NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 18, 2015

To: All NYS EMS Agencies
Re: Voucher Submissions for
Training Reimbursements

To Whom It May Concern:

The New York State Office of the State Comptroller has issued a new Claim For Payment voucher, AC3253-S, which replaces the previous form, AC92. Effective as of the date of this letter, all Claims For Payment must be submitted using AC3253-S.

Agencies are eligible to submit to the Bureau of EMS for reimbursement for those members and/or employees of their agency, who have become certified through a NYS BEMS Certification Course. BEMS Policy 09-06 outlines all eligibility and submission requirements. Please make sure you follow Policy 09-06 and any future updates to this policy.

Form AC3253-S is a fill-in-able Adobe PDF document, which can be filled out on your computer, printed, then submitted to BEMS. We encourage you to take advantage of this format instead of printing the form and then filling it out so the form is legible and accurate. Following are the instructions to fill out the form:

A maximum of 6 providers can be on a single voucher. If you have more than 6 providers, you must submit additional vouchers. Only one certification level can be submitted on one voucher. For example, if you have 2 providers (1 EMT and 1 Paramedic) you are submitting for reimbursement, you need to complete 2 separate vouchers.

Agency Code	Your BEMS 4 digit agency code.
Vendor Name	Agency name.
Address, City, State, Zip Code	Agency's official mailing address.
Vendor Identification Number	Agency's vendor ID number as assigned by the Office of the State Comptroller. If you have not received your vendor ID, please go to: http://www.sfs.ny.gov/ and follow the information for "Vendor Support".
Invoice Number ***Updated 9/18/2015***	EMS – Agency Code – Course Number – Date of invoice For Example: **EMS-4519-125076-09/18/15** For CME Program: **CME-4519-125000-09/18/15**
Course Level	The level of the certified provider(s) you are seeking reimbursement.
Course Number	Course number the provider attended to become certified. If this is a CME recertification, no course number is required for agencies.
Original, Refresher, CME	Check the box that is appropriate for the course the provider took to become certified. Only one box may be checked.
Cert. Number	Certified provider's BEMS certification number.

Provider's Name	Certified provider's name you are submitting for reimbursement.
Number Passed State Written Exam	Total number of certified providers you are listing on this voucher.
Reimbursement Rate	The reimbursement rate that corresponds to the course level and if it was original, refresher or CME. Please make sure you are using the current rate as listed in Policy 0-06.
Amount	This will automatically calculate for you.
Total	This will automatically calculate for you.
Discount %	Leave blank.
Net	This will automatically calculate for you.
Vendor's Signature	Must be signed in ink once form is printed.
Title	Title of person signing this voucher.
Date	Date of signature.
Name of Company	Leave blank.

The AC3253-S and other information can be found on our web site at: http://www.health.ny.gov/nysdoh/ems/main.htm. If you have questions regarding submission of vouchers, please contact our Funding Unit at (518) 402-0996.

Sincerely,

Andrew G. Johnson, BS, EMT-P, CIC
Deputy Director for Education and Certification
Bureau of Emergency Medical Services

AC3253-S (Effective 1/12)

State of New York

CLAIM FOR PAYMENT

Agency Code:

Vendor Information

Vendor Name	Vendor Identification Number		
Address	City	State	Zip Code
	Invoice Number		

Purchase Order No. and Date	Description of Materials/Service	Quantity	Unit	Price	Amount
	Course Level: Original ☐ Refresher ☐ CME ☐ Course Number: Cert. Number Provider's Name Number Passed State Written Exam: Reimbursement Rate per Student: **$000** ***Current rates can be found in the current Funding Policy on the Bureau's web site.***				**$0**

Vendor Certification

I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Vendor's Signature in Ink _____ Title _____

Date _____ Name of Company _____

Total	**$0**
Discount %	
Net	**$0**

NYS Agency Information

Vendor Identification Number	Vendor Location ID		Vendor Address Sequence	
Voucher ID	Business Unit Name	Bus. Unit	Interest Eligible (Y/N)	Contract ID
Payment Date (MM) (DD) (YY)	Liability Date (MM) (DD) (YY)		Merch/Inv. Rec'd Date (MM) (DD) (YY)	
Withholding Class	Withholding Amount	Handling Code	Payee Amount	
Invoice Number	Invoice Date			

PeopleSoft Format Charge Lines (If Applicable)

Business Unit	Department	Program	Fund	Account
DOH01	3450355	28308	20809	60301
Budget Reference	Project ID	Activity	Class	Operating Unit
Product	Chartfield 1 - Accumulator	Chartfield 2 - Agency Use	Chartfield 3	Amount
	11850			

Legacy Format Charge Lines (If Applicable)

Expenditures								Liquidation			
Dept	Cost Center	Var	Yr.	Object	Accum Dept.	Accum Statewide	Amount	Orig.Agency	PO/Contract	Line	F/P

Liability Date	From Date	TC	Subledger	Optional