eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: MCDNY

Medicaid New York
837 and 835

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- SAVE this document to your computer.
- OPEN the file in the Adobe Reader program and type directly onto the form.
- COMPLETE the form using the provider's billing/group information as credentialed with payer.
- ERA enrollment processing timeframe is approximately 14 days.
- Support Vendors may contact the payer directly at 800-343-9000 to follow up on the ERA setup request.
- If sending the ERA form, be sure the Certification Statement has already been processed by Medicaid. The provider will not be setup for 835s until the 837 Electronic Claim Submission has been approved.
- Original signatures are required. Please use **blue** ink.
- EFT enrollment is required to receive ERAs. If you have previously completed the EFT enrollment with Medicaid please complete and mail the attached EFT confirmation page along with your ERA form.

837 Claims Transactions and 835 Electronic Remittance Advice:

1. **Certification Statement for Provider Billing Medicaid (2 pages including instructions)**
   This form is REQUIRED- must be completed and submitted for the provider group and EACH individual rendering providers submitting claims under this group.
   On Page 1, Provider must sign, date, print name, and title where indicated in the presence of a Notary Public.
   Notary Public must notarize and add stamp or seal to the agreement.
2. **Electronic or PDF Remittance Advice Request Form (1 page)**
   Provider must sign, date, print name and email address where indicated.
3. **Electronic Funds Transfer Authorization Form (2 pages)**
   On Page 1, complete the 'Provider Contact Information' section.
   On Page 1, complete the 'Financial Institution Information' section.
   Under the 'Submission Information' section on Page 1, select your reason for submission and indicate whether an Original Voided Check or Original Bank Letter is included with the enrollment agreement.
   At the bottom of Page 1, Provider must sign, date, print name and title where indicated.
4. **Default ETIN Selection Form (1 page)**
   Provider must print name, email address, phone number, date and sign where indicated.

Submit Completed Documents:

BEFORE mailing the Original, Completed document(s) to the payer...
--SAVE copy of the completed form pages to your PC.

WITHIN EDIinsight- Enrollment Manager-

--ADD or LOCATE Payer Enrollment Record
--SELECT record, CLICK **[ATTACH File]** to attach copy of completed document (payer enrollment form) to the record.
--CLICK **[ADD Action Taken]**, SELECT- **"Enrollment Form Sent to Payer/Trading Partner"**
-- ENTER note with details of mailing the form to payer, such as date mailed, etc.

Mail all pages of original, completed, signed and notarized document(s) to Medicaid NY at the following address (same address provided on form).

eMedNY
Attn: Provider Enrollment Support
P O Box 4614
Rensselaer, NY 12144-8614

(1) ETIN **0WC** **(2)** BILLING SERVICE NAME (IF APPLICABLE) **Practice Insight**

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

(6) (8-digit Medicaid Provider Number -- If NPI exempt)

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; I (or the entity) have adopted and implemented, where applicable, an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Codes, Rules and Regulations Part 521; 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) _____

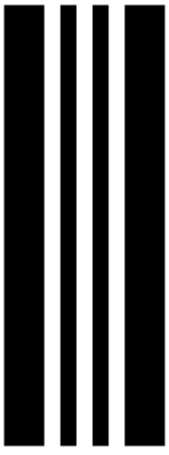
STATE OF __
COUNTY OF _____ **(12)**

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)

_____
NOTARY PUBLIC



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.

Please DO NOT use white-out or red ink on these forms, as they are imaged.

The numbered fields on the Certification Statement correspond with the explanations given below. Any changes to fields 1-12 must be initialed by the provider.

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, or name of organization.

Field 5: **10-Digit National Provider Identifier (NPI)** Enter the NPI, unless exempted from NPI.

Field 6: **8-Digit Medicaid Provider ID Number** Enter the Medicaid Provider ID number if NPI exempt.

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. The notary's commission expiration date/year must be entered and legible. This information may be hand-written if it does not appear on the stamp/seal. The provider's name must be entered as the person who personally came before the notary.

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

eMedNY
ATTN: Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614

ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

Prior to submitting this form, providers must:

- Have a valid and active eMedNY eXchange, Core Web Services, or VPN User ID prior to submitting this form. If you do not have an active User ID, **STOP** and contact the eMedNY Call Center at 1-800-343-9000 to start the ePACES enrollment process before completing this form.
- Be associated with the ETIN entered in the 'Provider Information' section below. If the provider is not currently associated with the ETIN entered on this form, **STOP**. You **must** complete a certification statement for the ETIN entered (EMEDNY form # 490601) and mail both forms together to the address below.

THIS FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED

Required Information:

(1) Provider Name: _____

Enter the name of either the individual provider or organization for which this form is being submitted.

(2) NPI (National Provider Identifier) (Required, unless exempt)**:** _____

The NPI entered must match the provider or organization name entered above in section (1).

(3) *MMIS Provider ID _____

**Required only if NPI exempt or an atypical provider.*

(4) ETIN: 0WC

*The 3 or 4 digit **E**lectronic **T**ransmitter **I**dentification **N**umber. Only one ETIN per form is allowed. For multiple providers, a separate form must be submitted for each provider.*

(5) Remittance Type Selection (Select One):

☑ 835/820 Electronic Remittance **OR** ☐ PDF *(can only be used with eXchange delivery method)*

- *For 835/820 electronic remittance types, software to interpret HIPAA formatted records is strongly recommended. eMedNY cannot provide remittance interpretation service.*

(6) Remittance Delivery Method (Select One): ☐ eXchange **OR** ☐ VPN **OR** ☑ Core WEB Services

(7) Current eXchange, Core WEB Services, or VPN User ID: EKING119

- The eXchange, Core Web Services, or VPN user ID submitted on the form must be valid and activated.
- Only one User ID is allowed per ETIN/Provider combination.

Authorized Signature

The person signing this form, even if on behalf of the Provider, warrants that s/he has the legal authority to do so.

_____ _____

Signature of Person Submitting Enrollment *Submission Date*

_____ _____

Printed Name of Person Submitting Enrollment *Email Address of Person Submitting Enrollment*

Mail or fax completed form to:

eMedNY
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, New York 12144-8614
FAX: (518) 257-4632

PLEASE ALLOW UP TO 14 BUSINESS DAYS FOR PROCESSING.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FORM

Provider Information

Provider Name _____

Provider Address

Street _____

City _____ State/Province _____ ZIP Code/Postal Code _____

Provider Identifiers Information

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number: ☑ TIN ☐ EIN _____

National Provider Identifier (NPI) *(Required, unless exempt)*: _____

Other Identifiers – Assigning Authority – New York Medicaid

Trading Partner ID: **MMIS Provider ID #** *(Required, if NPI exempt)*: _____

Provider Contact Information

Provider Contact Name

Contact _____ Telephone Number _____ Extension ____

Email Address _____ Fax Number _____ ___

Financial Institution Information

Financial Institution Name _____

Financial Institution Address

Street _____

City _____ State/Province _____ ZIP Code/Postal Code _____

Financial Institution Routing Number	
Type of Account at Financial Institution (Check one)	☐ CHECKING **OR** ☐ SAVINGS
Provider's Account Number with Financial Institution	
Account Number Linkage to Provider Identifier Provider Tax Identification Number (TIN) OR National Provider Identifier (NPI)	LEAVE THIS SECTION BLANK

Submission Information

Reason for Submission	☐	New Enrollment	**OR**	☐ Change Enrollment
Include with Enrollment Submission	☐	Original Voided Check	**OR**	☐ Original Bank Letter

Authorized Signature: If submitting the form for a practitioner, the practitioner must sign below.

If submitting this form for a group, business or institution, the authorized representative must sign below.

☒ _____ _____

Written Signature of Person Submitting Enrollment *Submission Date*

_____ _____

Printed Name of Person Submitting *Printed Title of Person Submitting Enrollment*

The eMedNY Fiscal Agent contractor for the New York State Department of Health will have the right to recover any amount that has been credited to your account incorrectly.

FOR EMEDNY USE ONLY – DO NOT WRITE

Date Received: _____

Pick Up Indicator: No: ☐ Yes: ☐ Facility Location: _____

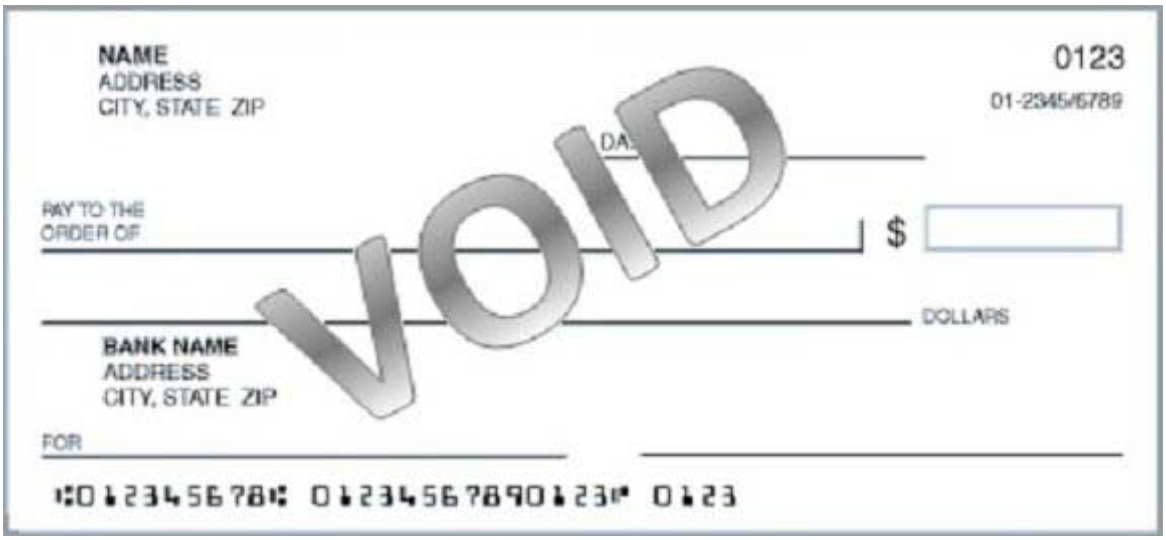
Processed by: _____ Date: _____

Authorized by: _____ Date: _____

Effective Start Date: _____ Cycle #: _____

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FORM

ATTACH ORIGINAL VOIDED CHECK HERE



To request EFT of New York Medicaid funds, complete all sections of the form below.
Questions about completing this form should be directed to eMedNY Call Center at 1-800-343-9000.
Providers will be sent a letter indicating when the new remittance advice option will begin.

DEFAULT ETIN SELECTION FORM

Prior to submitting this form, providers must:

- Have a valid and active ETIN associated to the NPI/MMIS. If the provider is not currently associated with the ETIN entered on this form, **STOP**. You must complete a certification statement for the ETIN entered (EMEDNY form # 490601)
- Have the ETIN entered on this form set up for PDF or Electronic Remittances. If the ETIN is **NOT** currently set up for PDF or Electronic Remittances, **STOP**. You **must** complete an Electronic Remittance Advice Request (ERA) Form for the ETIN entered (EMEDNY form # 700201).

THIS FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED

eMedNY uses a Default **E**lectronic **T**ransmitter **I**dentification **N**umber (ETIN), linked to your MMIS Provider ID/NPI, for reporting the following types of claims on your electronic or PDF remittance. You must select a default ETIN to identify where remittances for these types of claims are to be routed:

- Claims submitted on paper forms
- State submitted adjustments/voids
- Automated Medicare crossover claims

To select or change your Default ETIN, indicate the ETIN in the space provided below.
Please note: You can only have **ONE** default ETIN per MMIS/NPI.

Default **ETIN** (The ETIN is **NOT** your Tax ID/EIN number): 0WC_____

NPI #:_____

MMIS Provider ID # (Required Only If NPI exempt): _____

Authorized Signature

The person signing this form, even if on behalf of the Provider, warrants that s/he has the legal authority to do so.

SIGNATURE: _____ DATE SIGNED: _____

SIGNED BY (PRINT NAME): _____

EMAIL ADDRESS: _____ PHONE #: _____

Please mail or fax this completed form to:

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

PLEASE ALLOW UP TO 14 BUSINESS DAYS FOR PROCESSING