

- Medicare is Primary
- Medicaid is Secondary

**Example 1a**  
**Inpatient Medicare**  
**Deductible &**  
**Coinurance**

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2		3a PAT. CNTRL. # 0812345	3b MED. REG. #	3c FED. TAX NO.	4 TYPE OF BILL 0111
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8 PATIENT NAME a DOE, JANE E.	9 PATIENT ADDRESS b	c	d	e
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10 BIRTHDATE	11 SEX	12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
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31 OCCURRENCE DATE 50 04 04 08	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE FROM THROUGH	37 CODE	38 OCCURRENCE SPAN THROUGH
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39 VALUE CODES AMOUNT 80 2	40 VALUE CODES AMOUNT A1 536.00	41 VALUE CODES AMOUNT A2 448.00
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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	7	471200	0
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50 PAYER NAME A MEDICARE B MEDICAID	51 HEALTH PLAN ID	52 REL INFO Y	53 ASG BEN. Y	54 PRIOR PAYMENTS 2240.00	55 EST. AMOUNT DUE 0	56 NPI 1234567890	57 020024	58 HS99IP
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58 INSURED'S NAME A DOE, JANE E. B DOE, JANE E.	59 P.REL.	60 INSURED'S UNIQUE ID 574500000A 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	75 OTHER PROCEDURE CODE 032008	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI

80 REMARKS	81CC a b c d
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**Example 1b**  
**Inpatient Medicare**  
**Deductible &**  
**Coinsurance**

RA NUMBER: 000000001      RA DATE: 04/04/08      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-DUCTIBLE	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	536.00 984.00	448.00 0.00	0.00 0.00	2240.00
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	209800	1014.67			
0270		03/21/08	25600	136.53			
0350		03/21/08	97600	520.53			
0450		03/20/08	106300	398.14			
0460		03/21/08	31900	170.13			

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

### Scenario: Inpatient Claim Form, with Medicare Deductible and Coinsurance

- Medicare is Primary
- Medicaid is Secondary

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 mm/dd/yy format.
2. Field 39a: <i>Value Codes/Amount</i>	Already filled with Covered days Value Code and Units
3. Field 40a: <i>Value Codes/Amount</i>	Enter Value Code "A1" and the Medicare deductible in the Amount field. <b>Note:</b> Medicare is the primary payer in field 50A, therefore, the value code for Medicare deductible is A1.
4. Field 41a: <i>Value Codes/Amount</i>	Enter Value Code "A2" in the Code field. Enter the Medicare coinsurance in the Amount field. <b>Note:</b> Medicare is the primary payer in field 50A, therefore, the value code for Medicare coinsurance is A2.
5. Field 50A: <i>Payer Name</i>	As Medicare is the primary payer, enter the word "Medicare". Line A: enter all information pertaining to Medicare.
6. Field 54:	
<ul style="list-style-type: none"> <li>• Medicare is the primary payer;</li> <li>• Medicaid is the secondary payer;</li> </ul>	Line A: enter the Medicare Paid Amount. Line B: no entry needed.
7. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid; this is the sum of the Medicare coinsurance and deductible amount. <b>Note:</b> Medicaid is the secondary payer in field 50B, therefore, the estimated amount due from Medicaid is entered in field 55B.
8. 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: <http://medicaidalaska.com/providers/Billing.asp>.