400 Vermillion Street ● Hastings, MN 55033
Ph 800-482-3518 ● Fax 651-389-9152
www.edsedi.com

NEW YORK MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CKNY1** (to be used ONLY by Dental Offices whose category of service is 0200) **CKNY2** (to be used ONLY by Dental Clinics)
ELECTRONIC REGISTRATIONS Agreements Required	**EDS Provider Enrollment Form** • Please complete all requested information. **Certification Statement for Provider Utilizing Electronic Billing** • Fill in all requested information at the top of the form. • At the bottom of the form an original signature, date, name and title will be required when **notarized**.
SEND REGISTRATION FORMS TO	EDS 400 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment
ENROLLMENT CONFIRMATION	EDS will notify the provider or their PMS vendor, as defined by the PMS vendor, when registration is complete.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Computer Sciences Corporation 800-343-9000 Electronic Dental Services 800-482-3518
SPECIAL NOTES	Effective November 2007 NY Medicaid and their administrator Computer Sciences Corporation (CSC) elected to stop verifying provider demographics for EDS. Due to this change in process EDS 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.

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CLAIMS MAILED TO:	Claims which need to go out on paper 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 Please contact Computer Sciences Corporation at 800-343-9000 for details on submitting prior authorization requests.
CLAIM FILING GUIDELINES	▪ Maximum of 20 procedure lines per claim. ▪ Recipient (Insured) ID number must be 8 characters. Two letters followed by five digits followed by one character. (i.e., XXNNNNNX)
MEDICAID SPECIFIC PROVIDER ITEMS **Rate Code**	▪ Rate codes are assigned by Medicaid. ▪ This information must be coordinated with EDS Provider Enrollment so that we may maintain this value for your claims. ▪ Should any this value change in the future, please contact EDS Provider Enrollment so that we may update our systems.
MEDICAID SPECIFIC CLAIM ITEMS **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: ▪ **Service Authorization Exception Code values with a keyword of "SVCAUTH="** 1 = Urgent Medical Care 2 = Services rendered in a retroactive period 3 = Emergency Care 4 = Client has temporary Medicaid 5 = Request from county for a second opinion to determine if recipient can work 6 = Request for override pending 7 = Special Handling **e.g., In your remarks area of the claim type "SVCAUTH=P".** Please click here for full details on Submitting claims over 90 days from date of service. ▪ **Over 90 Days Indicator values with a keyword of "OV90="** **e.g., In your remarks area of the claim type "OV90=5"** Code Reason 1 Proof of eligibility unknown or unavailable - must be submitted within 30 days from the date of notification of eligibility. 2 Litigation - must be submitted within 30 days from the time submission came within the control of the Provider. 3 Authorization Delays - Delays previously approved by the State - must be submitted within 30 days from the date of notification.

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	4 Delay in Certifying Provider - must be submitted within 30 days from the date of notification of the change in provider's enrollment status. 5 Delay in Supplying Billing Forms - must be submitted within 30 days from the time submission came within the control of the Provider - reason 5 not accepted for electronic claims. 6 Delay in Supplying Custom-made Appliances NYS Medicaid does not accept this reason for delay and will deny a code value of "6". 7 Third Party Processing Delay - must be submitted within 30 days from the time submission came within the control of the Provider. 8 Delay in Eligibility Determination - must be submitted within 30 days from the date of notification of eligibility. 9 Original Claim Rejected or Denied Due to a Reason unrelated to the Billing Limitation Rules - corrected claim must be submitted within 60 days of the date of notification. 10 Administration Delay in the Prior Approval Process - must be submitted within 30 days from the date of notification. 11 Other - This delay reason only applies to adjustments of paid claims and limited situations, which are listed below on the Delay Reason Code form and in your Provider Manual. NOTE: for your convenience, EDS 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.

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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 #: _____

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 0Q2 **(2)** BILLING SERVICE NAME (IF APPLICABLE) Claims Processing Service dba Emdeon Dental

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