

## Payer Agreement Instructions for New York Medicaid - 00047

### Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. NDCHealth **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Provider ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 4- 6 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from ProxyMed or your claims will reject.

### Guidelines for completing: New York Medicaid- Payer ID 00047

#### Certification Statement For Provider Utilizing Electronic Billing

Field	Instructions
<i>Complete entire form and have it Notarized</i>	This form must be Notarized and have the Notary Seal affixed and signed by the provider. <i>If not Notarized the Payer will reject the agreement.</i>  Provider must sign with <i>original</i> signature using BLUE INK. Do not alter this form in any way.

#### Trading Partner Agreement

Field	Instructions
<i>Each Provider must sign a Trading Partner Agreement</i>	
<i>Page 1</i>	Complete entry fields on Page 1
<i>Page 4</i>	Sign, with original signature and date.

### Return the Agreement to the Payer:

**Physical address for USPS, FedEx, UPS, etc.**

Attn: EMC Control - First Floor  
 CSC Healthcare  
 800 N. Pearl Street  
 Albany, N.Y. 12204

(1)  
ETIN \_\_\_\_\_

(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)

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

**TRADING PARTNER AGREEMENT**

This Trading Partner Agreement ("*Agreement*") is made and entered into on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ (the "*Effective Date*"), by and between \_\_\_\_\_ ("*Trading Partner*"), whose provider number is \_\_\_\_\_, and Electronic Transmitter Identification Number (ETIN) is \_\_\_\_\_, and the New York State Department of Health ("*NYS Medicaid*").

**WITNESSETH**

**WHEREAS**, NYS Medicaid, through its fiscal agent, and Trading Partner electronically exchange information and data in connection with certain healthcare transactions; and

**WHEREAS**, NYS Medicaid and Trading Partner want to address certain requirements that are now or will become applicable to the parties under regulations issued pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (as the same may be amended from time to time, "*HIPAA*") including, without limitation, the Standards for Electronic Transactions, which were issued in their final form on August 17, 2002 (as the same may be amended from time to time, the "*Transaction Regulations*"), and the Security Standards, which were issued in their final form on February 20, 2003 (as the same may be amended from time to time, the "*Security Standards*").

**NOW, THEREFORE**, in consideration of the foregoing and of the mutual covenants and agreements herein contained, Trading Partner and NYS Medicaid agree to the foregoing and as follows:

**1. General Obligations.**

**1.1 Compliance With Transaction Regulations.** Each party shall, and shall cause its applicable subcontractors and agents to, comply with the applicable requirements of the Transaction Regulations and any applicable Implementation Specifications issued therein.

**1.2 No Changes.** With respect to each transaction, each party agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications. Further, neither party will take any action to change the meaning or intent of the Implementation Specifications.

**1.3 No Additions.** With respect to each transaction, each party agrees that it will not add any data elements or segments to the maximum defined data set as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications.

**1.4 No Use.** With respect to each transaction, each party agrees that it will not use any code or data elements that either are marked "not used" or are not in the Transaction Regulations and/or the applicable Implementation Specifications.

**1.5 Testing Requirements.** The Technical Supplementary Companion Guide sets forth the testing requirements that Trading Partner and/or its contractors and/or agents must implement and/or complete prior to submitting any live, production transactions to NYS Medicaid, or its fiscal agent. Trading Partner agrees to satisfy these requirements.

**1.6 Communications.** The Technical Supplementary Companion Guide sets forth specifications for establishing connectivity with, and transmitting transactions to, NYS Medicaid or its fiscal agent. Trading Partner agrees to satisfy these requirements.

**1.7 Supplementary Specifications.** The Technical Supplementary Companion Guide sets forth the current supplementary specifications ("*Supplementary Specifications*") of NYS Medicaid with respect to the Transaction Regulations and any applicable Implementation Specifications. NYS Medicaid shall have the right to amend the Supplementary Specifications and/or to provide additional supplementary specifications to Trading Partner from time to time (all of which shall constitute Supplementary Specifications for purposes of this Agreement). Trading Partner shall be required to implement such amendments and additions within thirty (30) calendar days following NYS Medicaid publication of same, unless a shorter period is necessary to conform to applicable laws and/or regulations.

**1.8 Security Requirements.**

(a) Each party will take reasonable care to ensure that the information submitted in each transaction is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to: (i) its own and the other party's transmission and processing systems; (ii) the transmissions themselves; and (iii) the control structure applied to transmissions between them.

(b) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

(c) If required under the final HIPAA Security Regulations, the parties will enter into a Business Associate agreement relating to the electronic exchange of data, and will implement such additional requirements as may be specified in the Security Regulations including, without limitation, requirements relating to encryption, Public Key Infrastructure (PKI) and other similar technologies.

2. **Costs and Expenses.** Each party shall be responsible for any and all costs and expenses related to such party's compliance with the Transaction Regulations, any applicable Implementation Specifications and the terms of this Agreement. Further, each party shall be responsible for all costs, charges and fees it may incur in connection with transmitting and receiving transactions.

3. **Term and Termination.**

3.1 **Term; Effect of Termination.** This Agreement shall remain in effect until one party provides written notice of termination to the other, which termination shall be effective thirty (30) days following the other party's receipt of the notice.

Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and state laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

3.2 **Limitation of Liability.** NEITHER PARTY (including any fiscal agent of NYS Medicaid) SHALL BE LIABLE TO THE OTHER FOR ANY DIRECT CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL OR PUNITIVE DAMAGES, REGARDLESS OF WHETHER THE CLAIM GIVING RISE TO SUCH DAMAGES IS BASED UPON BREACH OF WARRANTY, BREACH OF CONTRACT, NEGLIGENCE, TORT OR OTHER THEORY OF LIABILITY, EVEN IF A PARTY HAS BEEN ADVISED OF THE POSSIBILITY THEREOF.

3.3 **Injunctive Relief.** Each party agrees that the remedies at law for any breach by it of the terms of this Agreement shall be inadequate and that monetary damages resulting from such breach are not readily measured. Accordingly, in the event of a breach or threatened breach by a party of the terms of this Agreement, the non-breaching party shall be entitled to immediate injunctive relief.

4. **Miscellaneous.**

4.1 **Defined Terms.** Capitalized terms used in this Agreement but not defined herein shall have the meanings ascribed to them in the Transaction Regulations and/or in HIPAA.

4.2 **Interpretation.** Any ambiguity in any term or condition of this Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

**IN WITNESS WHEREOF**, NYS Medicaid and Trading Partner have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.

On behalf of NYS Medicaid

Trading Partner: \_\_\_\_\_

By: Steph O'Connell

By: \_\_\_\_\_

Print Name: Stephanie O'Connell

Print Name: \_\_\_\_\_

Title: Director Omm/DeIT

Title: \_\_\_\_\_