

**NEW YORK MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<p align="center"><b>CKNY1</b>  <i>(to be used ONLY by Dental Offices whose category of service is 0200)</i></p> <p align="center"><b>CKNY2</b>  <i>(to be used ONLY by Dental Clinics)</i></p>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<p><b>Electronic Payer Profile</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information in full.</li> </ul> <p><b>Certification Statement for Provider Utilizing Electronic Billing</b></p> <ul style="list-style-type: none"> <li>• Fill in Date, Provider Name, Provider Number and NPI number at the top of the form.</li> <li>• At the bottom of the form an original signature, date, name &amp; title will be required when <b><u>notarized</u></b>.</li> </ul>
<b>SPECIAL INSTRUCTIONS</b>	<p>Effective November 2007 NY Medicaid and their administrator Computer Sciences Corporation (CSC) elected to stop verifying provider demographics for Emdeon. Due to this change in process Emdeon is requiring all providers complete the Electronic Payer profile in full. Any request which is not complete in its entirety will be returned to the office.</p>
<b>SEND REGISTRATION FORMS TO:</b>	<p align="center">Emdeon Business Services          220 Burnham Street          South Windsor, CT 06074          Attn: Provider Enrollment</p>
<b>ENROLLMENT CONFIRMATION</b>	<p>Enrollment will be coordinated between Emdeon Business Services and Computer Science Corporation. WebMD Dental will notify the provider or their software vendor when enrollment is complete.</p>
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>



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business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

<b>CONTACT PHONE NUMBERS</b>	Computer Sciences Corporation                      800-343-9000 Emdeon Business Services                              888-255-7293
<b>CLAIMS MAILED TO:</b>	Claims which need to go out on paper (i.e., prior authorizations) must be printed and sent from the Provider's office and mailed to:  800 North Pearl Street Albany, NY 12204 Or P.O. Box 4444 Albany, NY 12204
<b>CLAIM FILING GUIDELINES</b>	<ul style="list-style-type: none"><li>▪ Maximum of 20 procedure lines per claim.</li><li>▪ Provider number must be 8 digits.</li><li>▪ Recipient (Insured) ID number must be 8 characters. Two letters followed by five digits followed by one character. (i.e., XXNNNNNX)</li></ul>
<b>MEDICAID SPECIFIC PROVIDER ITEMS</b>  <b>Category of Service</b> <b>Location Code</b> <b>Rate Code</b>	<ul style="list-style-type: none"><li>▪ Category of service, location code and rate codes are assigned by Medicaid.</li><li>▪ This information must be coordinated with Emdeon Business Services Provider Enrollment so that we may maintain these values for your claims.</li><li>▪ Should any of these values change in the future, please contact Emdeon Business Services Provider Enrollment so that we may update our systems.</li></ul>



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**MEDICAID SPECIFIC  
CLAIM ITEMS**

**Co-pay Exception Code**

**Service Authorization  
Exception Code**

**Over 90 Days Indicator**

Current data processing software and networked electronic claims systems may not allow this Payer specific information to be passed through on your claims.

To submit such exception items along with your claim, please use the remarks (comments) area with the following guidelines:

- **Co-pay Exception Code Values with a keyword of “COPAY=”**
  - 01 = Pregnancy
  - 02 = Resident of an OMH/OMRDD Certified Community Resident or OMRD Home and community Based Services (HCBS) waiver Program  
**e.g., In your remarks area of the claim type “COPAY=02”.**
  
- **Service Authorization Exception Code values with a keyword of “SVCAUTH=”**
  - J = Urgent Medical Care
  - K = Services rendered in a retroactive period
  - L = Emergency Care
  - M = Client has temporary Medicaid authorization card (DSS-2831A)
  - N = Request from county for a second opinion to determine if recipient can work
  - P = Request for increase in recipient service limits pending
  - S = Special Handling**e.g., In your remarks area of the claim type “SVCAUTH=P”.**
  
- **Over 90 Days Indicator values with a keyword of “OV90=”**
  - 1 Proof of Eligibility Unknown or Unavailable
  - 2 Litigation
  - 3 Authorization Delays
  - 4 Delay in Certifying Provider
  - 5 Delay in Supplying Billing Forms
  - 6 Delay in Delivery of Custom-made Appliances
  - 7 Third Party Processing Delay
  - 8 Delay in Eligibility Determination
  - 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
  - 10 Administration Delay in the Prior Approval Process
  - 11 Other**e.g., In your remarks area of the claim type “OV90=5”**

NOTE: for your convenience, Emdeon Business Services automatically detects when a claim is over 90 days old and defaults the reason code to 9.

These items may be included anywhere within the remarks section and in any order.



**NEW YORK MEDICAID  
ELECTRONIC CLAIMS PAYER PROFILE**

Office / Group or Clinic Name: \_\_\_\_\_

Rendering Provider's Name: \_\_\_\_\_

Rendering Office Address: \_\_\_\_\_

Tax Identification #: \_\_\_\_\_

Group NPI #: \_\_\_\_\_  
*(if applicable)*

Software Vendor: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Clinic ID # (if applicable): \_\_\_\_\_

Group ID # (if applicable): \_\_\_\_\_

Service ID # (individual provider Medicaid number): \_\_\_\_\_  
*(Clinic members may use their state license #)*

NPI #: \_\_\_\_\_

Profession Code: (3 digits) \_\_\_\_\_

Locator Code: (3 digits) \_\_\_\_\_

Category of Service: (4 digits) \_\_\_\_\_

Rate Code: (4 digits, required for clinics) \_\_\_\_\_

I authorize Emdeon Business Services to attach the above information to my New York Medicaid claims.



\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

(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)

\_\_\_\_\_  
NOTARY PUBLIC

