New York State Billing Guidelines

TRANSPORTATION

Version 2026 - 01

3/24/2026

eMedNY is the name of the 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 eMedNY. More information about eMedNY can be found at www.emedny.org.

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

1. Purpose Statement

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

This document is customized for Transportation providers and should be used by the provider as an instructional, as well as a reference tool. For providers new to NYS Medicaid, it is required to read the Trading Partner Information Companion Guide available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide.

2. Claims Submission

Transportation providers can submit their claims to NYS Medicaid in electronic or paper formats.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and 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 Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.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 required to update their Certification Statement on an annual basis. Renewal information is sent when the Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking: eMedNY Trading Partner Information Companion Guide.

2.1 Electronic Claims

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

Direct billers should refer to the sources listed below to comply with the NYS Medicaid requirements:

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

Further information on the 5010 transaction is available at www.emedny.org by clicking: eMedNYHIPAASupport.

2.2 Paper Claims

Transportation providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A).

An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide.

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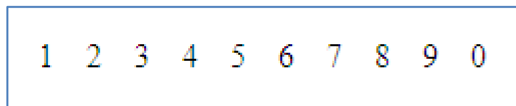
2.2.1 General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be 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

Written As	Intended As	Interpreted As	
6. 0 0	6.00	6. 6 0	→ Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

Written As	Intended As	Interpreted As	
2	2	7	→ Two interpreted as seven
3	3	2	→ Three interpreted as two

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

Exhibit 2.2.1-4

Written As	Intended As	Interpreted As	
23	23	illegible →	Entry cannot be interpreted properly

- 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 Claim Form A – eMedNY-000201

To order the New York State Medicaid Claim Form A – eMedNY-000201, please contact the eMedNY call center at 1-800-343-9000.

To view the eMedNY-000201 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.4 Transportation Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Transportation providers. Although the instructions that follow are based on the eMedNY-000201 paper claim form, they are also intended as guidelines for electronic billers to find out information they need to provide in their claims. For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking: eMedNY Transaction 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 Emergency Transportation crossover claims only.

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 ***Part-D*** claims are ***not*** part of this process.

Providers must review their Medicare remittances for crossovers 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 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: Default Electronic Transmitter Identification Number (ETIN) Selection Form.

2.4.2 Claim Form A – eMedNY-00201 Field Instructions

Header Section: Fields 1 through 24B

The information entered in the Header Section of the claim form (fields 1 through 24B) applies to all claim lines entered in the Procedure Section of the form.

Provider ID Number (Field 1)

837P Reference: Loop 2010AA NM1 and REF

For Emergency Services Only

Enter the provider's 10-digit National Provider Identifier (NPI). In the un-numbered area below Field 1, enter the provider's name and address, using the full nine-digit ZIP code.

For Non-Emergency Transportation Only

Enter the provider's assigned eight-digit Medicaid ID number. In the un-numbered area below Field 1, enter the provider's name and address, using the full nine-digit ZIP code.

Billing Date (Field 2)

837P Reference: BHT04

For paper claims, leave this field blank.

For Electronic Claims, enter the billing date.

Group ID Number (Field 3)

837P Reference: Loop 2010AA NM109

Not applicable to transportation.

Locator Code (Field 4)

837P Reference: Loop 2010BB REF02 when REF01 = LU

For electronic claims, leave this field blank.

For paper claims, enter the locator code assigned by NYS Medicaid.

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, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Inquiry.

SA EXCP Code [Service Authorization Exception Code] (Field 5)

837P Reference: Loop 2300 REF02 when REF01 = 4N

Not applicable to transportation.

Adjustment/Void Code (Field 6)

837P Reference: 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 (Field 6A)

837P Reference: Loop 2300 REF02 when REF01 = 6R

Leave this field blank when submitting an original claim or resubmission of a denied claim.

If submitting an adjustment or a void, enter the appropriate ***Transaction Control Number (TCN)*** in this field. A TCN is a 16-digit identifier that is assigned to each claim.

2.4.2.1 Adjustment

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

- Billing 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 0825219876543200 is shared by three individual claim lines. This TCN was paid on September 16, 2008. 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.

Exhibit 2.4.2.1-1

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567

2. BILLING DATE (MO | DAY | YR): 09 08 08

3. GROUP ID NUMBER:

4. LOCATOR CODE: 003

5. SA EXCP. CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — 6. CODE (X / V); 6A. ORIGINAL TRANSACTION CONTROL NUMBER

7. RECIPIENT ID NUMBER: AB12345C

8. DATE OF BIRTH: 05201990

8A. SEX (M / F): X

9. RECIPIENT NAME - FIRST: Jane

9A. RECIPIENT NAME - LAST: Smith

10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB12345

11. OFFICE USE ONLY

DIAGNOSIS CODE — 12. PRIMARY; 12A. SECONDARY

13. EMERGENCY? (Y N); 13A. POSSIBLE DISABILITY? (Y N); 13B. FAMILY PLANNING? (Y N); 14. ACCIDENT CODE; 15. PATIENT STATUS CODE; 16. EPSDT/C/THP (Y N); 17. RECIPIENT OTHER INSURANCE CODE; 18. ABORT STER CODE; 19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE — 20. CODE: 11; 20A. ADDRESS

21. SERVICE PROVIDER ID/LICENSE NUMBER; 21A. PROF CD; 21B. NAME

22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER; 22A. PROF CD; 22B. NAME

23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER: 0123456789; 23A. PROF CD; 23B. NAME: Mark Lane, M.D.

24. SHARED HEALTH FACILITY ONLY; 24A. SIGNATURE; 24B. DIAGNOSIS

LINE	25. DATE OF SERVICE (MO. DAY YR.)	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	29. TOOTH	29A. SURFACE (M IO D F/B L)	30. AMOUNT CHARGED	31. CO INSURANCE	31A. DEDUCTIBLE	31B. CO PAY	31C. PAID	32. OTHER INSURANCE PAID
1	09 02 08	A0130	13				14.30					
2	09 04 08	A0130 TN	13				14.30					
3	09 07 08	A0130 TN	13				14.30					
4												
5												
6												
7												
8												
9												

33. CASE MGR — TOTALS: 34.; 35.; 35A.; 35B.; 35C.; 36.

DO NOT STAPLE IN BARCODE AREA

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

37. SIGNATURE: James Strong

37A. COUNTY*

38. DATE (MO DAY YR): 09 08 08

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

EMEDNY - 000201 (01/04)

Exhibit 2.4.2.1-2

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567
2. BILLING DATE (MO DAY YR): 10 06 08
3. GROUP ID NUMBER:
4. LOCATOR CODE: 003
5. SA EXCP. CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: 7
6A. ORIGINAL TRANSACTION CONTROL NUMBER: 0825219876543200

7. RECIPIENT ID NUMBER: AB12345C
8. DATE OF BIRTH: 05201990
8A. SEX (M / F): X (F)
9. RECIPIENT NAME - FIRST: Jane
9A. RECIPIENT NAME - LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB12345
11. OFFICE USE ONLY

DIAGNOSIS CODE: 12. PRIMARY / 12A. SECONDARY
13. EMERGENCY? Y N | 12A. POSSIBLE DISABILITY? Y N | 12B. FAMILY PLANNING? Y N | 14. ACCIDENT CODE | 15. PATIENT STATUS CODE | 16. EPSDT/ C/THP Y N | 17. RECIPIENT OTHER INSURANCE CODE | 18. ABORT STER CODE | 19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE: 20. CODE: 11 | 20A. ADDRESS
21. SERVICE PROVIDER (LICENSE NUMBER) | 21A. PROF CD | 21B. NAME
22. OTHER REFERRING/ORDERING PROVIDER (LICENSE NUMBER) | 22A. PROF CD | 22B. NAME
23. ORDERING/REFERRING PROVIDER (LICENSE NUMBER): 0123456789 | 23A. PROF CD | 23B. NAME: Mark Lane, M.D.
24. SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE | 24B. DIAGNOSIS

LINE	25. DATE OF SERVICE (MO DAY YR)	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	29. TOOTH	29A. SURFACE (M O/I D F/B L)	30. AMOUNT CHARGED	31. CO INSURANCE	31A. DEDUCTIBLE	31B. CO PAY	31C. PAID	32. OTHER INSURANCE PAID
1	09 02 08	A0130	13				14.30					
2	09 04 08	A0130 TN	13				14.30					
3	09 08 08	A0130 TN	13				14.30					
4												
5												
6												
7												
8												
9												

33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36.

DO NOT STAPLE IN BARCODE AREA

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

37. SIGNATURE: James Strong | 37A. COUNTY* | 38. DATE (MO DAY YR): 10 06 08

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

EMEDNY - 000201 (01/04)

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 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 0824911234567800 contained two claim lines, which were paid on September 11, 2008. Later, the provider became aware that the member had other insurance coverage. The other insurance was billed and 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

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

Field	Entry
1. Provider ID Number	01234567
2. Billing Date (MO / DAY / YR)	09 05 08
3. Group ID Number	
4. Locator Code	003
5. SA Exep Code	
Only to be used to adjust or void a paid claim: 6. Code (A / V); 6A. Original Transaction Control Number	
7. Recipient ID Number	AB12345C
8. Date of Birth	05 20 1990
8A. Sex (M / F)	X (F)
9. Recipient Name - First	Jane
9A. Recipient Name - Last	Smith
10. Office Account Number (Optional)	AB12345
11. Office Use Only	
Diagnosis Code: 12. Primary; 12A. Secondary	
13. Emergency (Y / N); 13A. Possible Disability (Y / N); 13B. Family Planning (Y / N); 14. Accident Code; 15. Patient Status Code; 16. EPSDT C/THP (Y / N); 17. Recipient Other Insurance Code; 18. Abort/Ster Code	
19. Prior Approval Number	
Place of Service: 20. Code; 20A. Address	11
21. Service Provider ID/License Number; 21A. Prof CD; 21B. Name	
22. Other Referring/Ordering Provider ID/License Number; 22A. Prof CD; 22B. Name	
23. Ordering/Referring Provider ID/License Number	0123456789
23A. Prof CD; 23B. Name	
24. Shared Health Facility Only; 24A. Signature; 24B. Diagnosis	

Line	25. Date of Service (MO DAY YR)	26. Procedure Code	27. Times Performed	28. Oral Cavity	29. Tooth	29A. Surface (M, IO, D, F/B, L)	30. Amount Charged	31. CO Insurance	31A. Deductible	31B. CO Pay	31C. Paid	32. Other Insurance Paid
1	09 04 08	A0130	13				14.30					
2	09 05 08	A0130 TN	13				14.30					
3												
4												
5												
6												
7												
8												
9												

Columns 31 to 31C are grouped under the heading MEDICARE.

33. Case Mgr — TOTALS: 34. — 35. — 35A. — 35B. — 35C. — 36.

DO NOT STAPLE IN BARCODE AREA

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

37. Signature	37A. County*	38. Date (MO / DAY / YR)
James Strong		09 / 05 / 08

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

EMEDNY - 000201 (01/04)

Exhibit 2.4.2.2-2

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 01234567
2. BILLING DATE (MO DAY YR): 100608
3. GROUP ID NUMBER:
4. LOCATOR CODE: 003
5. SA EXCP CODE:

ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE (A / V): 8
6A. ORIGINAL TRANSACTION CONTROL NUMBER: 0824911234567800

7. RECIPIENT ID NUMBER: AB12345C
8. DATE OF BIRTH: 05201990
8A. SEX (M / F): X
9. RECIPIENT NAME - FIRST: Jane
9A. RECIPIENT NAME - LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB12345
11. OFFICE USE ONLY

DIAGNOSIS CODE: 12. PRIMARY; 12A. SECONDARY
13. EMERGENCY? (Y N); 13A. POSSIBLE DISABILITY? (Y N); 13B. FAMILY PLANNING? (Y N); 14. ACCIDENT CODE; 15. PATIENT STATUS CODE; 16. EPSDT C/THP (Y N); 17. RECIPIENT OTHER INSURANCE CODE; 18. ABORT STER CODE; 19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE: 20. CODE: 11; 20A. ADDRESS
21. SERVICE PROVIDER ID/LICENSE NUMBER; 21A. PROF CD; 21B. NAME
22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER; 22A. PROF CD; 22B. NAME
23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER: 0123456789; 23A. PROF CD; 23B. NAME
24. SHARED HEALTH FACILITY ONLY; 24A. SIGNATURE; 24B. DIAGNOSIS

LINE	25. DATE OF SERVICE (MO DAY YR)	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	29. TOOTH	29A. SURFACE (M IO D F/B L)	30. AMOUNT CHARGED	31. CO INSURANCE	31A. DEDUCTIBLE	31B. CO PAY	31C. PAID	32. OTHER INSURANCE PAID
1	09 04 08	A0130	13				14.30					
2	09 05 08	A0130 TN	13				14.30					
3												
4												
5												
6												
7												
8												
9												

33. CASE MGR; TOTALS: 34.; 35.; 35A.; 35B.; 35C.; 36.

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CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
37. SIGNATURE: James Strong
37A. COUNTY*
38. DATE (MO DAY YR): 10 06 08

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

EMEDNY - 000201 (01/04)

Recipient ID Number (Field 7)

837P Reference: Loop 2010BA NM109

Enter the Member ID. This information may be obtained from the member's Common Benefit ID Card (CBIC).

Date of Birth (Field 8)

837P Reference: Loop 2010BA DMG01

Enter the member's birth date. This information may be obtained from, the CBIC.

Sex (Field 8A)

837P Reference: Loop 2010BA DMG03

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

Recipient Name (Fields 9 and 9A)

837P Reference: Loop 2010BA NM1

Enter the member's first name in Field 9 and last name in Field 9A.

Office Account Number (Optional) (Field 10)

837P Reference: Loop 2300 CLM01

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

Diagnosis Code [Primary/Secondary] (Fields 12 and 12A)

837P Reference: Loop 2300 HI01-2

For paper claims, leave this field blank.

For electronic claims, this is a required field and R69 may be used when a more specific diagnosis is not available.

Emergency (Field 13)

837P Reference: Loop 2400 SV109

Ambulance

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

Ambulette, Taxis, Day Program, and Livery

Leave this field blank.

Possible Disability (Field 13A)

837P Reference: Loop 2300 CLM12

Not applicable to transportation.

Family Planning (Field 13B)

837P Reference: Loop 2400 SV112

Not applicable to transportation.

Accident Code (Field 14)

837P Reference: Loop 2300 CLM11

If applicable, enter the appropriate code from the list below to indicate whether the service rendered was for a condition resulting from an accident or a crime.

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

Patient Status Code (Field 15)

837P Reference: N/A

Not applicable to transportation.

EPSDT C/THP Code (Field 16)

837P Reference: Loop 2300 CRC01

Not applicable to transportation.

Recipient Other Insurance Code (Field 17)

837P Reference: Loop 2330B NM109

Leave this field blank.

Abortion/Sterilization Code (Field 18)

837P Reference: Loop 2300 HI01-2

Not applicable to transportation.

Prior Approval Number (Field 19)

837P Reference: Loop 2300 REF02 when REF01 = G1

Non-Emergency Transportation

Enter the 11-digit prior authorization number obtained by the ordering provider and assigned for this service by the appropriate agency of the New York State Department of Health. The prior authorization number appears on the Transportation roster. 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:

- ***All non-emergency transportation services involving Medicare coverage do not require prior authorization unless the actual service is not covered by Medicare.***
- ***For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer the Transportation Prior Authorization Guidelines, which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Prior Authorization Guidelines.

Place of Service Code (Field 20)

837P Reference: Loop 2300 CLM05-1

Enter the Place of Service. Please note that place of service code is different from Locator Code. Place of Service Codes may be found on the Centers for Medicare and Medicaid Services (CMS) website: www.cms.gov.

For non-emergency, use code 99.

For emergency, use 41 (land) or 42 (water or air).

Place of Service Address (Field 20A)

837P Reference: Loop 2010AB N3 and N4

Enter the exact address of the location where the service was performed.

Service Provider [Medicaid] ID/License Number (Field 21)

837P Reference: Loop 2310B NM1 or REF

Ambulette Services Only

Enter the license plate number of the vehicle used for transport in this field as shown in Exhibit 2.4.2-3

Exhibit 2.4.2-3

21. SERVICE PROVIDER ID/LICENSE NUMBER
		|N|Y|S|1|2|3|4

PROF Code [Profession Code – Service Provider] (Field 21A)

Leave this field blank.

Name [Service Provider] (Field 21B)

837P Reference: Loop 2310B

Leave this field blank.

Other Referring/Ordering Provider ID/License Number (Field 22)

837P Reference: Loop 2310A

Ambulette Services Only

Enter the nine-character driver's license number of the transport driver in this field as shown in Exhibit 2.4.2-4

Exhibit 2.4.2-4

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
	1	2	3	4	5	6	7	8	9

NOTE: When reporting an out of state driver's license number with more than nine (9) characters, only the first nine (9) characters should be reported. Exhibit 2.4.2-5 shows an entry where the driver's license is A123456789B. If a driver's license number contains fewer than nine (9) characters, the entry must be right justified and zero-filled to complete the nine (9) characters. Exhibit 2.4.2-6 shows an entry where the driver's license is 3456789.

Exhibit 2.4.2-5

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
A 1 2 3 4 5 6 7 8

Exhibit 2.4.2-6

22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER
0 0 3 4 5 6 7 8 9

PROF CD [Profession Code – Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

Name [Other Referring/Ordering Provider] (Field 22B)

Leave this field blank.

Ordering/Referring Provider ID/License Number (Field 23)

Non-Emergency Ambulance, Ambulette, Taxi/Livery, and Transportation Network Company (TNC)

Non-emergency transportation services must be ordered by a medical practitioner. Enter the ordering provider's National Provider Identifier (NPI) in this field. This information is provided by the ordering provider and appears on the Transportation Prior Authorization roster.

Note: Claims without an ordering provider's NPI will be rejected.

When providing non-emergency transportation services to a member who is restricted to a primary physician or facility, the NPI of the member's primary physician must be entered in this field. ***The license number of the primary physician is not acceptable in this case. If a member is restricted to a facility, the NPI of the practitioner in the facility the member is restricted to must be entered. The NPI of the facility cannot be used.***

Emergency Ambulance Services

Leave this field blank.

Taxi and Day Program

Leave this field blank except when providing services to a member who is restricted to a primary physician or facility. In such case, the NPI of the member's primary physician must be entered in this field. ***The license number of the primary physician is not acceptable in this case. If a member is restricted to a facility, the NPI of the practitioner in the facility the member is restricted to must be entered. The NPI of the facility cannot be used.***

PROF CD [Profession Code – Ordering/Referring Provider] (Field 23A)

Leave this field blank.

Name [Ordering/Referring Provider] (Field 23B)

837P Reference: Loop 2310A

If field 23 was completed, enter the ordering provider's name. Otherwise, leave this field blank.

Signature (Field 24A)

837P Reference: Loop 2300 CLM06

Leave this field blank.

Procedure Section: Fields 25 to 32

The claim form can accommodate up to nine procedures for a single member when all the information in the Header Section of the claim (Fields 1–24B) applies to all the procedures.

Date of Service (Field 25)

837P Reference: Loop 2400 DTP03 when DTP01 = 472

Enter the date the service was rendered in the format MM/DD/YY.

NOTE: A service date must be entered for each procedure code listed in Field 26.

Procedure Code (Field 26)

837P Reference: Loop 2400 SV101-1

Enter the appropriate five-character Procedure Code in this field.

Enter the two-character modifiers as appropriate to the right of the solid line.

Leave the two spaces to the right of the solid line blank as in the sample below. Proper entry of a Procedure Code is shown in Exhibit 2.4.1-3.

Exhibit 2.4.1-3

26. PROCEDURE CODE

A 0 1 3 0

NOTE: Procedure codes, modifiers, definitions, prior approval requirements (if applicable), etc. are available at www.emedny.org by clicking on the link to the webpage as follows: Transportation Manual.

Times Performed (Field 27)

837P Reference: Loop 2400 SV104

If a trip was performed more than one time on the same date of service, enter the number of round trips in this field.

If applicable, enter the number of miles associated with a given transportation service.

Oral Cavity (Field 28)

837P Reference: N/A

Not applicable to transportation services.

Tooth Code (Field 29)

837P Reference: N/A

Not applicable to transportation services.

Surface (Field 29A)

837P Reference: Loop N/A

Not applicable to transportation services.

Amount Charged (Field 30)

837P Reference: Loop 2400 SV103

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge. When billing for a round trip, multiply the fee for a one-way trip by two and enter the amount in this field.

If the number of miles was entered in Field 27, enter the charge per mile multiplied by the number of miles.

Special Instructions for Fields 31, 31A, 31B and 31C

Fields 31, 31A, 31B, and 31C are only applicable if the member is a Medicare beneficiary.

If the provider knows that the service rendered is not covered by Medicare, enter zero in field 31C. Ambulette, Taxi, Day Program, and Livery services are examples of when 0.00 may be entered without first submitting a claim to Medicare.

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.

Medicare Co-Insurance (Field 31)

837P Reference: Loop 2430 CAS

If applicable, enter the Medicare co-insurance amount for the specific procedure.

Medicare Deductible (Field 31A)

837P Reference: Loop 2430 CAS

If applicable, enter the Medicare deductible amount for the specific procedure.

Medicare Co-Pay (Field 31B)

837P Reference: Loop 2430 CAS

If applicable, enter the Medicare co-pay amount for the specific procedure.

Medicare Paid (Field 31C)

837P Reference: Loop 2430 SVD02

If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denied payment, enter 0.00.

NOTE: If the provider knows that the service rendered is not covered by Medicare, enter 0.00 in field 31C.

Other Insurance Paid (Field 32)

837P Reference: Loop 2430 SVD02

This field must be completed if the member is covered by insurance other than Medicare. Leave this field blank if the member has no other insurance coverage.

If applicable, enter the amount actually paid by the other insurance carriers in this field.

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

NOTE: It is the responsibility of the provider to determine whether the member is covered by other insurance and whether the insurance carrier 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 submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.

Certification Section: Fields 37 to 38

Signature (Field 37)

837P Reference: Loop 2300 CLM06

The provider or an 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.

County (Field 37A)

837P Reference: N/A

Enter the name of the county where the claim form is signed. The county may be left blank ***only*** when the provider's address, entered in Field 1, is within the county where the claim form is signed.

Date (Field 38)

837P Reference: N/A

Enter the date 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: General Billing.

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 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: General Remittance Billing Guidelines.

Appendix A
Claim Samples

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

- 1. PROVIDER ID NUMBER: 01234567
- 2. BILLING DATE (MO DAY YR): 09 05 08
- 3. GROUP ID NUMBER:
- 4. LOCATOR CODE: 003
- 5. SA EXCP CODE:
- ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — 6. CODE (A / V); 6A. ORIGINAL TRANSACTION CONTROL NUMBER:
- 7. RECIPIENT ID NUMBER: AB12345C
- 8. DATE OF BIRTH: 05201990
- 8A. SEX (M / F): X (F)
- 9. RECIPIENT NAME - FIRST: Jane
- 9A. RECIPIENT NAME - LAST: Smith
- 10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB12345
- 11. OFFICE USE ONLY
- DIAGNOSIS CODE — 12. PRIMARY; 12A. SECONDARY
- 13. EMERGENCY? (Y / N); 13A. POSSIBLE DISABILITY? (Y / N); 13B. FAMILY PLANNING? (Y / N); 14. ACCIDENT CODE; 15. PATIENT STATUS CODE; 16. EPSDT C/THP (Y / N); 17. RECIPIENT OTHER INSURANCE CODE; 18. ABORT STER CODE; 19. PRIOR APPROVAL NUMBER
- PLACE OF SERVICE — 20. CODE: 11; 20A. ADDRESS
- 21. SERVICE PROVIDER ID/LICENSE NUMBER; 21A. PROF CD; 21B. NAME
- 22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER; 22A. PROF CD; 22B. NAME
- 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER: 0123456789; 23A. PROF CD; 23B. NAME
- 24. SHARED HEALTH FACILITY ONLY; 24A. SIGNATURE; 24B. DIAGNOSIS

LINE NO.	25. DATE OF SERVICE (MO DAY YR)	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	29. TOOTH	29A. SURFACE (M IO D F/B L)	30. AMOUNT CHARGED	31. CO INSURANCE	31A. DEDUCTIBLE	31B. CO PAY	31C. PAID	32. OTHER INSURANCE PAID
1	09 04 08	A0130	13				14.30					
2	09 05 08	A0130 TN	13				14.30					
3												
4												
5												
6												
7												
8												
9												

(MEDICARE spans columns 31 to 31C.)

33. CASE MGR — TOTALS: 34. | 35. | 35A. | 35B. | 35C. | 36.

DO NOT STAPLE IN BARCODE AREA

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

- 37. SIGNATURE: James Strong
- 37A. COUNTY*:
- 38. DATE (MO DAY YR): 09 05 08

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

EMEDNY - 000201 (01/04)