

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 11a
Anesthesia - Coinsurance
and Deductible

Form with 33 numbered sections containing patient information, insurance details, and provider information. Includes fields for name, address, birth date, insurance type, and charges.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

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Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 12a
Anesthesia -
Coinsurance Only

Form with 33 numbered sections containing patient and insured information, including names, addresses, birth dates, insurance details, and charges.

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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

8

Note: Your EOMB may be formatted differently.

**Example 12b
Anesthesia -
Coinsurance Only**

04/04/10 9:21A

PAGE 1

MEDICARE SERVICE CENTER
PROVIDER #: 2012345678
CHECK/EFT #: 880099999

ALASKA ANESTHESIA LLC
04/04/10

MEDICARE
REMITTANCE
NOTICE

| PERF | PROV | SERV DATE | POS | NOS | PROC | MODS | BILLED | ALLOWED | DEDUCT | COINS | GRP/RC-AMT | PROV PD |
|------------|-----------|-----------|-----|-----|---------------|----------------|--------|-------------------|-------------------|-------|---------------------|-----------------------|
| ----- | | | | | | | | | | | | |
| | DOE, JANE | | | | | HIC 987654321A | | ACNT 11434-099999 | ICN 1111987654321 | | ASG Y MOA MA01 MA07 | |
| 2012345678 | 0320 | 032010 | 24 | 000 | 01740 | QZ | 251.02 | 213.12 | .00 | 42.62 | C0-45 PR-2 | 37.90 170.50 42.62 |
| PT RESP | | 42.62 | | | CLAIM TOTALS: | | 251.02 | 213.12 | .00 | 42.62 | | 80.52 170.50 |

*** NOTE: CLAIM FORWARDED TO COMPLIMENTARY INSURER: STATE OF ALASKA MEDICAID PROGRAM

170.50 NET

1500

HEALTH INSURANCE CLAIM FORM

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Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 13a
Anesthesia -
Deductible Only

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form with 33 numbered sections containing patient and insured information, diagnosis, charges, and provider details. Includes fields for name, address, birth date, insurance type, and charges.

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Note: Your EOMB may be formatted differently.

***Example 13b
Anesthesia -
Deductible Only***

04/04/10 9:21A

PAGE 1

MEDICARE SERVICE CENTER
PROVIDER #: 2012345678
CHECK/EFT #: 880099999

ALASKA ANESTHESIA LLC
04/04/10

MEDICARE
REMITTANCE
NOTICE

| PERF | PROV | SERV DATE | POS | NOS | PROC | MODS | BILLED | ALLOWED | DEDUCT | COINS | GRP/RC-AMT | PROV PD |
|--|-----------|-----------|-----|-----|---------------|----------------|--------|-------------------|-------------------|-------|------------|-----------------------|
| ----- | | | | | | | | | | | | |
| | DOE, JANE | | | | | HIC 987654321A | | ACNT 11434-099999 | ICN 1111987654321 | | ASG Y MOA | MA01 MA07 |
| 2012345678 | 0320 | 032010 | 24 | 000 | 01740 | QZ | 251.02 | 213.12 | 42.62 | .00 | C0-45 PR-1 | 37.90 170.50 42.62 |
| PT RESP | | 42.62 | | | CLAIM TOTALS: | | 251.02 | 213.12 | 42.62 | .00 | | 80.52 170.50 |
| *** NOTE: CLAIM FORWARDED TO COMPLIMENTARY INSURER: STATE OF ALASKA MEDICAID PROGRAM | | | | | | | | | | | | 170.50 NET |
| ----- | | | | | | | | | | | | |

**Anesthesia
Examples 11 - 13
Instructions**

Completing the CMS-1500 Claim Form for Professional Medicare Crossover Paper Claims

Providers should complete the CMS-1500 for Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover components of these claims are listed below.

Rule: Only one service line per document is permitted.

Additional requirements for Professional Crossover claims:

| | | |
|-----------|--|--|
| 1. | Field 1: | Check both the Medicare and Medicaid box. |
| 2. | Field 10d: <i>RESERVED FOR LOCAL USE</i> | Enter the Medicare pay date using the mm/dd/yy format. |
| 3. | Field 11: <i>INSURED'S POLICY GROUP OR FECA NUMBER</i> | Enter the word "MEDICARE". |
| 4. | Field 19: <i>RESERVED FOR LOCAL USE</i> | Enter the deductible amount using qualifier A1 and the coinsurance amounts using qualifier A2; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44). If there was a third-party payment from a source other than Medicare, enter this amount using qualifier TP; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44 TP 42.00). |
| 5. | 24f, shaded area: \$ <i>CHARGES</i> | Enter the Medicare allowed amount. Be sure to enter the decimal point. |
| 6. | Field 28: <i>TOTAL CHARGE</i> | Enter the Medicare billed amount. |
| 7. | Field 29: <i>AMOUNT PAID</i> | Enter the Medicare paid amount. |
| 8. | The EOMB | A copy of the Medicare EOMB must be attached to the claim. |

For more information on completing the CMS-1500, download the appropriate claim form instructions at: <http://medicaidalaska.com/providers/provupdates.shtml>