescribed.
- Periodic examinations associated with a contraceptive method.
- Visits during which sterilization or other methods of birth control are discussed.

Sterilization procedures.

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)

837P Ref: Loop 2300 REF02 when REF01 = G1

If the provider is billing for a service that requires Prior Approval/Prior Authorization, enter 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 separate 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: Inquiry.
- For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines located in the applicable provider manual
- For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules located in the applicable provider manual.

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

837P Ref: No Map

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



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 member 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 member does not have Medicare coverage.

Member 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.

Member 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 member has insurance coverage other than Medicare or Medicaid or whether the member 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 member does not have other insurance coverage.

Member has Other Insurance coverage – Source Code Indicator = 2

This code indicates that the member 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.

Member Participation – Source Code Indicator = 3

This code indicates that the member 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.
M / 1 / /		
23B. PAYM'T SOURCE CO	Code 1 – No Medicare involvement. Field 24J should contain the amount charged and field 24K must be left blank.	Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other insurance did not cover the service or denied payment. ** You 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
M/ <u>3</u> /*/*		also involved, enter the total payments in 24L and ** enter the two-digit insurance code.
23B. PAYM'T SOURCE CO	Code 2 – Medicare Approved Service. Field 24J should contain the Medicare Approved amount and field 24K should contain the Medicare payment amount.	Code 1 - No Other Insurance involvement. Field 24L must be left blank.
2 1 1 111	contain the medicale 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 service or
┣━/ ಈ / * / *		denied payment. ** You must indicate 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
2/3/*/*		payments in 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	Code 1 – No Other Insurance involvement. Field 24L must be left blank.
3 1 / /	field 24K should contain \$0.00.	
23B. PAYM'T SOURCE CO	Code 3 – Medicare denied payment or did not cover the service. Field 24J should contain the amount charged and field 24K should contain \$0.00.	Code 2 – Other Insurance involved. Field 24L should contain the amount paid by the other insurance or \$0.00 if the other
32′′′′		insurance did not cover the service or denied payment. ** You must indicate 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 3 – Indicates patient's participation. Field 24L should contain the patient's participation amount. If Other Insurance is also involved, enter the total
<u>v</u> v v v v v v v v v v v v v v v v v v		payments in 24L and ** enter the two-digit insurance code.

Procedure Section: Fields 24A to 240

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

Date of Service (Field 24A)

837P Ref: Loop 2400 DTP03 when DTP01 = 472

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)

837P Ref: Loop 2300 CLM05-1

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. Place of Service Codes may be found in the NUBC UB-04 Man

Procedure Code (Field 24C)

837P Ref: Loop 2400 SV101-2

Enter the appropriate five-character procedure code.

NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org in the applicable provider manual.

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

837P Ref: Loop 2400 SV101-3, 4, 5, 6, and 7

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 in conjunction 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 can be found on the web page for this manual under Procedure Codes and Fee Schedule, which can be found at www.emedny.org in the applicable provider manual.

Diagnosis Code (Field 24H)

837P Ref: Loop 2400 SV107 (Diagnosis Pointers)

Enter an ICD-10-CM Diagnosis Code as shown in Exhibit 2.4.2-9.

Exhibit 2.4.2-9

24H.				
D	IAGN	IOSIS	CODE	Ξ
2	6	8.0		

Days or Units (Field 24I)

837P Ref: Loop 2400 SV104

Enter the appropriate number of units.

Charges (Field 24J)

837P Ref: Loop 2400 SV102

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. The Amount Charged may not exceed the provider's customary charge for the procedure.

Medicare Approved Amount

When Box M in field 23B has 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 wasrendered.
- 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.
- 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)

837P Ref: No Map

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

Box M=3

Enter 0.00 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)

837P Ref: No Map

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,
 - If there is only one insurance carrier, enter the other insurance payment.
 - If more than one insurance carrier contributes to payment of the claim, enter the total amount paid by all other insurance carriers.
- When Box O has an entry value of 3,
 - Enter the amount the member paid.
 - If the member is covered by other insurance and the member made payment, enter the sum.

If the other insurance carrier denied payment, enter 0.00 in field 24L. Proof of denial of payment must be maintained in the member's billing record.

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

NOTES:

- It is the responsibility of the provider to determine whether the member'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.



This section must be completed only by the following provided types:

- Midwife
- Nurse Practitioner
- Physician
- Podiatry

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

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

837P Ref: Loop 2400 DTP03 when DTP01 = 472

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)

837P Ref: Loop 2400 SV101-2

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:

- 90238
- 90240 through 90282
- 🧶 94997
- 99231 through 99233
- 99296 through 99297
- 🧶 99433

MOD [Modifier] (Field 240)

837P Ref: Loop 2400 SV101-3, 4, 5, 6, and 7

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

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 Procedure Section of the form.

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

837P Ref: Loop 2300 CLM06

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)

837P Ref: Loop 2010AA NM109 OR Loop 2310B NM109

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

Medicaid Group Identification Number (Field 25B)

837P Ref: 837P Ref: Loop 2010AA NM109

For a Group Practice, enter the NPI assigned to the group.

If the provider or the service(s) rendered is not associated with a Group Practice, leave this field blank.

Locator Code (Field 25C)

837P Ref: No Map

Enter the locator code assigned by NYS Medicaid that corresponds to the address where the service was performed.

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: <u>Inquiry</u>.

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

837P Ref: Loop 2300 REF03 when REF01 = 4N

If required, enter the SA exception code that best describes the reason for the exception. For valid SA exception codes, please refer to Appendix B - Code Sets.

NOTE: If the services being claimed has enhanced or special pricing, the value '7' must be entered.

General Policy. If not applicable leave this field blank.

County of Submittal (Unnumbered Field)

837P Ref: No Map

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)

837P Ref: No Map

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>General Billing</u>.

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

837P Ref: Loop 2010AA NM1, N3, and N4

Enter the provider's name and correspondence address, using the 5 digit ZIP code or the ZIP plus four.

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: <u>General Inquiry</u>.



837P Ref: Loop 2300 CLM01

This field can accommodate up to 20 alphanumeric characters and will be returned on the Remittance Advice.

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

837P Ref: Loop 2310A NM109

Leave this field blank.

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

Leave this field blank.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals (by category, status and member ID) and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: <u>General Remittance Billing Guidelines</u>.



APPENDIX A CODE SETS

The eMedNY Billing Guideline Appendix A: Code Sets contains a list of SA Exception Codes, Specialty Codes Exempted from UT, Sterilization/Abortion Codes, and a list of accepted Unites States Standard Postal Abbreviations.



Code	Description
1	Immediate/Urgent Care
2	Services rendered in retroactive period
3	Emergency Care
4	Client has temporary Medicaid
5	Request from count for second opinion to determine if recipient can work
6	Request for override pending
7	Special Handling

Note: Code 7 must be used when billing for a physician service with a specialty from the Utilization Threshold Program. Exempt Specialties are listed below.

Specialty Codes Exempted from Utilization Thresholds

- CodeDescription020Anesthesiology
- 150 Pediatrics
- 151 Pediatrics: Cardiology
- 152 Pediatrics: Hematology-Oncology
- 153 Pediatrics: Surgery
- 154 Pediatrics: Nephrology
- 155 Pediatrics: Neonatal-Perinatal Medicine
- 156 Pediatrics: Endocrinology
- 157 Pediatrics: Pulmonology
- 158 PPAC: Preferred Physicians and Children Program
- 159 Moms: Medicaid Obstetrical & Maternal Service Program
- 161 Pediatrics: Pediatric Critical Care
- 169 Moms: Health Supportive Services

- 186 T.B. Directly Observed Therapy/Physician
- 191 Child Psychology
- 192 Psychiatry
- 193 Child Neurology
- 195 Psychiatry and Neurology
- 196 Clozapine Case Manager
- 205 Therapeutic Radiology
- 247 Managed Care Physician Enhanced Fee
- 249 HIV Primary Care Services
- 270 CHAP: Child Health Assurance Program

Sterilization Abortion Codes

Code Description

- A Induced Abortion Danger to the woman's life
- B Induced Abortion Physical health damage to the woman
- C Induced Abortion—victim of rape or incest
- D Induced Abortion Medically necessary

E Induced Abortion – Elective (i.e., Not considered medically necessary by the attending physician. Provision of elective abortions is restricted to New York City members.

F Procedure performed for the purpose of sterilization
APPENDIX B Sterilization Consent Form – LDSS-3134

A Sterilization Consent Form, LDSS-3134, must be completed for each sterilization procedure. A supply of these forms, available in English and in Spanish [LDSS-3134(S)], can be obtained from the NYS DOH 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 LDSS-3134, please follow the guidelines below:

- An illegible or altered form is unacceptable and will cause a paper claim to deny
- Ensure that all five copies are legible.
- Each required field must be completed in order to ensure payment.
- If a woman is not Medicaid eligible at the time she signs the LDSS-3134 [or LDSS-3134(S)] form but becomes eligible prior to the procedure and 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 NA	ME	1.		CF	ART NO		ECIPIEN	TID NO	1.
STERILIZA	TION	HOSPITAL/C	1.000				1			111	1111
CONSENT		HOSPITALIC	LININ								
NOTICE YOUR DE		ANY TIME NOT TO D BY PROGRAMS						AL OR V	THHOL	DING OF A	NY
	ONSENT 1	TO STERILIZATI			1	STATEN	IENT OF P	ERSON	OBTAIN		SENT
I have asked for a	nd received	d information abo	ut steril	ization from	Before		1	3.			signed the
		. Wh						e of Indivi			e sterilizatio
Information. I was to up to me. I was told not to be sterilized, i or treatment. I will receiving Federal fu getting or for which I I UNDERSTAND CONSIDERED PER DECIDED THAT ID CONSIDEREN OR FAT I was told about to available and could father a child in the chosen to be sterilize I understand that	I that I couli my decisio I not lose nds, such i may beco D THAT RMANENT O NOT W/ HER CHIL hose temp be provide future. I ed. I will be	d decide not to b n will not affect n any help or be- as A.F.D.C. or M me eligible. THE STERILI2 AND NOT RE ANT TO BECOMI DREN. orary methods of d to me which wi have rejected to sterilized by an	e steriliz ny right nefits fr edicaid CATION VERSII E PREC f birth c III allow hese all operatio	zed. If I decid to future can room program that I am nov MUST BI BLE. I HAVI INANT, BEAI ontrol that an me to bear o ternatives an on know as	e a final a e benefits a i count of birth c sterilization services of To the e sterilized d appears procedum a	ind irrev associate seled the control a on is diffined the i n at an or any bio best o is at lea knowling to und	ersible pro ed with it. e individual re available erent becas, ndividual to y time and enefits prov of my kno- ast 21 year ily and voi lerstand 19	to be st which a set is p be steri i be steri i ded by I viedge a s old ar untarily	and the erilized the are temp wermaner lized that of she with Federal fu and belie and belie and appea requeste	discomfor orary. 1 e t. this/her co il not los unds. of the ind rs mental d to be	ntended to I rts, risks all ative metho- axplained th onsent can I e any heal lividual to I ily competes sterilized all ence of the
associated with the	operation	The discomfort have been expl	 risks ained to 	and benefit o me. All m	500		person obtair	ung conse	bot	-	Date
questions have been I understand that	answered	to my satisfactio	m.		10 10 10	80.00 180.85		1	6.		00000
days after I sign this any time and that m	form. I un	derstand that I ca	an chan	ge my mind a	it .			Acktres	11.0		
result in the withhold	ding of any	benefits or med	ical service	vices provide							
by federally funded p I am at least 21 ye	pars of age	and was born on	4				PHYSIC				
L 5. free will to be steriliz	8	, hereby	conse	nt of my own	Shortly	before I	performed 18.	a steriliz	tation ope	eration up on	on 19.
free will to be steriliz	ed by	6 (Docto	v)		No	Pure of and	ividual to be	steralized	1.00	Date o	stenigation
by a method called _ expires 180 days fro		A		My conser	e	Operat	ion lization ope			20.	the
				ral laws wer	d discomfor e I couns	rts, risks seled the	and benefit	to be st	ated with enliged th	hat alterna	ative method
	opy of this	for determining sform.	if Fede	ral laws wer	d discomfore e I count of birth o sterilizatio	rts, risks seled the control ar on is diff ned the i	and benefit individual re available erent becau ndividual to	ts associ to be st which a se it is p be steril	lated with enliged th are temp ermaner liged that	orary. 1 e tt. this/her co	ative methor explained th
observed. I have received a You are requested	copy of this 8 - Signature	for determining s form0	ate:	9.	d discomfore e I count of birth c sterilization I inform withdrawn services of	rts, risks seled the control ar on is diffi ned the i n at an or benefi	and benefit individual re available erent becau ndividual to y time and its provided	ts associ to be st which is be steril that h by Fede	lated with enilized th are temp ermanen lized that e/she with rral funds	n It. hat alterna orary. I e tt. I his/her co II not los	ative metho explained th onsent can l e any heal
bserved. I have received a You are requested	copy of this 8 - Signature	for determining s formD r the following inf	ate:	9.	d discomfo e I count of birth c sterilizatio I inform withdrawn services t To the sterilized	rts, risks seled the control at on is diffi- ned the i n at an or benefi- best or is a lea	and benefit individual re available erent becau ndividual to y time and ts provided of my kno- set 21 year	to be st which is be steril that h by Fede viedge is s old an	lated with enilized th are temp ermanen lized that e/she with eral funds and belie id appea	in it. hat alterna orary. I e it. this/her co ill not los i. of the ind rs mental	ative metho explained th onsent can i e any heal lividual to i ly competer
observed. I have received a You are requested required: Race and ethnicity d	but only copy of this 8. Signature d to supply 1 lesignation	for determining s form. 0 the following inf 0 . (please check)	if Fede	9.	d discomfore e I counts of birth c sterilizatic I inform withdrawn services of To the sterilized He/She I appeared	rts, risks seled the control ar on is diffi ned the i n at an or benef best o is a lea knowing t to un	and benefit individual re available erent becau ndividual to y time and ts provided of my kno- st 21 year y and voli	ts associ to be st which is be steri is that h by f'ede viedge is s old an untarily	lated with enilized th are temp ermanen lized that e/she with rai funds and belie d appea requester	n II. hat alterna orary. I e t. his/her co ill not los of the ind rs mental d to be	ative methor explained the onsent can the e any heat lividual to the ly competent sterilized an
observed. I have received a You are requester required: Race and ethnicity d	but only copy of this 8. Signature d to supply 1 lesignation	for determining s form. 0 the following inf	if Fede	9.	d discomfore e I counts of birth c sterilization I inform withdrawn services of To the sterilized HerShe I appeared procedure Instruct	rts, risks seled the control at on is diff ned the i n at an or benefit best of is a lea knowing d to un e. ctions for	and benefit a individual re available erent becau ndividual to y time and ts provided f my know set 21 year y and voli derstand t or use of r	ts associ to be st which is be steri be steri by fede viedge is s old an untarily he natu	lated with enlized th are temp memaner lized that e/she wi real tunds and belie d appea requeste re and ve final	hit. hat alterna orany. I e tt. his/her co ill not los fr the ind rs mental d to be conseque paragrap	ative method explained th onsent can t e any heal lividual to t ly competer sterilized ar ances of th ohs: Use th
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native	but only copy of this 8. Signature d to supply 1 esignation o or	for determining s form. 0 the following inf 0 . (please check)	if Fede	9. 9. onth Day Yea n, but it is no	d discomfor e I count of birth o sterilizatio I inform withdraw services (t To the sterilized He/She i appeared procedur Instruce (first para emergen)	rts, risks seled the control a on is diffi- ined the i n at an or benefi- best or is a lea knowing t to un e, ctions fi- graph b cy abdo	and benefit individual to re available erent becau- ndividual to y time and ts provided if my kno- ust 21 year y and volid derstand t or use of - elow excep- minal surgen	ts associ to be st which a real tisp be steri is that h by fede viedge a sold an untarily he natu alternati of in the ary when	lated with enliged to are temp emaner liged that eshe with real funds ind belie d appeate re and ve final case of e the st	hit. hat alterna orary. I et t. this/her co ill not los if the ind rs mental d to be conseque paragrap promature erilization	ative methor explained th onsent can I e any heal lividual to I ly competer sterilized ar ences of th ohs: Use th re delivery is perform
observed. I have received a - You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His	but only copy of this <u>B</u> . <u>Signature</u> d to supply <u>1</u> (esignation to or Islander upanic origi	for determining s form. (please check) 4 Hispani 5 White (r n)	if Fede	9. 9. onth Day Yea n, but it is no	d disconto e I count of birth c sterilizatio I inform withdrawn services (t To the sterilized HeiShe I appeared procedur Instruct first para emergen less than consent f	rts, risks seled the control an on is different or benefit best of is a leas knowing of to un e. ctions for graph b cy abdo 3 day form. In	and benefit individual to re available erent becau- ndividual to ty time and its provided of my knov- sit 21 year y and volid derstand t or use of i elow excep- minal surges after the	ts associ to be st which is be steril by fede viedge a s old an untarily in the natu alternati of the the ary where date of t	lated with enliged the are temp emanen- liged that eishe with rai funds and belie d appea requester re and ve final case of e the st the indivi- he ond pa	hit. hat alterni orary. I d orary. I d t. his/her co il. not los f the ind rs mental d to be paragrap paragrap prestu erilization dual's sig ragraph b	ative methor explained th onsent can t e any heal lividual to t ly competer sterilized ar inces of t bhs: Use t re delivery is perform nature on t
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His IN	but only copy of this 8. Signature d to supply 1 lealgnation or Islander spanic origi cTERPRET	for determining s form. D the following inf O . (please check) d Hispani d S White (r n) rER'S STATEME	If Fede	9 . 9 . onth Day Yea n, but it is no ispanic origin	d disconto e I count of bith c sterilizati i inform withdraw t To the sterilized He/She i appaared procedum Instruc first para emergen less than consent f used. (C	rts, risks seled the ion is diffi- ned the i n at an or benefi- best or is a lea knowing to un e, ctions fi graph b cy abdo i 30 day form. In ross out	and benefit individual individual to y time and the provided of my know- st 21 year y and volu- derstand t or use of i elow excep- minal surges a fler the the paragri	ts associ to be st which a set is possible by fields vieldge a sold an untarily the natu alternation tin the s, the se ph when	lated with enlized that are temp ermaner lized that or al funds ind belie d appea requeste- re and ve final case of e the st the indivi cond pa h is not u	h it. hat alterna orary. I d it. it his/her co il not los i. if the ind or be ind conseque paragraph paragraph dual's sig ragraph b	ative method explained th onsent can t e any heal lividual to t ly competer sterilized ar ences of th ohs: Use the re delivery / is performs enture on the elow must t
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His I have translated t I have translated t I have translated t I notvidual to be steril also read 11.	but only copy of this 8. Signature d to supply 1 lealgnation or Islander spanic origi atterpret the informa lized by the him/her	for determining s form. (please check) d Hispani d S White (r n) rER'S STATEME tion and advice p s person obtaining the cons language	If Fede	9. 9. onth Day Yea n, but it is no ispanic origin ispanic origin dorally to th onsent. I hav form i explained it	d discontion e I counts of birth c sterilization i inform withdrawn sterilized HerShe i appeared proceduri Instruct Instruct proceduri Instruct consent f used. (C) (1) At e sterilized (2) Th n th th th th th th th th th th	rits, risks seled the control at on is diffi- ned the in- n at an or benefi- best or is a leak knowingig to un- e, control to a leak knowingig to un- e, control to a lograph b cy abdo of a boto pross out least to dividual's dividual's dividual's an 72 h	and benefit individual individual to the available erent becas, ndividual to the provided f my know- ist 21 year by and volid derstand the or use of i elow excep- minal surges a after the the paragra- hity days i s signature s was perfo- zation was purs after the the paragra- hity days i s signature	to associ to be st which a use it is possible be steril by Fedsviedge a sold an untarily he naturenation alternation tin the ary when date of to s, the se any when date of the tin the solution the med, preform he date	ated with enliged to are temp ermaner lized that efshe wi real funds ind belied d appea requeste re and ve final case of e the st he indivi cond pa h is not u ssed be s conser ed less t of the in	hat alterna oracy. I o the industry oracy. I this/her co il not los if the ind rs mentail d to be i conseque paragraph prematuu erilization dual's sig ragraph b ised.) tween the nt form d than 30 d	ative method explained th onsent can t e any heal lividual to t ly competer sterilized ar ences of th ons: Use the method the elow must t e date of the and the da lays but mo
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His I have translated t I have translated t	but only copy of this 8. Signature d to supply 1 resignation to or Islander spanic origin cTERPRET provided to he information the information here him wher To the be	for determining s form. (please check) d Hispani d S White (r n) rER'S STATEME tion and advice p s person obtaining the cons language	If Fede	9. 9. onth Day Yea n, but it is no ispanic origin ispanic origin dorally to th onsent. I hav form i explained it	d discontion a count of birth c sterilizati inform withdrawn withdrawn withdrawn to the sterilizati appeared procedum Instruc first para emergen less than consent f used. (C (1) At inform the sterilizati emergen less than consent f used. (C) (1) At inform the sterilizati inform consent f used. (C) (1) At inform the sterilizati (1) At (1)	rts, risks seled the control as on is diffi- ned the i or benefi- best to is a leak knowing of to un e. ctions fi graph b cy abdo of 30 day form. In ross out least ti dividual? erilization is sterill an 72 h is conse heck app Prematu	and benefit individual individual to the available erent becas, ndividual to the provided if my know- ist 21 year y and volu- derstand to or use of i- elow excep- minal surges a after the those case the paragra- hity days i- s signature s was perfo- zation was perfo- zation was perfo- ticable and ire delivery	to be st which is use it is p be sterif that h by Feds viedge 4 s old an untarily 1 he natu alternati tin the naturnati tin the s, the se on this med, preform he date of the set on this med, preform he date of the set on this tin the set of the set of the set of the tin the set on this tin the set on this tin the set tin the set tin the set of the set of the set of the set of the set of the set of the set of the set of the set of tin the set of tin the set of tin the set of the set of the set of the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin the set of tin	ated with enliged to are temp ermaner liged that eishe with requester re and ve final case of estes at the indivi- cond pa h is not u ssed be s conset ed less to of the in of the for ormation	hat alterna orany. I of the industry orange in not los in the industry in the industry in the industry paragraph paragraph promatu eritization dual's sig ragraph b ised.) tween the nt form a dividual's allowing or requested	ative method explained th onsent can te e any heal lividual to t ly competer sterilized an ences of th ons: Use the method the elow must te elow must te elow must the elow must the elow must the elow the da and the da alays but moo elincumstance d):
observed. I have received a - You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t individual to be steril also read 11. contents to him/her. understood this expl	but only copy of this 8. Signature d to supply 1 fesignation or islander upanic origi or tERPRET provided to the informa lized by the him/her To the be anation. 12.	for determining s form. (please check) d Hispani d S White (r n) rER'S STATEME tion and advice p s person obtaining the cons language	If Fede	9. onth Day Yea n, but it is no ispanic origin be sterilized: id orally to the onsent. I have form i explained it d belief he/she	d discontion clicounts of birth c sterilizativ inform withdrawn sterilizativ tinform withdrawn sterilizativ tinform withdrawn sterilizativ tinform withdrawn sterilizativ tinform sterilizati	rts, risks seled the control as on is diffi- ned the in- n at an or benefi- best or is a leak knowingid to un- e, or is a leak knowingid to un- graph b cy abdo is do un- to a leak to un- to un- t	and benefit individual individual to the available erent becas, ndividual to the provided for use of in- elow excep- minal surgers after the those case the paragra- hity days i- s signature s was perfo- zation was s signature int form b- kilcable and are delivery after sepecte	to be st which is be steril be steril be steril by Feds vedge a s old an untarily alternati tin the atternati tin the atternati on this med. preform he date of s, the se sph which cause on this med. preform d date of till in infi	ated with enliged to are temp ermaner liged that efshe with al funds ind belied d appearequester requester re and ve final case of eshe sind the indivi- cond pa h is not u ssed be s conser ed less to of the in of the for ormation f delivery	hat alterna orany. I of the industry orange in not los in the industry in the industry in the industry paragraph paragraph promatu eritization dual's sig ragraph b ised.) tween the nt form a dividual's allowing or requested	ative method explained th onsent can le e any heal lividual to t ly competer sterilized ar ences of th ohs: Use the re delivery is perform elow must le elow must
observed. I have received a - You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t individual to be steril also read 11. contents to him/her. understood this expl	but only copy of this 8. Signature d to supply 1 resignation to or Islander spanic origin cTERPRET provided to he information the information here him wher To the be	for determining s form. (please check) d Hispani d S White (r n) rER'S STATEME tion and advice p s person obtaining the cons language	If Fede	9. 9. onth Day Yea n, but it is no ispanic origin ispanic origin dorally to th onsent. I hav form i explained it	d discontion clicounts of birth c sterilizativ tinform withdrawn sterilizativ to the sterilizativ tro the sterilizativ tro the sterilizativ tro the sterilizativ tro the sterilizativ the She 1 appeared procedum Instruct first para consent f used (C (1) At inform the sterilizativ the consent f used (C (1) At inform the struct (2) The struct (2) The struct (2	rts, risks seled the control and on is diffi- ned the in- or benefi- best oc- is a leat knowing 1 to un- e. control to un- control to un- control to un- control to un- control to un- control to un- to a leat knowing 1 to un- e. control to un- to a leat knowing to a leat to un- to u	and benefit individual individual to the available erent becas, ndividual to the provided if my know- ist 21 year y and volu- derstand to or use of i- elow excep- minal surges a after the those case the paragra- hity days i- s signature s was perfo- zation was perfo- zation was perfo- ticable and ire delivery	to be st to be st which is be steril be steril by Fede vedge is s old an untarily i he nature alternation the nature atternation the nature aph which have pa on this med. preform he date scause fill in infi- d date of nal surge	ated with enliged to are temp ermaner liged that efshe with al funds ind belied d appearequester requester re and ve final case of eshe sind the indivi- cond pa h is not u ssed be s conser ed less to of the in of the for ormation f delivery	hat alterna orany. I of the industry orange in not los in the industry in the industry in the industry paragraph paragraph promatu eritization dual's sig ragraph b ised.) tween the nt form a dividual's allowing or requested	ative method explained th onsent can te e any heal lividual to t ly competer sterilized an ences of th ons: Use the method the elow must te elow must te elow must the elow must the elow must the elow the da and the da alays but moo elincumstance d):
observed. I have received a - You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t individual to be steril also read 11. contents to him/her. understood this expl	but only copy of this 8. Signature d to supply 1 fesignation or islander upanic origi or tERPRET provided to the informa lized by the him/her To the be anation. 12.	for determining s form. (please check) d Hispani d S White (r n) rER'S STATEME tion and advice p s person obtaining the cons language	If Fede	9. onth Day Yea n, but it is no ispanic origin be sterilized: id orally to the onsent. I have form i explained it d belief he/she	d discontion clicounts of birth c sterilizativ tinform withdrawn sterilizativ to the sterilizativ tro the sterilizativ tro the sterilizativ tro the sterilizativ tro the sterilizativ the She 1 appeared procedum Instruct first para consent f used (C (1) At inform the sterilizativ the consent f used (C (1) At inform the struct (2) The struct (2) The struct (2	rts, risks seled the control and on is diffi- ned the in or benefi- best or is a leak knowing of to un e. ctions fr graph be cy abdo is a leak knowing form, in ross out least ti dividual's erilization is steriil an 72 his sconse heck app Prematu Individue Emergen be circui	and benefit individual to re available erent becas ndividual to its provided if my know- ist 21 year y and voli- derstand t or use of , elow excep- minal surg- s after the those case the paragro- s after the these case the paragro- s atter the these case the paragro- the par	to be st to be st which is be steril be steril by Fede vedge is s old an untarily i he nature alternation the nature atternation the nature aph which have pa on this med. preform he date scause fill in infi- d date of nal surge	ated with enliged to are temp ermaner liged that efshe with al funds ind belied d appearequester requester re and ve final case of eshe sind the indivi- cond pa h is not u ssed be s conser ed less to of the in of the for ormation f delivery	hat alterni oracy. I o t. his/her co ill not los or the ind rs mental d to be i conseque paragraph prematu erilization dual's sig ragraph b ised.) tween the nt form o than 30 d dividual's	ative method explained th onsent can te e any heal lividual to t ly competer sterilized ar ences of th ences of the re delivery is performs nature on th elow must t elow must
observed. I have received a - You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t individual to be steril also read 11. contents to him/her. understood this expl	but only copy of this 8. Signature d to supply 1 resignation or Islander upanic origii of TERPRET provided to the informatic Read by the him/her To the be anation. 12. therpreter	for determining s form. (please check) (please check) 4 Hispani 5 White (r n) TERS STATEME to assist the individent s person obtainin the cons language est of my knowled	If Fede Nate: XE formatio c not of H NT • dual to l vesente g this co- ent ent ent dge and dge and {	P . 9 . onth Day Yea n, but it is no ispanic origin be sterilized: id orally to the onsent. I have form i explained it d belief he/she Date	d discontion l count of birth c sterilizati inform withdrawn sterilizati HerShe i appeared procedum Instruct first para emergeni less than consent f used. (C (1) At ist inform less than consent f used. (2) Th th th th th th th th th th t	rts, risks seled the control as on is diffi- ned the i n at an or beneficial best to is a leak knowingig to un e. cons fit graph b cy abdo j to un e. cons out least to dividual's erilization is sterill an 72 h es conse heck app Prematu Individual Emerger be circui	and benefit individual individual to the available erent becas, ndividual to its provided if my know- its provided of my know- sit 21 year y and volid derstand t or use of i elow excep- minal surgers s after the those case the paragra- hirty days i s signature n was perfor- zation was s signature n was perfor- zation was s signatures nours after t int form b- kilcable and mstances): 24	to be st to be st which is possible be steril is that his by Fede vedge a sold an untarily is he nature alternation the nature alternation the solution on the solution the med. preform he date of fill in infi- d date or nal surge	ated with enliged that enliged that ere temp ized that of the state of	hat alterna oracy. I of the industry oracy. I of the industry of the in not los of the industry paragraph paragraph paragraph prematuu erilization dual's sig ragraph b ised.) tween the nt form of than 30 d than 30 d	ative method explained th onsent can te e any heal lividual to t ly competer sterilized ar inces of th ohs: Use th re delivery / is performs re delivery / is performs telow must te e date of th and the da alays but mo circumstance d): 22. 23.
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 f an interpreter is 1 have translated t individual to be steri also read 11. contents to him/her. understood this expl # THE FOLLOWING 1, 25.	but only copy of this 8. Signature d to supply lesignation or Islander spanic origi atterpreter binyther To the be anation. 12. the juncter	for determining s form. D the following inf O . (please check) G 4 Hispani S White (r n) TERS STATEME to assist the indivi- tion and advice g person obtaining the cons language est of my knowled E COMPLETED do certify that on	If Fede NT = dual to lo vesente g this co ent dual to lo vesente and dge and dge and for st	P	d discontion i counts of birth c sterilizati i inform withdrawn services c to the services c to t	rts, risks seled the control as on is diffi- ned the i on is diffi- ned the i on is diffi- ned the i or beest or is a leek knowing of to un e. conso out of abdo of a day form. In ross out least to dividual? erilization is sterill an 72 h heck app Prematu Individual Emerger be circu	and benefit individual individual to y time and the provided y time and the provided y time and the provided or use of in- elow excep- with a volu- derstand to or use of in- elow excep- minal surges a signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signatures the parager the par	to be st to be st which is be stell is p be stell is that h by Fede viedge 4 s old an untarily i he natu alternati ti n the s the st ph which be date of s, the st ph which be date of fill in inf d date o nal surge K CITY - counselor	ated with enliged that enliged that ere temp ized that erequeste real and ve final case of e the st he individed to cond pa he individed to sed less to of the in of the fix of the fix	hat alterni oracy. I o that alterni oracy. I o this/her co ill not los of the Ind is mental d to be in conseque paragraph paragraph prematuu erilization dual's sig ragraph b ised.) tween the nt form o than 30 d collowing c requested	ative method explained th onsent can te e any heal lividual to t ly competer sterilized ar ences of th ohs: Use the re delivery is performe elow must te elow must te elow must to elow mus
observed. I have received a ' You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 an interpreter is 1 have translated the individual to be steril also read 11. contents to him/her, understood this exploated THE FOLLOWINK 1 25. form to	but only copy of this 8. Signature d to supply lesignation or Islander spanic origi (TERPRET the informa lized by the him/her To the be anation. 12. therpreter Augusta	for determining s form. D the following inf O - (please check) = 4 Hispani = 5 White (r n) TER'S STATEME o assist the indivi- tion and advice je person obtainin the cons language set of my knowled E COMPLETED do certify that on _ and	If Fede Nate: All formatio c not of H not of H dual to l vesent g this co ent g this co ent for and dge and for saw the	Pail laws were 9. path Day Yea n, but it is no ispanic origin be sterilized: to orally to the pasent. I have form it schlaned it belief he/sh Date TERILIZATIO 26. patient sign the	d discontion i counts of birth c sterilizati i inform withdrawn services c to the services c to t	rts, risks seled the control as on is diffi- ned the i on is diffi- ned the i on is diffi- ned the i or beest or is a leek knowing of to un e. conso out of abdo of a day form. In ross out least to dividual? erilization is sterill an 72 h heck app Prematu Individual Emerger be circu	and benefit individual individual to y time and the provided y time and the provided y time and the provided or use of in- elow excep- with a volu- derstand to or use of in- elow excep- minal surges a signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signatures the parager the par	to be st to be st which is be stell is p be stell is that h by Fede viedge 4 s old an untarily i he natu alternati ti n the s the st ph which be date of s, the st ph which be date of fill in inf d date o nal surge K CITY - counselor	ated with enliged that enliged that ere temp ized that erequeste real and ve final case of e the st he individed to cond pa he individed to sed less to of the in of the fix of the fix	b it hat alterna orany. I of the inderse mental in not los in not los in not los in not los in not los in not los in not los paragraph paragraph paragraph paragraph seed.) tween the induits sig ragraph b ised.) tween the ised.) tween the	ative method explained th onsent can te e any heal lividual to t ly competer sterilized ar ences of th ohs: Use the re delivery is performe elow must te elow must te elow must te elow must to elow mus
observed. I have received a You are requested required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t i have translated t i ndividual to be steri also read 11. contents to him/her. understood this expl THE FOLLOWING 1, 25. form to	but only copy of this 8. Signature d to supply lesignation or Islander spanic origi (TERPRET the informa lized by the him/her To the be anation. 12. therpreter Augusta	for determining s form. D the following inf O - (please check) = 4 Hispani = 5 White (r n) TER'S STATEME o assist the indivi- tion and advice je person obtainin the cons language set of my knowled E COMPLETED do certify that on _ and	If Fede NT = dual to lo vesente g this co ent dual to lo vesente and dge and dge and for st	Pail laws were 9. path Day Yea n, but it is no ispanic origin be sterilized: to orally to the pasent. I have form it schlaned it belief he/sh Date TERILIZATIO 26. patient sign the	d discontion i counts of birth c sterilizati i inform withdrawn services c to the services c to t	rts, risks seled the control as on is diffi- ned the i on is diffi- ned the i on is diffi- ned the i or beest or is a leek knowing of to un e. conso out of abdo of a day form. In ross out least to dividual? erilization is sterill an 72 h heck app Prematu Individual Emerger be circu	and benefit individual individual to y time and the provided y time and the provided y time and the provided or use of in- elow excep- with a volu- derstand to or use of in- elow excep- minal surges a signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signature the parager hitty days i s signatures the parager the par	to be st to be st which is be stell is p be stell is that h by Fede viedge 4 s old an untarily i he natu alternati ti n the s the st ph which be date of s, the st ph which be date of fill in inf d date o nal surge K CITY - counselor	ated with enliged that enliged that ere temp ized that erequeste real and ve final case of e the st he individed to cond pa he individed to sed less to of the in of the fix of the fix	b it hat alterna orany. I of the industry orange in not los if the industry of in not los if the industry of in not los if the industry of paragraph paragraph paragraph paragraph paragraph paragraph paragraph paragraph sised.) tween the int form a than 30 d dividual's paloving of requested iss CERT oxplained to DATE	ative method explained th onsent can be e any heal lividual to b ly competer sterilized ar inces of th ohs: Use th re delivery - is performs elow must b e date of th and the dat elow must b e date of th and the dat ays but mo elignature of circumstance d): 22. 23.
You are requested required: Race and ethnicity of 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t individual to be steril also read 11. contents to him/her, understood this expl THE FOLLOWING 1. SHONATURE OF WITH X REAFFIRMATION (to	but only copy of this B. Signature to supply tesignation to or Islander upanic origination trillePRET provided to he information Islander upanic origination trillePRET provided to him/her To the be anation. 122. Augustor Augustor 2.7. pabert 2 row 2.8. bo ugned by the under the trip test of the test of tes	for determining s form. (please check) (please check) 4 Hispani 5 White (r n) TER'S STATEME o assist the indivi- tion and advice p s person obtaining the cons language sst of my knowled E COMPLETED do certify that on me) who patient on admini- tion	If Fede Nate: XE formatio c not of H NT • dual to 1 vesente g this co- ent • and dge and for ST FOR ST Saw the TITL restaon 5	9. 9. onth Day Yea n. but it is no Ispanic origin be steriilized: id orally to the form i explained it belief he/sh Date Patient sign the E 29. or Stantization)	d disconto count of birth c sterilizati inform withdrawn sterilizati appaared procedum Instruct first para emergenu less than consent f used. (2) (1) At inform instruct consent f used. (2) 10 10 10 10 10 10 10 10 10 10	rts, risks seled the control as on is diffi- ned the in or benefi- best or is a leak knowing of to un e. cons figraph b cy abdo of a day form, in ross out least ti dividual'y erilization is sterill an 72 h res conse heck app Prematu Emerger be circu	and benefit individual individual to the available erent becas dividual to the provided of my know- ist 21 year y and volid elow excep- minal surge- s after the those case the paragra- minal surge- s signature s signature s signature s signature s signature the the paragra- ning days bilicable and will be end in the paragra- ning days a signature s signatures s signatures s signatures s signatures s signatures s signatures the paragra- ning days a signatures s signatures s signatures s signatures s signatures the paragra- ning days s signatures s signatures the paragra- ning days s signatures s signatures the paragra- site of the paragra- te of the paragra- site of the paragra- te of the paragra- site of the paragra- site of the paragra- site of the paragra- site of the paragra- te of the paragra- te of the paragra- site of the paragra- site of the paragra- te of the paragra- te of the paragra- te of the paragra- te of the paragra-	to be st to be st which is one st ise it is possible be steril be steril be steril be steril be steril be steril be steril state of the national surger diate of the scause on this med. diate of the scause fill in inf diate of the scause fill in inf diate of the scause fill in inf k CiTY - counselor	ated with erilized that erilized that erise temp ized that of the finds of a pea requeste re and ve final case of e the st he indivision cond pa he indivision cond pa he indivision ed less to of the in of the fit of the fit read and	b it. hat alterna oracy. I of the industry oracy. I of the industry of the industry of the industry of the industry of conseque paragraph prematuu erilization dual's sig ragraph b ised.) tween the nt form of than 30 d than 30 d than 30 d than 30 d the industry of requested conseque paragraph prematuu erilization the industry of the ind	ative method asyptained the consent can be any healt lividual to b by competent serviced any serviced any ances of the other. Use this re delivery of is performed to the data of the elow must b e date of the elow must b e date of the and the data and the data and the data and the data of circumstance d): 22. 23. 24. 200 TIFICATION
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 have translated t I have translated t I have translated t I. Contents to him/her. understood this expl THE FOLLOWING I, 25. form to 6 SIGNATURE OF WITN X	but only copy of this 8. Signature d to supply leaignation or Islander spanic origi atterpreter binyther To the be anation. 12. the informatized by the him/ther To the be anation. 12. the provided to be informatized by the him/ther To the be anation. 2.7 publicities and 2.5 bit of the be anation. 2.2 bit of the below of the bel	for determining s form. D the following inf O - (please check) 4 Hispani 5 White (r n) TER'S STATEME o assist the indivi- tion and advice p person obtaining the cons language st of my knowled E COMPLETED do certify that on and reie) 2 the patient on admini- reie)	If Fede NT = formatio c not of H NT = dual to l vesents g this co ent g this co ent g this co ent g this co ent g this co ent formation f FOR ST saw the TITL restaon f ton, adv	rai laws wern 9. path Day Yea n, but it is no ispanic origin be sterilized: id orally to the onsent. I have form i explained it d orally to the patient is to belief he/she Date E 29. or Stanitzation rec and explan	d discontion d discontion of birth c sterilization t inform withdrawn withdrawn withdrawn withdrawn t To the appeared procedum Instruct frist para emergen- less than consent f used. (C (1) At birth c sterilized (c) Th the strue (c) Th the (c) Th the strue (c) Th the strue s	rts, risks seled the on is diffi- need the is diffi- need the is diffi- need the is diffi- need the is diffi- end the is diffi- graph b cy abdo is do un e. ctions fi graph b cy abdo is do un e. ctions fi graph b cy abdo is do un is sterill an 72 h his conse heck app Prematu Individual Emerger be circuit (MED IN was prese in his heat	and benefit individual individual to y time and the provided f my know- its provided of my know- its provided of my know- its 21 year y and volu- derstand t or use of i elow excep- minal surges a signature the parager inty days i is signature the sacaster the parager inty days i s signature the sacaster the parager inty days i s signature the sacaster the parager inty days i s signatures the parager inty file and re delivery is expecter my von NEW YOR nit while the r handwriting	to be step owhich a sent is point is that he by Feder viedge 4 sold an untarily in the natural alternation of the sent on the natural preformed and surge date of is sold an preformed date of fill in info didate of nal surge K CITY - counselor	atted with enliged to are temp ermaner ligzed that we final case of equeste- re and ve final case of espea- requeste- re and ve final case of espea- requeste- re and ve final case of espea- sconsel ed less to f the in of the fin ormation f delivery NY: 23.	b it. hat alterna oracy. I of the industry oracy. I of the industry of the industry of the industry of the industry of conseque paragraph prematuu erilization dual's sig ragraph b ised.) tween the nt form of than 30 d than 30 d than 30 d than 30 d the industry of requested conseque paragraph prematuu erilization the industry of the ind	ative method asyptained the consent can be any healt lividual to b by competent serviced any serviced any ances of the other. Use this re delivery of is performed to the data of the elow must b e date of the elow must b e date of the and the data and the data and the data and the data of circumstance d): 22. 23. 24. 200 TIFICATION
observed. I have received a You are requester required: Race and ethnicity d 1 American Indian Alaska Native 2 Asian or Pacific 3 Black (not of His 1 an interpreter is I have translated t I an interpreter is I from to 11 THE FOLLOWING I 25 SIGNATURE OF WITN X REAFFIRMATION (5) I certify that I have care I have decided that I s SIGNATURE OF PATH	but only copy of this 8. Signature to supply 1 lesignation or islander upanic origi or islander upanic origi or islander islander upanic origi or islander isl	for determining s form. D the following inf O - (please check) 4 Hispani 5 White (r n) TER'S STATEME o assist the indivi- tion and advice p person obtaining the cons language st of my knowled E COMPLETED do certify that on and reie) 2 the patient on admini- reie)	If Fede Nate: XE formatio c not of H vesente g this co- ent ent ent ent ent for sites for sites	rai laws wern 9. path Day Yea n, but it is no ispanic origin be sterilized: id orally to the onsent. I have form i explained it d orally to the patient is to belief he/she Date E 29. or Stanitzation rec and explan	d discontion d discontion of birth c sterilization t inform withdrawn withdrawn withdrawn withdrawn t To the appeared procedum Instruct frist para emergen- less than consent f used. (C (1) At birth c sterilized (c) Th the strue (c) Th the (c) Th the strue (c) Th the strue s	rts, risks seled the control as on is diffi- ned the in or beneficial or best or is a leak knowing of to un e. ctions fr graph b cy abdo of to un e. dividual" entization is sterill an 72 h ts conse heck app Pre- matu Individual Emerger be circu Pre- ment the form, an RE OF W	and benefit individual individual to the available erent becas, ndividual to the provided of my know- sit 21 year y and volid derstand t or use of i elow excep- minal surges a after the those case the paragra- hity days 1: s signature s signatures s signatures s signatures s signatures s signatures s signatures s signatures s signatures the paragra- hity days 1: hit form b- bilicable and mstances): 24. Typecom NEW YOR nt while the bilicable order 1 hendwriting	to be step owhich a sent is point is that he by Feder viedge 4 sold an untarily in the natural alternation of the sent on the natural preformed and surge date of is sold an preformed date of fill in info didate of nal surge K CITY - counselor	atted with enliged to are temp ermaner ligzed that we final case of equeste- re and ve final case of espea- requeste- re and ve final case of espea- requeste- re and ve final case of espea- sconsel ed less to f the in of the fin ormation f delivery NY: 23.	b it. hat alterna orary. I of the index orary. I of the index orary. I of the index orary. I of the index orary is of the index orary is of the index orary is paragraph	ative method astive method explained the onsent can b e any healt lividual to b by competent sterilized an ences of the other use the elaivery of is performed the date of the elait of the elait of the and the dat and the d

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

Patient Identification

Field 1

Enter the member's name, Medicaid ID number, and chart number.

The hospital or clinic name 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 (24) cannot obtain the consent.

Field 3

Enter the name of sterilization procedure to be performed.

Field 4

Enter the member's date of birth. Check to see that the member is at least 21 years old. If the member is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

Field 5

Enter the member's name.

Field 6

Enter the name of the doctor expected to perform the sterilization. It is understood this may not be the doctor who eventually performs the sterilization (24).

Field 7

Enter the name of sterilization procedure.



The member must sign the form.

Field 9

Enter the date of member'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.

Exceptions to the 30 day rule include instances of premature delivery (22), or emergency abdominal surgery (23) 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 member's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the member must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (24).



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 member's name.

Field 19

Enter the date the sterilization operation 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), cross out the second paragraph and sign (24) 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, complete the following fields:

Field 21

Select one of the check boxes as necessary.

Field 22

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

Field 23

If the member 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 (21) and describe the circumstances(23).



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 member when the member consents to sterilization. In addition, upon admission for sterilization, the member is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 25

Enter the name of the witness.

Field 26

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

Field 27

Enter the member's name.

Field 28

The witness must sign the form.

Field 29

Enter the title, if any, of the witness.

Field 30

Enter the date of witness's signature.

Reaffirmation

Field 31

The member must sign the form.



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

Field 33

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 28.

Field 34

Enter the date of witness's signature.



An Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113, must be completed for each hysterectomy procedure. A supply of these forms, available in English and in Spanish, 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 hysterectomy procedures must be submitted on paper forms, and a copy of the completed and signed LDSS-3113 must be attached to the claim.

When completing the LDSS-3113, 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).
- Each required field must be completed in order to ensure payment.

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

DSS-3113 (Rev. 4/84) ACKNOWLEDGEMENT OF RECEIPT OF HYS (NYS MEDICAID PROGRAM)	STEREC	том	(INF	ORMA		N				
	1. RECIPIENT ID NO.							2. SURGEON'S NAME		
EITHER PART I OR PART II MUST BE COMPLETED		1	1	1	I I		1	NAME		
Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION										
RECIPIENT'S AC	KNOWL	EDGE	MENT	STAT	EME	NT				
It has been explained to me, <u>3.</u> (RECIPIENT I make it impossible forme to become pregnant or bea The reason for performing the hysterectomy and the been explained to me, and all my questions have	ar children discomfor	. Luno ts, risk	lerstand s and b	d that a enefits	hyste assoc	rector iated	nyisap with the	hysterectomy have		
4. RECIPIENT OR REPRESENTATIVE 5. DATE	6. INTER	PRETE	R'S SIG	NATUR	E (If re	quired)		7. DATE		
SIGNATURE	x									
x	^									
SURGE	ON'S CE	RTIF	CATIC	N						
The hysterectomy to be performed for the above mer not primarily or secondarily for family planning rea reproducing.										
	8. SURG	EON'S	SIGNAT	URE				9. DATE		
	x									
	~									
Part II: WAIVER OF ACKNOWLEDGEMENT AND	SURGE	ON'S	CERT	FICAT	ION					
The hysterectomy performed on <u>10.</u> (RECIF hysterectomy was not primarily or secondarily forfan incapable of reproducing. I did not obtain Acknowled complete Part I of this form because (please check indicated):	dgement o	ngreas fRece	pt of H	atis, fo /stered	rreno tomy i	lering nform	the reation fro	om her and have her		
1. She was sterile prior to the hysterector (briefly describe the cause of sterility)_										
12 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)										
3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.										
L	14. SUR	GEON:	S SIGNA	TURE				15. DATE		
	v									
DISTRIBUTION: File patient's medical record; hospital su claims for payment; patient	bmit with o	aim fo	orpaym	ient; su	rgeon	anda	inesthe	siologist submit with		

ACKNOWLEDGEMENT RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113 INSTRUCTIONS

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

Field 1

Enter the recipient's Medicaid ID number.

Field 2

Enter the surgeon's name.

Part I: Recipient's Acknowledgement Statement and Surgeon's Certification

This part must be signed and dated by the recipient or her representative unless one of the following situations exists:

- The recipient was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The member was not a Medicaid recipient on the day the hysterectomy was performed.

Field 3

Enter the recipient's name.

Field 4

The recipient or her representative must sign the form.

Field 5

Enter the date of signature.

Field 6

If applicable, the interpreter must sign the form.

If applicable, enter the date of interpreter's signature.

Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

Field 9

Enter the date of the surgeon's signature.

Part II: Waiver of Acknowledgement

The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the recipient's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

Field 10

Enter the recipient's name.

Field 11

If the recipient's acknowledgment was *not* obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 12

If the recipient's acknowledgment was *not* obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid recipient at the time the hysterectomy was performed.

Field 13

If the member's Acknowledgment was *not* obtained because she was not a Medicaid recipient at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

Field 15

Enter the date of the surgeon's signature.