

New York State Office of Pool Administration HCRA Menu

New York State Office of Pool Administration	
Home Page	Payors that have elected to pay the Public Goods Pool directly, third party administrators that have elected to participate in the Pool on behalf of their electing clients, and HCRA designated providers are required to file their Public Goods Pool reports electronically. In order to file electronically, you must establish an "Electronic Filing Account" , and have an assigned secure password with the Pool Administrator. Refer to "Frequently Asked Questions" , to learn more about obtaining an electronic filing password. To file a Public Goods Pool report electronically, refer to "HCRA Electronic Reporting" .
What's New	
Frequently Asked Questions	
HCRA Electronic Reporting	To see if you are a qualified electing payor, we've posted the "Elector List" , an alphabetical list of organizations that have voluntarily elected to make public good payments directly to the Department of Health's Pool Administrator. To be included on the list, an organization must have elected in conformance with HCRA provisions and Department requirements. This list is updated monthly.
Third Party Administrator Options	To see if you are a HCRA designated provider, we've posted the "Provider List" , a list of New York State health care providers, which offer services subject to HCRA surcharges. The list is subdivided by provider type as follows: general hospitals, comprehensive diagnostic and treatment centers, diagnostic and treatment centers that provide ambulatory surgical services, and clinical laboratories. Also included are extension clinics affiliated with hospitals and comprehensive diagnostic and treatment centers. Providers are listed alphabetically within provider type. This list is updated monthly.
Payor Options	
Provider Options	
Report And Payment Due Dates	All HCRA designated hospitals and comprehensive diagnostic and treatment centers are required, as part of their monthly Public Goods reporting, to review and submit to the Office of Pool Administration their extension clinic information, or to submit that there are no affiliated clinics. To review your Extension Clinic List, click on "Provider Options" and login using your Public Goods User ID and Password. You may make changes as often as necessary, however the list must be reviewed and submitted at least once every thirty (30) days prior to entering the financial portion of your Public Goods Pool report. When the information is submitted it will be reflected on the Provider List updated monthly.
New York State Department of Health Elector List	
New York State Department of Health Provider List	We are continually working to improve the accessibility of our web site. If you have a suggestion or comment, please "Contact Us" .
Documentation and Forms	More information about the New York State Health Care Reform Act, can also be obtained by referring to "New York State Department of Health HCRA Information" or "Frequently Asked Questions" .
New York State Department of Health HCRA Information	The forms on this page require Adobe Acrobat Reader Software to view or print them. If you do not have Adobe loaded on your computer, you can download a free version of Adobe Reader at www.adobe.com/products/acrobat/readstep2.html

This page provides basic information about The Health Care Reform Act (HCRA). It also includes links to the website of the New York State Department of Health if you require further information regarding HCRA.

Click on the Provider Options link to go to the next page. Then select the Bank Account Information option from the list of Provider Options.

NOTE: Each page will have a HELP link in the upper right-hand corner. You may click on the HELP link to retrieve the instructions for each page.

Provider Options Screen



This screen requires you to select one of the following options: Extension Clinic List, Bank Account Information, Distributions, or Delinquency Report.

To make your selection, click in the circle next to the option you want and then click on the Submit button to continue to the next screen.

NOTE: Hospitals must login with their Public Goods User ID and Password to access the Bank Account Information option. Hospitals may login with either their Public Goods or 1% Statewide UserID and Password to use the Delinquency Report option.

- The Extension Clinic List option is applicable to Hospitals and Comprehensive Diagnostic and Treatment Centers and must be verified at least every 30 days or prior to submitting the Health Care Reform Act (HCRA) Public Goods Pool Report.

- The Bank Account Information option is used to send HCRA distributions from the Office of Pool Administration directly into your facility's designated bank account via an Automated Clearing House (ACH) wire transaction.

- The Distributions option allows you to view, download and/or print the backup documentation for the distributions issued to your facility (if any).

- The Delinquency Report option allows you to request, view, download and/or print the current delinquency report for your facility (if any).

NOTE: The delinquency information for Hospitals will include both the Public Goods and the 1% Statewide reports (if any).

(Provider Options Screen is continued on the next page.)

Provider Options Screen

(Continued from Prior Page)

Extension Clinic List: Click here if you wish to verify your Extension Clinic List.

Bank Account Information: Click on this option to enter your bank account information.

Distributions: To retrieve the distribution information for your facility, click on this option.

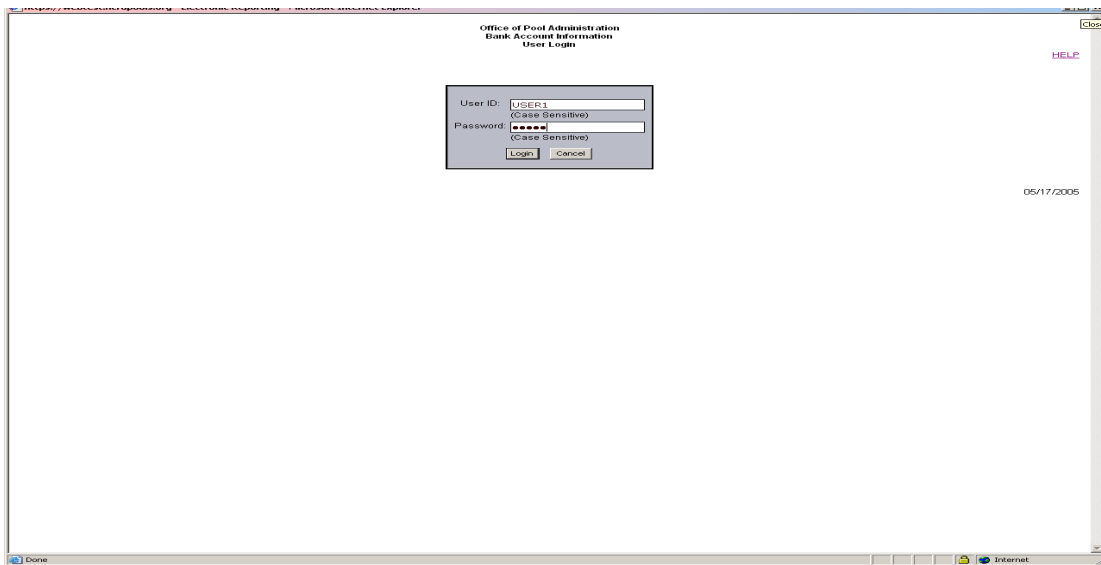
Delinquency Report: Click this option to request and retrieve the current delinquency information for your facility.

NOTE: The delinquency information for Hospitals will include both the Public Goods and the 1% Statewide reports (if any).

Submit: When you have made your selection, click the Submit button to proceed to the next screen.

Cancel: Click Cancel if you wish to exit or start over.

User Login Screen



This screen assures that the user has the proper authority to utilize the Office of Pool Administration's electronic report filing system.

NOTE: If you have lost your User ID and/or Password, you must contact the Office of Pool Administration in writing to receive a replacement. A copy of the User ID and Password will then be mailed to the individual who originally requested the password.

You may submit your request to the following email address: **webpools@hcrapools.org**.

You may also submit your request to the following address:

Office of Pool Administration
Excellus BlueCross BlueShield Central New York Region
333 Butternut Drive
Syracuse, NY 214-1803

User ID: Enter the User ID provided to you by the Office of Pool Administration. This is a required field.

NOTE: This field is case-sensitive.

Password: Enter the Password provided to you by the Office of Pool Administration. This is a required field.

NOTE: This field is case-sensitive.

Login: After you have entered your secure User ID and Password, click Login to proceed to the next screen.

Cancel: Click Cancel if you wish to exit or start over.

Bank Account Information: Provider Information Screen

Office of Pool Administration
Bank Account Information
Provider Information

Provider

This is the facility name and address currently on file with the Office of Pool Administration. This information is obtained from the Operating Certificate issued to the facility by the New York State Department of Health. The address shown is the physical location of the facility and cannot be changed to a billing address or other location.

If this information is correct, click the OK button to continue on to the next screen.

If the information shown is correct except for spelling errors, continue with the submission by clicking on the OK button. When your submission is complete, please notify the Office of Pool Administration of the spelling errors at (315) 671-3800 or via email: webpools@hcrapools.org.

If the facility displayed on the screen is not the correct facility (not your facility), please click on the Cancel button to exit this application and promptly notify the Office of Pool Administration at (315) 671-3800 or via email: webpools@hcrapools.org.

Operating Certificate Number: 1234567H
Name: TEST HOSPITAL
Address: TEST ADDRESS
City: ANY CITY
State: NY
Zip: 12345

OK Cancel Print

Done Internet

This screen displays the facility name and address currently on file at the Office of Pool Administration. This information is obtained from the Operating Certificate issued to the facility by the New York State Department of Health. The address shown is the physical location of the facility and cannot be changed to a billing address or other location.

Please review the information provided. If this information is correct, click the OK button to continue on to the next screen.

If the information shown is correct except for spelling errors, continue with the submission by clicking on the OK button. When your submission is complete, please notify the Office of Pool Administration of the spelling errors by calling (315) 671-3800 or via email: webpools@hcrapools.org.

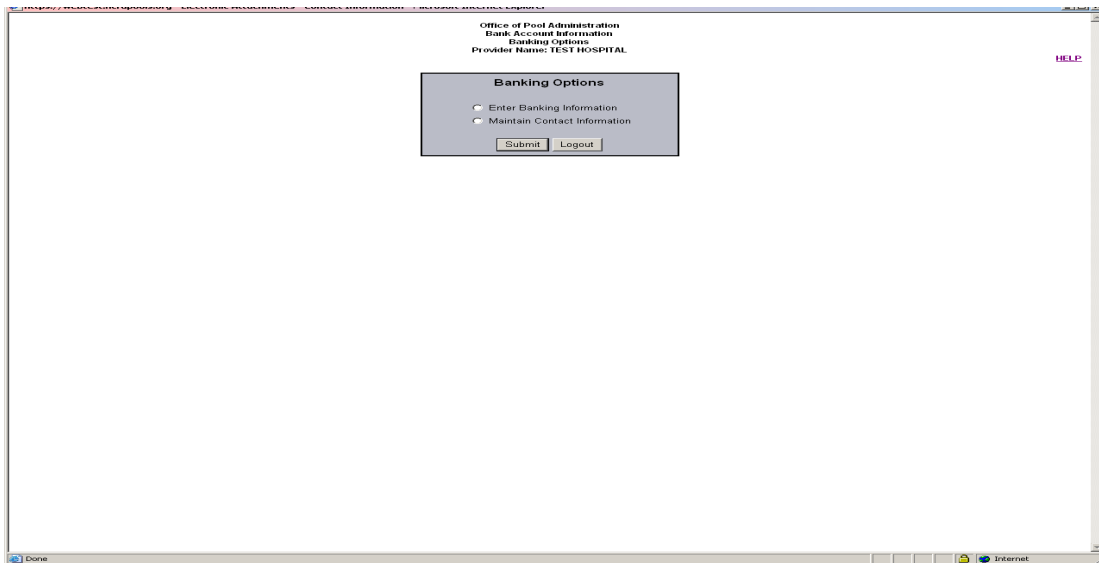
If the facility displayed on this screen is not the correct facility (not your facility), please click on the Cancel button to exit this application and promptly notify the Office of Pool Administration at (315) 671-3800 or via email: webpools@hcrapools.org.

OK: Click OK to proceed to the next screen.

Cancel: Click Cancel if you wish to exit or start over.

Print: Click here to print this screen for your records.

Bank Account Information: Banking Options Screen



This screen provides the banking information options. To make your selection, click in the circle next to the option you want and then click on the Submit button to continue to the next screen.

Enter Banking Information: Choose this option to enter the bank account information for your facility.

Maintain Contact Information: Choose this option to view, add, delete, or modify the contact information for your facility.

Submit: When you have made your selection, click the Submit button to proceed to the next screen.

Logout: Click the Logout button when you are ready to end this session.

Bank Account Information: Enter Banking Information Screen

Office of Pool Administration
Bank Account Information
Bank Information
Provider Name: TEST HOSPITAL

The information provided is used by the Office of Pool Administration to issue distribution funds to the facility indicated above via ACH wire transactions. Any changes must be submitted at least 7 days prior to the next distribution date. The Office of Pool Administration will verify the information/changes prior to the next distribution date.

Bank Account Number: 8888888888
Bank ACH ABA Number: 123456789
Type of Business Account: Checking Savings
Bank Name: BANK NAME
Address 1: 123 MAIN STREET
Address 2: PO BOX 123
City: ANY CITY
State: NY
Zip: 12345

Submit Return to Banking Options Cancel Print

This screen is used to enter the bank account information. This information will allow the Office of Pool Administration to issue distribution funds directly into this account through Automated Clearing House(ACH) wire transactions.

NOTE: Any changes must be submitted at least 7 days prior to the next distribution date. The Office of Pool Administration will verify the information/changes prior to the next distribution date.

Bank Account Number: Enter the facility's bank account number. The distribution funds will be deposited into this account. This is a required field.

NOTE: Only one bank account number can be entered for each facility.

Bank ACH ABA Number: Enter the ACH American Banking Association (ABA) Number. This may also be known as the Routing Number. This is a required field.

NOTE: Only one ABA number can be entered for each facility. The ABA number is 9 digits.

Bank Name: Enter the name of the bank. This is a required field.

Address 1: Enter the bank's address. This is a required field.

Address 2: Use this field to enter additional bank address information if necessary.

City, State, Zip: Enter the bank's city, state and zip code number. These are required fields.

Submit: When you have completed all required and applicable information on this screen, click the Submit button to proceed to the next screen.

Return to Banking Options: Click this button to go back to the Banking Options screen.

Cancel: Click Cancel if you wish to exit or start over.

Print: Click here to print this screen for your records.

Banking Information: Bank Details Confirmation Screen

Office of Pool Administration
Bank Account Information
Bank Details Confirmation
Provider Name: TEST HOSPITAL

HELP

Please review the information below. If modifications are needed, click the Back button to return to the Bank Account Information screen. If the information is correct, click the Submit Information button to complete this submission.

Bank Account Number:	55555555555
Bank ACH ABA Number:	123456789
Type of Business Account:	CHEQUING
Bank Name:	BANK NAME
Address:	123 MAIN STREET PO BOX 1-A
City:	ANY CITY
State:	NY
Zip:	12345

Submit Information Back Cancel Print

This screen allows you to review the facility's banking information. If modifications are needed, click the Back button to return to the Bank Account Information screen. If the information is correct, click the Submit Information button to complete the submission and send your banking information to the Office of Pool Administration.

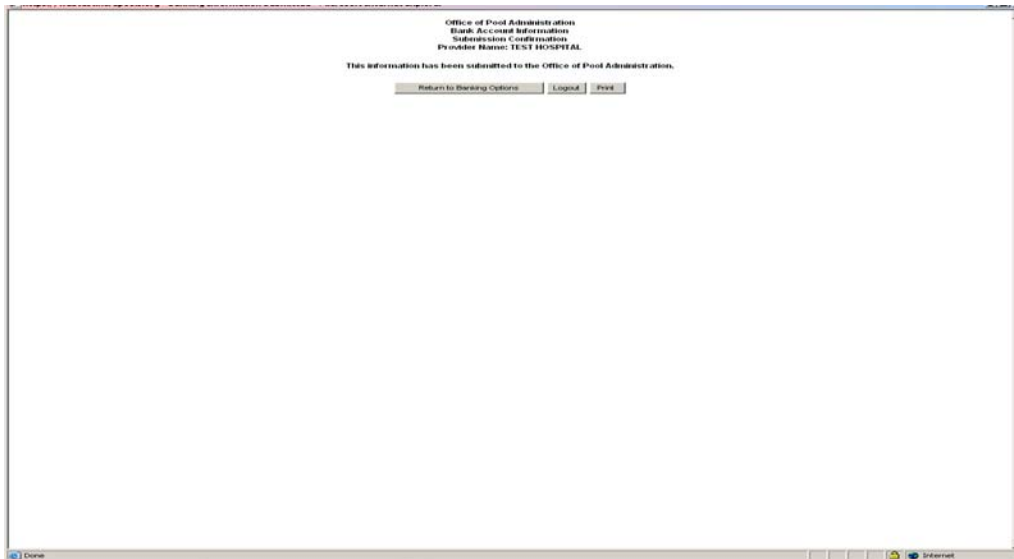
Submit Information: Click the Submit Information button to send the bank account information to the Office of Pool Administration.

Back: Click the Back button to return to the Enter Banking Information screen.

Cancel: Click Cancel if you wish to exit or start over.

Print: Click here to print this screen for your records.

Banking Information: Submission Confirmation Screen



This screen confirms that the bank account information you entered and reviewed on the previous screens has been submitted to the Office of Pool Administration. This information will allow the Office of Pool Administration to issue distribution funds directly into this account through Automated Clearing House (ACH) wire transactions.

NOTE: Any changes must be submitted at least 7 days prior to the next distribution date. The Office of Pool Administration will verify the information/changes prior to the next distribution date.

Return to Banking Options: Click this button to go back to the Banking Options screen.

Logout: Click the Logout button when you are ready to end this session.

Print: Click here to print this screen for your records.

Bank Account Information: Contact List Screen



This screen allows you to add, delete, or modify the Contact information. The Contact is the person or persons at your facility whom the Office of Pool Administration will contact if there are any problems regarding this information. You may enter as many Contacts as necessary, and a Contact may also be the same person who requested the User ID and Password. Prior to each wire distribution date, the Office of Pool Administration will send notification of ACH wire transactions to the Contact email addresses listed.

NOTE: If there are no Contacts listed for your facility, you will be directed to the Add Contact screen.

NOTE: The Date Submitted indicates the date that a new Contact was added or the date that a change was made to an existing Contact.

Delete: Click on the Delete button to remove this Contact from your Contact List.

Modify: Click on the Modify button if you wish to make changes to the information for an existing Contact. This action will take you to the Modify Contact screen.

Add Contact: Click on this button if you wish to add a Contact to your Contact List. This action will take you to the Add Contact screen.

Return to Banking Options: Click this button to go back to the Banking Options screen.

Logout: Click the Logout button when you are ready to end this session.

Print: Click here to print this screen for your records.

Banking Information: Add Contact Screen

Office of Pool Administration
Bank Account Information
Add Contact
Provider Name: TEST HOSPITAL

ACH wire transaction notification will be sent to the contact email address prior to wire distribution dates.

Contact Name: CHIEF FINANCIAL OFFICER
Contact Email: cfo_hospit adm@hospital.com
Contact Phone: 123-555-5555 Extension: 1212

Save Changes Return to Contact List Return to Banking Options Cancel Print

This screen allows you to add a new Contact to your facility's Contact List. Once all applicable information has been entered, you must click on the Save Changes button to finalize the addition. This action will then return you to the Contact List screen.

Contact Name: Enter the Contact name. This is a required field.

Contact Email: Enter a valid email address for the Contact. This is a required field.
NOTE: This field is case-sensitive.

Contact Phone: Enter the telephone number including area code, as an alternate method of contact. This is a required field.

Extension: Enter the telephone extension, if applicable.

Save Changes: After you have verified that the information entered is correct, click on the Save Changes button. This action will finalize the changes and return you to the Contact List screen.

Return to Contact List: Click on this button to return to your Contact List without making any changes/additions.
NOTE: This button is available only when the Contact List contains one or more entries.

Return to Banking Options: Click this button to go back to the Banking Options screen.

Cancel: Click Cancel if you wish to exit or start over.

Print: Click here to print this screen for your records.

Banking Information: Modify Contact Screen

Office of Pupil Administration
Bank Account Information
Modify Contact
Provider Name: TEST HOSPITAL

Contact Name	Contact Email	Phone Number	Date Changed	Action
Jane Doe	jane.doe@testhospital.org	(315)671-3000 ext 1234	Aug 21, 2007	Save Changes

Return to Contact List Return to Banking Options Cancel Print

HELP

This screen allows you to make changes to the information for an existing Contact. Once all modifications have been made, you must click the Save Changes button to finalize the changes. This action will then return you to the Contact List screen.

Contact Name: Enter the Contact name. This is a required field.

Contact Email: Enter a valid email address for the Contact. This is a required field.
NOTE: This field is case-sensitive.

Contact Phone: Enter the telephone number including area code, as an alternate method of contact. This is a required field.

Extension: Enter the telephone extension, if applicable.

Save Changes: After you have verified that the information entered is correct, click on the Save Changes button. This action will finalize the changes and return you to the Contact List screen.

Return to Contact List: Click on this button to return to your Contact List without making any changes/additions.

Return to Banking Options: Click this button to go back to the Banking Options screen.

Cancel: Click Cancel if you wish to exit or start over.

Print: Click here to print this screen for your records.