

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**  
**GENERAL INSTRUCTIONS**

General hospitals and freestanding comprehensive primary health care and ambulatory surgery center diagnostic and treatment centers issued an operating certificate pursuant to Article 28 of the Public Health Law that have not filed a DOH-4405, Provider Election Form for Medicaid Withholding, with the Department of Health's Pool Administrator are required to return surcharge payments received directly from the Medical Assistance Program. The completed report, corresponding payment and certification must be submitted within five days of receipt of each check received for Medical Assistance surcharges.

HEALTH CARE REFORM ACT - PUBLIC GOODS POOL  
REPORT OF MEDICAL ASSISTANCE SURCHARGE  
PAYMENTS FOR NON-ELECTING PROVIDERS

For Surcharge Medical Assistance Payment Received on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Provider Name: \_\_\_\_\_ Operating Certificate # \_\_\_\_\_

**WHOLE DOLLARS ONLY**

Pursuant to the New York State Health Care Reform Act, each year's pool receipts are dedicated to specific purposes and in specific amounts. As a result, reports filed by providers must segregate medical assistance surcharge payments into service year portions. For example, providers must report the medical assistance surcharge payment amount received, from the Medical Assistance Program, for services provided during the service year reported on the corresponding lines below.

Enter the medical assistance payment surcharge amount received directly from the Medical Assistance Program on the appropriate service year line specified below:

SERVICE YEAR	SURCHARGE AMOUNT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

A check made payable to the "Public Goods Pool", along with this completed form, must be mailed within 5 days from receipt of EACH Medical Assistance payment of surcharges to:

**Regular Mail**

Mr. Jerome Alaimo, Director  
Office of Pool Administration  
Excellus BlueCross BlueShield  
Central New York Region  
P.O. Box 4757  
Syracuse, New York 13221-4757

**Express or Overnight Mail**

Mr. Jerome Alaimo, Director  
Office of Pool Administration  
Excellus BlueCross BlueShield  
Central New York Region  
333 Butternut Drive  
Syracuse, New York 13214-1803

**PROVIDER CERTIFICATION**

For Surcharge Medical Assistance Payment Received on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

PROVIDER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FEDERAL TAX ID#: \_\_\_\_\_

OPERATING CERTIFICATE #: \_\_\_\_\_

COMPLETED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

**TYPE OF PROVIDER (check the appropriate box below):**

- ARTICLE 28 GENERAL HOSPITAL
- ARTICLE 28 DIAGNOSTIC & TREATMENT CENTER –  
providing a comprehensive range of primary health care services
- ARTICLE 28 DIAGNOSTIC & TREATMENT CENTER –  
providing ambulatory surgical services

**CERTIFICATION**

I, \_\_\_\_\_, CERTIFY THAT I AM THE CHIEF  
EXECUTIVE/FINANCIAL OFFICER AND/OR ADMINISTRATOR OF THE ABOVE MENTIONED ORGANIZATION, AND  
FURTHER CERTIFY TO ALL OF THE FOLLOWING:

- THAT THE DATA BEING PROVIDED HAS BEEN CAREFULLY PREPARED FROM THE BOOKS AND RECORDS WITHIN  
THIS ORGANIZATION IN ACCORDANCE WITH THE INSTRUCTIONS CONTAINED HEREIN, INCLUDING BUT NOT  
LIMITED TO THE PROPER SEGREGATION OF INFORMATION BY SERVICE YEAR AND,
- TO THE BEST OF MY KNOWLEDGE, I BELIEVE THE INFORMATION PRESENTED HEREIN IS ACCURATE AND  
CORRECT.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TYPE/PRINT NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_