MIF Claim Submission Guidance – Provider Claims

Overview

Below are claim submission guidelines for providers submitting claims to the Medical Indemnity Fund (MIF). This guidance will be updated periodically to address common questions and concerns relating to MIF claim submission. The guidance below assumes all applicable authorizations have been obtained.

If you have any questions about obtaining authorizations or submitting claims, please contact us: MIF@health.ny.gov or call 1-855-NYMIF33 (1-855-696-4333).

Overall Submission requirements

Due to the standardization of provider claims, it is preferable and more expedient if providers accept payment directly from the MIF and submit their claims directly to the MIF for reimbursement. If you are a member submitting a claim, please refer to the MIF Claim Submission Guidelines for Members available on the MIF website.

All completed claims are required to be received by the MIF within 90 days from the date services are rendered or purchased.

Provider Claims

- You are required to submit an IRS Form W9 and a list of providers who will be billing with the TIN/SSN listed on the W9 before payment can be made.
- You can submit your claims electronically or by mail.
  - **Electronically:** The Fund offers two options for submitting Electronic Data Interchange (EDI) claims. With the appropriate option in place for your electronic workflow, electronic billing results in fewer errors, lower costs and increased efficiency for businesses on both ends of the transaction. These options are detailed below:
    - **Clearinghouse Submitters:** Standard 837 file submission through a clearinghouse using the Fund's receiver ID, NYDFS. This PIN is the identifier at the Clearinghouse to route claims directly to the Claims Operation Department.
    - **Direct Submitters:** This option is for providers who choose to create their own 837 file and submit that file directly to the MIF portal. If you wish to request online access, you can send a request via email with your Tax ID and group NPI to MIF@health.ny.gov
  - **Mail:** Claims that are mailed must be submitted on completed CMS1500 or CMS1450 (also known as a UB04). Mail to:

    Medical Indemnity Fund
    c/o Public Consulting Group, Inc.
    P.O. Box 784
    Greenland, NH 03840-0784
    Phone: (855) NYMIF33 | (855) 696–4333

  - For Claims submitted via **certified mail**, mail to:

    Medical Indemnity Fund
    c/o Public Consulting Group, Inc.
    P.O. Box 784
    Greenland, NH 03840-0784

    Note: Photographs and faxes of claims are not acceptable and will not be processed.
- Legible, handwritten claims are acceptable; however, typed claims are preferred for more accurate and expedient processing.

- Correct usage of CPT and HCPC procedure codes (and when applicable Revenue and DRG codes) and ICD10 diagnosis codes. Using miscellaneous codes when there is a specific code available for the service or item being billed will result in a denial and a corrected claim will be required.
- Anesthesia claims require the start and end times of the procedure.
- Ambulance and Non Emergency Transportation claims require address of origin and destination.
- Please see Appendix A below for further MIF claims requirements for 1500 Professional Forms and Appendix B below for MIF Claims Requirements for UB Institutional Forms.
- Supporting documentation must accompany claims:
    - Durable Medical Equipment (DME) claims for items that don't have a specific procedure code and are billed with a miscellaneous procedure code require a manufacturers invoice (shipping and handling are not covered).
    - Claims for patients with primary commercial insurance coverage require a copy of the primary carrier explanation of payment or denial.
    - All respite and home care efforts require a summary of activities provided to or for the member for each day and/or time-period being billed. Nursing duty notes are acceptable.

Appendix A MIF Claims Requirements for 1500 Professional Form: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
1	Carrier Type	Optional		Type of Insurance
1a	Insured's ID Number	Required	12 alpha numeric	Insured's MIF ID Number - Enter the member's MIF number as it appears on the ID card.
2	Patient's Name	Required		Enter the member's name as is indicated on the ID card.
3	Patient's Date of Birth/Sex	Required	MMDDYYYY F or M or U	Patient's Birth date - Enter member's date of birth and check the box for male or female.
4	Insured's Name	Optional		Insured's Name
5	Patient's Address	Required		Patient's Address - Enter member's complete address and telephone number.
6	Patient's Relationship to Insured	Optional		Patient's Relationship to Insured
7	Insured Address	Optional		Insured Address
8	Reserved	DO NOT USE		
9	Other Insured's Name	Required (if box 11d is Yes)		Other Insured's Information Name
9a	Other Insured's Policy or Group Number	Required (if box 11d is Yes)		Other Insured's Information Policy/Group Number
9b	Reserved	DO NOT USE		
9c	Reserved	DO NOT USE		
9d	Insurance Plan Name or Program Name if Applicable	Required (if box 11d is Yes)		Other Insured's Information Employer/School Name, Insurance Plan/Program Name
10	Is Patient's Condition Related to:			
10a	Employment	Required (if applicable)		Check Yes or No
10b	Auto Accident	Required (if applicable)		Check Yes or No
10c	Other Accident	Required (if applicable)		Check Yes or No
10d	Reserved	DO NOT USE		
11	Insured's Policy Group or FECA Number	Required (if applicable)		Insured's Information - Policy/Group Number
11a	Insured's Date of Birth	Required (if applicable)	MMDDYYYY	Insured's Date of Birth
11b	Other Claim ID designated by NUCC	Required (if applicable)		
11c	Insurance Plan Name or Program Name	Required (if applicable)		Insured's Information - Plan/Program Name
11d	Is there Another Health Benefit Plan?	Required		Check Yes or No
12	Patient's or Authorized Person's Signature (Medical Records/Information Release) and Date	Required		Signature and Date
13	Insured's or Authorized Person's Signature (Assignment of Benefits)	Required		Insured's or Authorized Person's Signature

Appendix A MIF Claims Requirements for 1500 Professional Form Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
14	Date of Current Illness, Injury, Pregnancy, Qualifier	Optional	MMDDYY or MMDDCCYY	Date of Current - Illness (First Symptom) OR Injury OR Pregnancy (LMP) - Enter the date of onset of the member's illness, the date of accident/injury or the date of the last menstrual period.
15	Qualifier, First Date of Onset of Same/Similar Illness	Optional		If patient had same or similar illness give first date
16	Dates Unable to Work in Current Occupation	Optional	MMDDYY or MMDDCCYY	Dates Patient Unable to Work in Current Occupation
17	Qualifier/Name of Referring Physician	Required (if applicable)		Name of Referring Provider or Other Source - Enter the full name of the Referring Provider. A referring/ordering provider is one who requests services for a member, such as provider consultation, diagnostic laboratory or radiological tests, physical or other therapies, pharmaceuticals or durable medical equipment.
17a	Legacy Referring	Required (if applicable)		ID Number of Referring Physician - Enter State Medical License number.
17b	Referring Physician NPI#	Required (if applicable)	10 digit number	Enter Referring Provider's NPI number.
18	Qualifier/Hospitalization Dates Related to Current Services	Optional	MMDDYY or MMDDCCYY	Hospitalization Dates Related to Current Services - Enter the date of hospital admission and discharge if the services billed are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.
19	Additional Claim Information designated by NUCC	Optional	MMDDYY or MMDDCCYY	Reserved for Local Use - Use this area for procedures that require additional information, justification or an Emergency Certification Statement. • This section may be used for an unlisted procedure code when explanation is required and clinical review is required. • If modifier "-99" multiple modifiers is entered in section 24d, they should be itemized in this section. All applicable modifiers for each line item should be listed. • Claims for "By Report" codes and complicated procedures should be detailed in this section if space permits. • All multiple procedures that could be mistaken for duplicate services performed should be detailed in this section. • Anesthesia start and stop times. • Itemization of miscellaneous supplies, etc.
20	Outside Laboratory?	Optional		Check "yes" when diagnostic test was performed by any entity other that the provider billing the service. If this claim includes charges for laboratory work performed by a licensed laboratory, enter and "X". "Outside Laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory.

Appendix A MIF Claims Requirements for 1500 Professional Form Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
21	Diagnosis or Nature of Illness or Injury	Required	10 digit Alpha Numeric	Enter all letters and/or numbers of the ICD-10 code for each diagnosis, including fourth and fifth digits if present. The first diagnosis listed in section 21.1 indicates the primary reason for the service provided
22	Resubmission Code:	Required for correction or voiding of a claim only		Enter: 7 for a corrected claim 8 for a voided claim AND Original Reference Code: Enter the Claim ID number of the claim you are requesting to correct or void. Both Data elements above are required.
23	Prior Authorization Number	Required (if applicable)		Enter prior authorization or referral number.
24a	Date of Service, From and To	Required	MMDDYY or MMDDYYYY	Enter the date the service was rendered in the "from" and "to" boxes in the MMDDYY format. If services were provided on only one date, they will be indicated only in the "from" column. If the services were provided on multiple dates (i.e., DME rental, hemodialysis management, radiation therapy, etc), the range of dates and number of services should be indicated. "To" date should never be greater than the date the claim is received by the Health Plan.
24b	Place of Service	Required	2 digit number	Enter one code indicating where the service was rendered.
24c	Emergency Service	Optional		Check box and attach required documentation.
24d	Procedures, Services or Supply Code including modifiers if applicable NDC numbers	Required		Enter the applicable CPT and/or HCPCS National codes in this section. Modifiers, when applicable, are listed to the right of the primary code under the column marked "modifier". If the item is a medical supply, enter the two-digit manufacturer code in the modifier area after the five-digit medical supply code. ***Reminder***: Payment modifiers should be in first position.
24e	Diagnosis Pointer	Required		Enter the diagnosis code number from box 21 that applies to the procedure code indicated in 24D.
24f	Charges	Required		Enter the charge for service in dollar amount format. If the item is a taxable medical supply, include the applicable state and county sales tax.
24g	Days or Units	Required		Enter the number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc. Do not enter a decimal point or leading zeroes. Do not leave blank as units should be at least 1.

Appendix A MIF Claims Requirements for 1500 Professional Form Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
24h	EPSDT Family Plan	Optional		Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related
24i	ID Qualifier	Optional		Enter "X" if billing for emergency services.
24j	Provider ID Number Taxonomy Rendering Provider NPI Number	Optional Required	10 alpha numeric 10 digit number	Enter the Rendering Provider's NPI number
25	Federal Tax ID Number	Required	9 digit number	Enter the Federal Tax ID for the billing provider.
26	Patient's Account Number	Required	Length 20 max.	Enter the patient's medical record number or account number in this field. This number will be reflected on Explanation of Benefits (EOB) if populated.
27	Accept Assignment	Required		Check Yes or No
28	Total Charge	Required		Enter the total for all services in dollar and cents. Do not include decimals. Do not leave blank.
29	Amount Paid	Required (if applicable)		Enter the amount of payment received from the Other Health Coverage or member. Enter the full dollar amount and cents. Do not enter Medicare payments in this box.
30	Reserved	DO NOT USE		
31	Signature of Practitioner or Supplier and Date	Required		The claims must be signed and dated by the provider or a representative assigned by the provider in black pen. An original signature is preferred. Stamps are also acceptable. Initials and other facsimiles are not acceptable.
32	Service Facility Location/Location where services were rendered	Required		Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.
32a	Service Facility NPI if different from Billing Provider NPI	Required (if applicable)	10 digit number	Enter the NPI of the facility where the services were rendered.
32b	Other ID	Optional		Enter the provider number for an atypical service facility.
33	Billing Provider/Supplier's Name, Address, & Telephone Number as it appears on your W-9	Required		Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number.
33A	Billing Provider/Supplier's NPI Number	Required	10 digit number	Enter the billing provider's NPI.
33b	Other ID	Optional		Used for atypical providers only. Enter the provider number for the billing provider.

Appendix B MIF Claims Requirements for UB Institutional Forms: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
1	Provider Name, Address, and Phone	Required	Do not use P.O. boxes	Enter the provider name, address and zip code and telephone number this section.
2	Pay-to Name, address and Secondary Identification Fields	Required (If different than 1)		Enter the provider name, address and zip code and telephone number this section.
3a	Patient Control Number	Required	Length 20 max.	This number is reflected on the Explanation of Benefits for reconciling payments if populated.
3b	Medical/Health Record Number	Optional		This number will not be reflected on EOB if populated.
4	Type of Bill	Required	4 digit code	Enter the appropriate four-character type of bill code.
5	Federal Tax Number Pay-to-provider ≠ Billing Provider	Required	9 digit number.	Enter the Federal Tax ID for the billing facility.
6	Statement Covers Period (From-Through)	Required	MMDDYY	Enter the "From" and "Through" dates of services covered on the claim if claim is for inpatient services.
7	Not Used	DO NOT USE		
8a	Patient's Name	Required		Enter patient's name in 8b
8b	Patient Identifier	Required		Enter patient's last name, first name and middle initial if known.
9a-e	Patient's Address, State, and Zip Code	Required		Enter Patient Address
10	Patient's Date of Birth	Required	MMDDYYYY	Enter the patient's date of birth in an eight digit format, Month, Date, Year (MMDDYYYY) format.
11	Patient's Sex	Required	F or M	Use the capital letter "M" for male, or "F" for female.
12	Admission Date	Required (if applicable)	MMDDYY	Enter in a six-digit format (MMDDYY), enter the date of hospital admission.
13	Admission Hour	Required (if applicable)	Military Standard Time (00-23)	Enter hour of patient's admission.
14	Type of Admission	Required	Single digit code: 1-9	Enter the numeric code indicating the necessity for admission to the hospital. 1 - Emergency 2 – Elective

Appendix B MIF Claims Requirements for UB Institutional Forms Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
15	Source of Admission	Required	Single code: 1-9; A-Z	If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. 1 - Non-Healthcare Facility Point of Origin 2 – Clinic 4 - Transfer from a Hospital (Different Facility) 5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 - Transfer from Another Healthcare Facility 7 - Emergency Room 8 - Court/Law Enforcement 9 - Information Not Available B - Transfer from Another Healthcare Facility C - Readmission to the same Home Health Agency D - Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E - Transfer from Ambulatory Surgery Center F - Transfer from Hospice and is under a hospice plan of care or enrolled in a hospice program
16	Discharge Hour	Required (if applicable)	Military Standard Time (00-23)	Enter the discharge hour. For Inpatient only.
17	Patient Status	Required		Enter Patient Discharge Status
18-28	Condition Codes If Applicable Type of Admission	Required (if applicable)		
29	Accident State	Optional	2 alpha abbreviation	If visit or stay is related to an accident, enter in which state accident occurred.
30	Not Used	DO NOT USE		
31-34	Occurrence Codes and Dates	Required (if applicable)	MMDDYYYY	Enter the codes and associated dates that define the significant even related to the claim. Occurrence Codes covered by SFHP: 01 - Auto Accident 02 - No Fault Insurance Involvement - Including Auto Accident/Other 03 - Accident/Tort Liability 04 - Employment Related 05 - Other Accident 06 - Crime Victim
35-36	Occurrence Span Codes and Dates	Required (if applicable)	MMDDYYYY	Enter Occurrence Span Codes and Dates
37	Not Used	DO NOT USE		
38	Responsible Party Name and Address	Required (if applicable)		Enter the name and address of the party responsible for payment if different from name in box 50
39-41	Value Codes and Amounts	Required (if applicable)		Enter Value Codes and Amounts
42	Revenue Code	Required	4 digit code	Enter the four-digit revenue code for the services provided, e.g. room and board, obstetrics, etc.

Appendix B MIF Claims Requirements for UB Institutional Forms Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
43	Revenue Description	Required (if applicable)		Enter the description of the particular revenue code in box 42 or HCPCS code in box 44. Include NDC/UPN Codes here, when applicable.
44	CPT/HCPCS only	Required (if applicable)		Enter the applicable HCPCS codes and modifiers. For outpatient billing do not bill a combination of HCPCS and Revenue codes on the same claim form. When billing for professional services, use CMS 1500 form.
45	Service Dates	Required	MMDDYYYY	Enter the service date in MMDDYY format for outpatient billing.
46	Units of Service	Required		Enter the actual number of times a single procedure or item was performed or provided for the date of service.
47	Total Charges	Required		Enter Total Charges (By Rev. Code)
48	Non-covered Charges	Optional		Enter Non-Covered Charges
n/a	Creation Date	Required		
n/a	Totals	Required		
49	Not Used	DO NOT USE		
50a-c	Payer Name	Required		
51a-c	National Health Plan Identifier	Optional		Enter Health Plan ID
52a-c	Release of Information Certification Indicator	Required		Check Yes or No
53a-c	Assignment of Benefits Certification Indicator	Required		Check Yes or No
54a-c	Prior Payments	Required if Applicable		Enter any prior payments received from Other Coverage in full dollar amount.
55a-c	Estimated Amount	Optional		Enter Estimated Amount Due
56	National Provider ID (NPI)	Required	10 digit number	Enter NPI number
57a-c	Other Provider ID	Optional	10 digit number	Enter Other Provider IDs
58a-c	Insured's Name	Required		Enter the mother's name if billing for an infant using the mother's ID. If any other circumstance, leave blank.
59a-c	Patient's Relationship to Insured	Required		Enter "03" (child) if billing for an infant using the mother's Identification Number
60a-c	Insured's Unique ID	Required	12 alpha numeric	Enter the patient's 12-digit MIF ID number as it appears in the member's ID card.
61a-c	Insurance Group Name	Optional		Enter Insured Group Name
62a-c	Insurance Group Number	Optional		Enter Insured Group Number
63a-c	Treatment Authorization Code	Optional		Enter any authorizations numbers in this section. It is not necessary to attach a copy of the authorization to the claim. Member information from the authorization must match the claim.

Appendix B MIF Claims Requirements for UB Institutional Forms Continued: claims received with missing required elements will be rejected

Field #	Field Name	Instruction	Formatting Requirement	Description
64	Document Control Number (DCN)	Required for correction or voiding of a claim only		When the Type of Bill in box 4 ends in a 7 or an 8 enter the Claim ID number of the claim you are requesting to correct or void. This can be found on your Remittance Advice
65	Employer Name	Optional		Enter Employer Name
66	Diagnosis and Procedure Code Qualifier ICD Indicator:	Required	10 digit alpha numeric	Enter: 0—ICD-10-CM Diagnosis
67	Principle Diagnosis Code	Required	10 digit alpha numeric	Enter all letters and/or numbers of the ICD-9 or 10 CM code for the primary diagnosis including the fourth and fifth digit if present
67A-Q	Other Diagnosis Code (including POA Codes)	Required (if applicable)	10 digit alpha numeric	Enter all letters and/or numbers of the secondary ICD-9 or 10 CM code including fourth and fifth digits if present.
68	Not Used	DO NOT USE		
69	Admitting Diagnosis	Required (if applicable)	10 digit alpha numeric	Enter Admitting Diagnosis Code
70A-C	Patient's Reason for Visit	Required (if applicable)	10 digit alpha numeric	Enter Patient's Reason for Visit Code
71	Prospective Payment System (PPS) Code	Optional		Enter PPS Code
72	External Cause of Injury (ECI) Code	Optional	10 digit alpha numeric	Enter External Cause of Injury Code
73	Not Used	DO NOT USE		
74	Principle Procedure Codes and Date	Required (if applicable)	MMDDYYYY	Enter Principal Procedure Code/Date
74a-e	Other Procedure Codes and Dates	Required (if applicable)	MMDDYYYY	Enter Other Procedure Code/Date
75	Not Used	DO NOT USE		
76	Attending Provider Name and Identifiers (including NPI)	Required (if applicable)	10 digit number	Enter Attending Name/ ID-Qualifier 1G
77	Operating Provider Name and Identifiers (including NPI)	Required (if applicable)	10 digit number	Enter Operating ID
78-79	Other Provider Name and Identifiers (including NPI)	Required (if applicable)	10 digit number	Enter Other ID
80	Remarks	Optional		Enter Remarks
81a-d	Code to Code Field	Optional		Enter Code-Code Field/Qualifiers