Mail this information to the address below.

1) Completed, Signed & Notarized Certification

The Certification Form sent to CSC must contain original signatures. Copies of signatures or stamps will cause the form to be rejected. In addition, when the notary fills out his/her section of the Certification form in the field that comes right after "before me personally came", be sure the notary enters the name of the person who is signing the Certification Form. This is a common error that can cause the Certification to be rejected.

2) Completed & Signed Remittance Advice Request form

Section D of the Remittance Advice Request Form must be completed by an authorized provider representative.

eMedNY
Attn: Provider Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614
FAX: (518)257-4632

(1) ETIN **00E8** **(2)** BILLING SERVICE NAME (IF APPLICABLE) Public Consulting Group

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; 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) _____

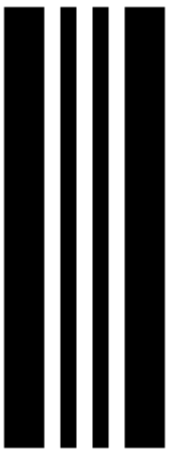
STATE OF _____
COUNTY OF _____ **(12)**

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



ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

To receive the New York Medicaid remittance advice in PDF format through eMedNY eXchange or electronic HIPAA-compliant 835 or 820 format through eMedNY eXchange, FTP or Core WEB Services, complete **all** sections below.
ALLOW 7 to 14 BUSINESS DAYS FOR PROCESSING.

Provider Information

Provider Name _____

Provider Identifiers Information

Provider Identifiers

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

☐ 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)*: _____

Trading Partner ID: ETIN: 00E8_____

NOTE: The ETIN listed on this form above will also serve as the **DEFAULT ETIN** for reporting paper claim submissions, state submitted adjustments/voids, and Medicare crossover claims, unless you indicate an alternate ETIN, which is set up for electronic/PDF remittances, in this field: _____

Provider Contact Information

Provider Contact Name Contact_____

Telephone Number _____ Extension _____

Email Address _____FAX Number _____

Electronic Remittance Advice Information

Method of Retrieval

Remittance Type (**Choose one**): ☑ 835/820 Electronic Remittance ☐ PDF *(eXchange delivery method only)*

Remittance Delivery Method (**Choose one**): ☑ eXchange ☐ FTP ☐ Core WEB Services

eXchange, Core WEB Services **or** FTP User ID: EPUBLICC_____

Submission Information

Reason for Submission ☐ New Enrollment ☐ Change Enrollment

Authorized Signature

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

_____ _____

Written Signature of Person Submitting Enrollment *Submission Date*

_____ _____

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

Mail the completed form to:

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

You can fax the remittance request form if the provider is already certified for the ETIN. Certification forms cannot be faxed. Only originals will be accepted.

This form will be returned if it contains incomplete or illegible information.