

1 CENTRAL ALASKA HOSPITAL
1000 HOSPITAL DR.
ANYTOWN, AK 99500-0000
(907) 333-3333

- **Aetna is Primary**
- **Medicare is Secondary**
- **Medicaid is Tertiary**

Example 2a
Inpatient w/ Third-Party Insurance, Medicare & Medicaid

3a PAT. CNTRL. # 0812345
4 TYPE OF BILL 0111
5 FED. TAX NO. 032008 032208

8 PATIENT NAME a DOE, JANE E. 9 PATIENT ADDRESS a

10 BIRTHDATE 11 SEX 12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28 29 ACDT STATE 30

31 OCCURRENCE DATE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 CODE OCCURRENCE FROM THROUGH 36 CODE OCCURRENCE SPAN THROUGH 37

38 39 CODE VALUE CODES AMOUNT 40 CODE VALUE CODES AMOUNT 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 PAGE 5 OF 1 CREATION DATE 04 05 08 TOTALS 471200 0

50 PAYER NAME AETNA MEDICARE MEDICAID 51 HEALTH PLAN ID 52 REL INFO Y Y Y 53 ASG BEN. 54 PRIOR PAYMENTS 3627.94 599.98 55 EST. AMOUNT DUE 400.00 56 NPI 1234567890 57 OTHER 020024 58 PPV ID HS99IP

58 INSURED'S NAME DOE, JANE E. 59 P.REL. 60 INSURED'S UNIQUE ID 1234567890 574500000A 0600611111 61 GROUP NAME 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

66 DX 4801

69 ADMIT DX 4801 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73

74 PRINCIPAL PROCEDURE CODE 8701 75 OTHER PROCEDURE CODE 032008 76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST 78 OTHER NPI QUAL LAST FIRST 79 OTHER NPI QUAL LAST FIRST

**Example 2b
Inpatient w/ Third-Party
Insurance, Medicare &
Medicaid**



P.O. BOX 999999
HARTFORD, CT 06115-0431
USA



EXPLANATION OF BENEFITS

Please Retain for Future Reference
Central Alaska Hospital/ PIN: 0001111111
Page 1 of 1

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

Patient Name: JANE E. DOE (self)

Claim ID: E123BZB6T24 Recd: 03/28/08 Member ID: 1234567890 Patient Account: 0812345

Member: Jane E. Doe
Group Name: Acme Inc.
Product: HealthPlanChoice
AETNA LIFE INSURANCE COMPANY

DIAG: 4801
Group Number: 123456-99-123
Network ID: 02101 AETNA NAP HOSPITAL + PPOM

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
3/20-22/08	21	120	2	2098.00			98.00	1		400.00	98.00	1600.00
3/20-22/08	21	270	12	256.00			47.88	2		41.62		166.50
3/20-22/08	21	350	1	976.00			1.94	2		194.81		779.25
3/20-22/08	21	450	2	1063.00			29.00	2		206.80		827.20
3/20-22/08	21	460	5	319.00			5.26	2		58.75		254.99
TOTALS				4,712.00			182.08			901.98	98.00	3627.94

ISSUED AMT: \$3627.94

Remarks:

- 1 - We have paid the maximum allowed by your plan of benefits for this service. The balance is the member's responsibility.
- 2 - The Provider has agreed to accept a discount for this charge. The member is not responsible for this amount.

For Questions Regarding This Claim:
P.O. Box 2250, Anytown, USA 12345-6789

CALL 1-800-777-7777 FOR ASSISTANCE

Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: \$999.98

Claim Payment: \$3627.94

RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER

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Central Alaska Hospital
 REMITTANCE REPORT

Example 2c
Inpatient w/ Third-Party
Insurance, Medicare &
Medicaid

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 111

Note: Your EOMB may be formatted differently.

NUMBER:	PROVIDER	PAYER
020024	020024	C24
NAME:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
ADDRESS:	1000 HOSPITAL DR.	PO BOX 6720
CITY/ST/ZIP:	ANYTOWN, AK 99500-0000	FARGO ND 58108-6720

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCPC 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		999.98 0.00	0.00 0.00	0.00 400.00	250.00 0.00	150.00 0.00	0.00 0.00	599.98
CAPITAL PMT:	0.00	HSP:	0.00	FSP:	0.00	DSH ADJ:	0.00		0.00			DRG CODE:	
HOLD HARM:	0.00	IME-ADJ:	0.00	EXCEPTIONS:	0.00								
COVERD CHARGES:	999.98	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	498.00	198.40			
0270		03/20/08 - 03/22/08	41.62	33.30			
0350		03/20/08 - 03/22/08	194.81	155.84			
0450		03/20/08 - 03/22/08	206.80	165.44			
0460		03/20/08 - 03/22/08	58.75	47.00			

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

Scenario: Inpatient Claim Form, with Aetna Primary and Medicare Deductible and Coinsurance:

- Aetna is Primary
- Medicare 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 Amount. Enter the qualifier in the code field and the value in the amount field.
3. Field 40a: <i>Value Codes/Amount</i>	Enter Value Code "B1" and the Medicare deductible amount in the Amount field. Note: The value code used corresponds with the payer in field 50B.
4. Field 41a: <i>Value Codes/Amount</i>	Enter Value Code "B2" in the Code field. Medicare is in field 50B, thereby the Medicare coinsurance Value Code is B2. Enter the Medicare coinsurance in the Amount field.
5. Field 50: <i>Payer Name</i>	
<ul style="list-style-type: none"> • Aetna is the primary payer; 	Line A: enter all information pertaining to Aetna.
<ul style="list-style-type: none"> • Medicare is the secondary payer; 	Line B: enter all information pertaining to Medicare.
<ul style="list-style-type: none"> • Medicaid is the tertiary payer; 	Line C: enter all information pertaining to Medicaid.
6. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> • Aetna is the primary payer; 	Line A: enter the Aetna Paid Amount.
<ul style="list-style-type: none"> • Medicare is the secondary payer; 	Line B: enter the Medicare Paid Amount.
<ul style="list-style-type: none"> • Medicaid is the tertiary payer; 	Line C: no entry needed.
7. Field 55C: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid; this is the sum of the Medicare coinsurance and deductible amount. Note: Medicaid is the third payer in field 50C; therefore, the estimated amount due from Medicaid is entered in field 55C.
8. the Aetna EOB	A copy of the Aetna EOB must be attached to the claim.
9. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

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