NEW YORK MEDICAID MEDICAL

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***************ATTENTION***************

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THIS PAYER EDI AGREEMENT MUST BE PROCESSED THROUGH EMDEON'S PAYER ENROLLMENT DEPARTMENT.

THIS IS DUE TO PAYER SPECIFIC ENROLLMENT REQUIREMENTS. DO NOT SEND THIS PAYER EDI AGREEMENT DIRECT TO THE PAYER.

THIS APPLIES TO ALL PROVIDERS ENROLLING FOR EDI APPROVAL FOR ELECTRONIC CLAIM SUBMISSIONS TO THIS PAYER THROUGH EMDEON.

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For Initial Enrollment with this payer:

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies accepted.
- Registration with Emdeon takes 28 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements. If a Provider is sending under both individual and group ids then a separate agreement for both IDs is required by the payer.
- You may obtain the form from our enrollment web site http://www.emdeon.com.or by calling our Fax on Demand service at 800-760-2804 (doc# 1091).

For Re-Enrollment (COS Change of Service) with this payer:

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies accepted.
- Registration with Emdeon takes 28 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements. If a Provider is sending under both individual and group ids then a separate agreement for both IDs is required by the payer.
- You may obtain the form from our enrollment web site http://www.emdeon.com.or by calling our Fax on Demand service at 800-760-2804 (doc# 1091).

If you are already APPROVED by this payer to submit through Emdeon:

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
  - You may obtain the form from our enrollment web site http://www.emdeon.com..or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
  - The Client Provided Approval form must be submitted to: payerregistration@emdeon.com or faxed to 615-885-3713.

Payer Registration Reminders:

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: http://www.emdeon.com.

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Instructions for submitting Payer Registration Forms:

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address below
- To obtain forms or additional payer information, visit our website: http://www.emdeon.com.

This Registration form is for a: ☐Provider ☐Group			
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address §			
☐NPI ID*		**☐Group ID*** **☐Provider ID***	
☐Tax ID* ☐ SSN		**Site ID***	
Vendor Submitter ID*		**Division ID***	
Vendor Name*			
Additional Info			

* Required Information if applicable. § All Approval Notifications will be sent to this address

Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services
Attn: Enrollment Dept
Donelson Corporate Ctr Bldg 3
3055 Lebanon Pike Ste 2000
Nashville, TN 37214

Fax: (615) 231-4843
Email: batchenrollment@emdeon.com

To avoid claim rejection, please do not submit electronic claims before receiving Emdeon Approval Notification.

CERTIFICATION STATEMENT INSTRUCTIONS

A Certification Statement must be completed:

1. When you are applying for an Electronic Transmitter Identification Number (ETIN) for the electronic 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 PROVIDER ENROLLMENT at 800-343-9000,OPTION #5.

Certification Statements are valid for one year. You will be provided with renewal information when your Certification Statement is near expiration.

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

Field 1: **ETIN** (Electronic 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: **PROVIDER NUMBER**
Enter the 8-digit Medicaid Provider ID Number assigned by NYSDOH.
For physician groups, a Certification Statement must be submitted for each individual provider ID number as well as for the group provider ID number.

Field 6: **SIGNATURE**
Enter the signature of the individual indicated in Field 4. This must be an original signature.

Field 7: **DATE**
Enter the date the Certification Statement was signed and notarized.

Field 8: **NAME AND TITLE**
Print the name and the title of the person whose signature appears in Field 6.

Field 9: **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: Provider Enrollment Support
1 CSC Way
Rensselaer, NY 12144

(1)
ETIN 01T

(2)
BILLING SERVICE NAME (IF APPLICABLE) ______________________________________

MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER UTILIZING ELECTRONIC BILLING

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

(4) (5)
by (provider name) ____ (provider number) ______________________________

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 Medicaid Management Information Systems 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 PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY 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 or State Departments of Social Services, 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 Social Services as set forth in title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including Medicaid Management Information System 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 ELECTRONIC CLAIMS SUBMITTED, USING MY (OR THE ENTITY'S) MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

(6) (7)
(Signature) ____ (Date) __________________________

(8)
(Typed Name and Title) ____

STATE OF _________________________________
COUNTY OF _______________________________ (9)

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

If you are billing for multiple locations, you must provide WebMD with your addresses and locator codes.

	Code	Address
1.	______________	______________________________
2.	______________	______________________________
3.	______________	______________________________
4.	______________	______________________________
5.	______________	______________________________
6.	______________	______________________________
7.	______________	______________________________
8.	______________	______________________________
9.	______________	______________________________
10.	______________	______________________________