

- Medicare is Primary
- Blue Cross is Secondary
- Medicaid is Tertiary

**Example 3a**  
**Inpatient w/ Medicare**  
**& Third-Party**  
**Coinsurance Only**

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2	3a PAT. CNTL. # 0812345	4 TYPE OF BILL 0111
8 PATIENT NAME a DOE, JANE E.			9 PATIENT ADDRESS a	

10 BIRTHDATE 03 20 08	11 SEX 08	12 DATE 08	13 HR 1	14 TYPE 7	15 SRC 17	16 DHR 01	17 STAT 01	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28				29 ACDT STATE 30	
31 OCCURRENCE DATE 50 03 28 08	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	OCCURRENCE FROM THROUGH 2		36 CODE	OCCURRENCE SPAN FROM THROUGH 3		37	38	39 CODE 80	VALUE CODES AMOUNT 2	40 CODE A2	VALUE CODES AMOUNT 942.40	41 CODE	VALUE CODES AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD - SEMI-PRIVATE			2	209800		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001	PAC 4 OF 1	CREATION DATE	04 05 08	TOTALS 6	471200	0
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50 PAYER NAME MEDICARE BLUE CROSS MEDIACAID	51 HEALTH PLAN ID	52 REL INFO Y Y Y	53 ASG BEN.	54 PRIOR PAYMENTS 3769.60 439.30	55 EST. AMOUNT DUE 0 503.10	56 NPI 1234567890	57 BY OTHER 020024	58 PRIV ID HS99IP
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58 INSURED'S NAME DOE, JANE E. DOE, JANE E. DOE, JANE E.	59 P.REL.	60 INSURED'S UNIQUE ID 574500000A 1234567890 0600611111	61 GROUP NAME	62 INSURANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 DX 4801	68
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69 ADMIT DX 4801	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE 8701	DATE 032008	a OTHER PROCEDURE CODE	b OTHER PROCEDURE DATE	75
c OTHER PROCEDURE CODE	d OTHER PROCEDURE DATE	e OTHER PROCEDURE CODE	e OTHER PROCEDURE DATE	
80 REMARKS	81CC a b c d	76 ATTENDING NPI	QUAL	
		77 OPERATING NPI	QUAL	
		78 OTHER NPI	QUAL	
		79 OTHER NPI	QUAL	

RUN DATE: 03/28/08  
 RUN TIME: 1412  
 RUN USER: DBCOOPER

7

Central Alaska Hospital  
 REMITTANCE REPORT

**Example 3b**  
**Inpatient w/ Medicare**  
**& Third-Party**  
**Coinsurance Only**

RA NUMBER: 000000001      RA DATE: 03/28/08      FILE NUMBER: 1223      CLAIM TYPE: 111

PROVIDER  
 NUMBER: 020024  
 NAME: CENTRAL ALASKA HOSPITAL  
 ADDRESS: 1000 HOSPITAL DR.  
 CITY/ST/ZIP: ANYTOWN, AK 99500-0000

PAYER  
 C24  
 MEDICARE PART A  
 PO BOX 6720  
 FARGO ND 58108-6720

**Note: Your EOMB may be  
 formatted differently.**

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
MEDICAL RECORD NUMBER	INTERNAL CONTROL NO	COST DAYS	COV DAYS	NONCOV DAYS	C O	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE-DUCTABLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED	
DOE, JANE E. 00047960	0812345 12345678901234	0 0	574500000A 2	03/20/08	03/22/08		4712.00 0.00	0.00 0.00	0.00 0.00	942.40 0.00	0.00 0.00	0.00 0.00	3769.60
CAPITAL PMT: HOLD HARM:	0.00 0.00	HSP: IME-ADJ:	0.00 0.00			FSP: 0.00 EXCEPTIONS: 0.00	DSH ADJ: 0.00					DRG CODE:	
COVERD CHARGES:	4712.00	CLAIM STATUS CODE:	0			TYPE OF BILL: 111							

CLAIM LEVEL  
 Reason Codes      Reason Amts      Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0120		03/20/08 - 03/22/08	2098.00	1678.40			
0270		03/20/08 - 03/22/08	256.00	204.80			
0350		03/20/08 - 03/22/08	976.00	780.80			
0450		03/20/08 - 03/22/08	1063.00	850.40			
0460		03/20/08 - 03/22/08	319.00	255.20			



P.O. Box 240489  
Anchorage, AK 99524

8

*Note: Your EOB may be formatted differently.*

*Example 3c  
Inpatient w/ Medicare  
& Third-Party  
Coinsurance Only*

Page C-20  
Date of Payment: MARCH 23, 2008  
Check Number: 0987654321  
Payment Reference #: 1234567890123456  
Provider Number: 200098765432  
Provider Tax ID Number: 123123123  
NPI ID: 1212121212

CENTRAL ALASKA HOSPITAL  
1000 Hospital Drive  
ANYTOWN, AK 99500-0000

**MARCH 23, 2008  
DETAILED EXPLANATION OF PAYMENT**

Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider of Service  Product	SERVICE DATES	Rev Code	UNITS BILLED/ ALLOWED	APC/ APG/ DRG/ ROOM TYPE	BILLED CHARGES	INFORMATIONAL	PROVIDER	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY	PAYABLE AMOUNT	REASON REMARKS	
						AMOUNT ALLOWED	ADJUSTMENT (A) DISALLOWED (D)		FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)			
AK HERITAGESELECT												
DOE, JANE	032008 032208	0120	2 / 2		419.60	419.60		0.00	0.00	209.80 C	209.80	
1234567890	032008 032208	0270	12 / 12		51.20	51.20		0.00	0.00	25.60 C	25.60	
0812345	032008 032208	0350	1 / 1		195.20	195.20				97.60 C	97.60	
SEUSS, THEODOR G	032008 032208	0450	2 / 2		212.60	212.60				106.30 C	106.30	
312894723498	032008 032208	0460	5 / 5		63.80	63.80				63.80 D		
CENTRAL HOSPITAL												
HERITAGE PLUS 1	Claim Total	Paid To: P			\$942.40	\$942.40		\$0.00	\$0.00		\$439.30	

Our records indicate your current TAX ID as being 920009999

Reason Remarks Explanation

- E CONDITION ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED.
- X THE COORDINATION OF BENEFITS INFORMATION RECEIVED IS INCOMPLETE. OTHER CARRIER PAYMENT INFORMATION IS NEEDED BEFORE CLAIM CAN BE PROCESSED.
- O BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
- P THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
- S A DISCOUNT WAS APPLIED TO THIS CLAIM.
- T THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET
- B THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
- M AMOUNT WHICH REIMBURSEMENT TO PROVIDER IS LESS THAN THE AMOUNT OF BILLED CHARGES.

*Example 3d  
Inpatient w/ Medicare  
& Third-Party  
Coinsurance Only*

## Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims

### Scenario: Inpatient Claim Form, with Medicare as Primary and Third-Party as Secondary

- Medicare is Primary
- Blue Cross is Secondary
- Medicaid is Tertiary

Providers should complete the UB-04 for institutional Medicaid 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 component of these claims are listed in *mm/dd/yy* format below.

#### **Additional requirements for Institutional Medicare crossover claims:**

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Already filled with covered days Value Code and Units
3. Field 40a:	Enter Value Code "A2", and the recipient's Medicare coinsurance amount. <b>Note:</b> Medicare is the primary payer in field 50A, therefore, the value code for Medicare coinsurance is A2.
4. Field 50: <i>Payer Name</i>	
<ul style="list-style-type: none"> <li>• Medicare is the primary payer;</li> </ul>	Line A: enter all information pertaining to Medicare.
<ul style="list-style-type: none"> <li>• Blue Cross is the secondary payer;</li> </ul>	Line B: enter all information pertaining to Blue Cross.
<ul style="list-style-type: none"> <li>• Medicaid is the tertiary payer;</li> </ul>	Line C: enter all information pertaining to Medicaid.
5. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> <li>• Medicare is the primary payer;</li> </ul>	Line A: enter the Medicare Paid Amount.
<ul style="list-style-type: none"> <li>• Blue Cross is the secondary payer;</li> </ul>	Line B: enter the Blue Cross Paid Amount.
<ul style="list-style-type: none"> <li>• Medicaid is the tertiary payer;</li> </ul>	Line C: no entry needed.
6. Field 55C: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid. <b>Note:</b> The entry in row C corresponds to the position of Medicaid as the tertiary payer in Field 50C.
7. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.
8. the Blue Cross EOB	A copy of the Blue Cross EOB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <http://medicaidalaska.com/providers/Billing.asp>.