Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
11/28/2011 (IE)

Medicaid - New York

Enrollment Instructions
Professional/Institutional Claims and ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing Provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure They are valid and accurate. Incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

837 Form - MAIL COMPLETED REQUEST FORMS TO:
Computer Sciences Corporation
ATTN: Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614

835 Form - FAX to 518-257-4632

837 - Initial Provider Enrollment (New) or Re-Enrollment (Change of Service)

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

1. Certification Statement for Provider Billing Medicaid (2 pages including instructions)
   IMPORTANT: Certification Statements must be COMPLETED and NOTARIZED for EACH Medicaid Provider ID, including the group Billing Provider ID, if applicable.

NOTE: The enrollment with the ***Medicaid NY ePACES*** application is separate from this edi enrollment via Practice Insight. The provider must obtain their own ETIN # with Medicaid NY and then request access to ePACES using their own ETIN #. Providers can contact the eMedNY Call Center at 1-800-343-9000 for more information about ePACES enrollment and/or go to the Medicaid NY website at https://www.emedny.org/selfhelp/ePACES/epaces_generalinfo.aspx for information and forms.

835- Electronic Remittance Request (New) or (Change of Service)

If the provider wishes to authorize Practice Insight to retrieve 835 ERA files, the provider must complete this form:

1. Electronic Remittance 835/820 Request Form (1 page)
   NOTE: This one page ERA request form can be mailed with original Certification Statement to the above mailing address or this form can be faxed to:
   CSC, Attn: Provider Enrollment - Fax No: 518-257-4632.
   ****DO NOT Submit** the ERA request prior to submitting claims enrollment, or it will be rejected. **

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller for assistance or phone Medicaid NY at 1-800-343-9000.

CERTIFICATION STATEMENT INSTRUCTIONS

A Certification Statement must be completed:

1. When you are applying for an Electronic/Paper Transmitter Identification Number (ETIN) for the electronic or paper submission of New York Medicaid data. At least one Certification Statement must accompany the ETIN Application Form. If you have multiple providers that you want linked to the new ETIN, you must complete and notarize a Certification Statement for each provider that is to be linked to the new ETIN, and send the Certification Statement(s) along with the ETIN Application Form.

2. When you are adding a provider ID number to an existing ETIN, you must complete and notarize a Certification Statement for the provider ID to be added, and indicate the ETIN in the top left corner of the form.

In both instances above, if you want the provider/ETIN combination to receive remittances electronically, you must also complete an Electronic Remittance Request form for the provider(s) and ETIN you are certifying. You must do this each time you link a new provider to your ETIN. Failure to do so will result in a paper, rather than electronic, remittance for that provider/ETIN combination.

> **NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING ELECTRONIC REMITTANCE. ALL DOCUMENTS PERTAINING TO ELECTRONIC REMITTANCE CAN BE FOUND AT WWW.EMEDNY.ORG OR BY CALLING THE EMEDNY CALL CENTER AT: 1-800-343-9000.**

Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis.

The numbered fields on the Certification Statement correspond with the explanations given below:

Field 1: **ETIN (Electronic/Paper Transmitter Identification Number)** If you are using this form to obtain an ETIN, leave this field blank. If you wish to add a provider ID number to an existing ETIN, please indicate the ETIN in the top left corner of the form.

Field 2: **BILLING SERVICE NAME** If applicable, enter the name of the billing service that the provider is enrolled with. If you are not using a billing service, leave this field blank.

Field 3: **DATE** Enter the date the Certification Statement is submitted to the fiscal agent.

Field 4: **PROVIDER NAME** Enter the name of the provider whose signature is being notarized.

Field 5: **8-Digit Medicaid Provider ID Number** Until NPI implementation by NYSDOH, the Provider's Medicaid Number must be entered in this field.

Field 6: **10-Digit National Provider Identifier (NPI)** Enter the NPI, unless exempted from NPI.

Field 7: **SIGNATURE** Enter the signature of the individual indicated in Field 4. This must be an original signature.

Field 8: **DATE** Enter the date the Certification Statement was signed and notarized.

Field 9: **NAME AND TITLE** Print the name and the title of the person whose signature appears in Field 7.

Field 10: **TELEPHONE #** Enter the telephone number of the person whose signature appears in Field 7.

Field 11: **EMAIL ADDRESS (If Available)** If available, enter the email address of the person whose signature appears in Field 7.

Field 12: **NOTARY PUBLIC** To be completed and signed by the Notary Public. The fiscal agent cannot accept Certification Statements that are not notarized. In addition to the notary signature, NYSDOH requires a notary seal or stamp on this document.

Please mail original (FAX copies are not acceptable) completed Certification Statements to:

Computer Sciences Corporation
ATTN: Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614

(1) ETIN ______________ **(2)** BILLING SERVICE NAME (IF APPLICABLE) __________________________________

eMedNY/MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID

(3) As of (date) __________, all claims submitted electronically or on paper to the State's Medicaid fiscal agent, for services or supplies furnished

(4) by (provider name) ________________________________ **(5)** (8-digit Medicaid Provider Number -- REQUIRED) [ ]

(6) (10-digit National Provider ID (NPI) -- REQUIRED unless exempted from NPI) [ ]

will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer, or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed services; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the eMedNY Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the Manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipient, the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any other source other than the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE FINED AND/OR PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY VIOLATION OF THE TERMS OF THIS CERTIFICATION, INCLUDING BUT NOT LIMITED TO FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payment therefor shall be promptly furnished upon request to the local Department of Social Services, the State Department of Health, the Office of the Medicaid Inspector General, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by the provider, and (2) accept the claim under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of the law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or my entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON THE ABOVE CERTIFICATION WILL APPLY TO ALL CLAIMS SUBMITTED ELECTRONICALLY OR ON PAPER, USING MY (OR THE ENTITY'S) NPI OR MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

PLEASE DO NOT STAPLE OR WRITE IN BAR CODE AREA

(7) (Signature) ____ **(8)** (Date) ____________________

(9) (Print Name and Title) ____

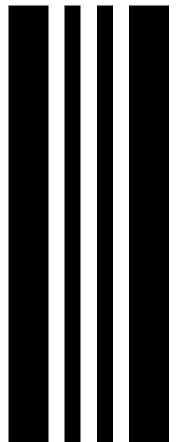
(10) (Telephone #) ____________________ **(11)** (eMail, if available) ______________________________

STATE OF ______________________________
COUNTY OF ____________________________ **(12)**

On this ___________ day of _______________, 20____, before me personally came

_______________________, to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

(SEAL)



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NOTARY PUBLIC

ELECTRONIC REMITTANCE 835/820 REQUEST FORM

In order to receive the New York Medicaid remittance advice in the electronic HIPAA-compliant 835 or 820 format through eMedNY eXchange or FTP, please complete **all** of the following information and either mail or fax the completed form to:

Computer Sciences Corporation
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, New York 12144
FAX: (518) 257-4632

WARNING: YOUR SYSTEM MUST BE READY TO ACCEPT THIS FORMAT PRIOR TO REQUESTING ELECTRONIC REMITTANCES.

NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING THE ELECTRONIC REMITTANCE ADVICE. IF USING EXCHANGE, PLEASE LOG INTO EPACES TO ACTIVATE YOUR USER ID. PLEASE ENTER YOUR ASSIGNED eXchange or FTP USER ID BELOW.

1. ETIN (formerly TSN): ____________________

2. PROVIDER Medicaid ID: __ __ __ __ __ __ __ __ (Required)

NPI: __ __ __ __ __ __ __ __ __ __ (Required, unless NPI exempt)

(For multiple provider IDs, please submit a separate list, TYPE WRITTEN IN ASCENDING ORDER, attached to this form.) Please note: If you have submitted a Certification Statement to link a provider to your ETIN, this form must also be submitted to request an electronic 835/820 remittance for each newly linked provider. (Otherwise, the default is a paper remittance.)

3. GROUP Medicaid ID: __ __ __ __ __ __ __ __ (Required)

NPI: __ __ __ __ __ __ __ __ __ __ (Required, unless NPI exempt) (If applicable)

(Only if billing with a Group ID. If this request is for a Group remittance, no individual Provider ID should be entered.)

4. If this is your only ETIN, the electronic remittance for this ETIN will be used for reporting paper claim forms and adjustments/voids submitted by the State. Otherwise, if you have multiple ETIN's, and want the ETIN listed above to be used for this purpose, place an "X" in this box. ☐
(In the future, should you elect to have these types of claims sent to a different ETIN's remittance, you will need to submit another request form.)

5. ORGANIZATION NAME: ____

6. ADDRESS: ____

____

7. CONTACT NAME: ____

8. CONTACT PHONE #: ____

9. eMAIL ADDRESS: ____

10. FAX #: ____

ENTER YOUR ASSIGNED USER ID BELOW AND CHECK YOUR CHOSEN METHOD OF REMITTANCE RETRIEVAL (eXchange or FTP). Check paper to switch back to paper remittance.

USER ID: ____________________ eXchange __________ FTP __________ paper __________

SIGNATURE: ____________________________ DATE SIGNED: ____________________

SIGNED BY (PRINT NAME): ____________________________ TITLE: ____________________

Please note: This form will be returned if it contains incomplete or illegible information.