

• Medicare Primary
• Medicaid Secondary

Example 4a
Outpatient
Medicare
Coinsurance Only

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2	3a PAT. CNTRL. # b. MED. REG. # 5 FED. TAX NO.	0812345	4 TYPE OF BILL 0131
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8 PATIENT NAME a	DOE, JANE E.	9 PATIENT ADDRESS b	
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10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28				29 ACCT STATE	30
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31 OCCURRENCE DATE 50 04 04 08	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
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38	39 VALUE CODES A2	AMOUNT 367.20	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
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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
0258	N400026064871UN1234.567	J1480		1	14000		
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 3 OF 1	CREATION DATE	04 05 08	TOTALS	275400	0
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50 PAYER NAME A MEDICARE B MEDICAID	51 HEALTH PLAN ID	52 REL INFO Y Y	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 1468.80 367.20	56 NPI 1234567890 020024 HS990P
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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 78650	5990	79099	78720	4019	68
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69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73					
74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL	

80 REMARKS	81CC a b c d	76 ATTENDING NPI	QUAL		77 OPERATING NPI	QUAL		78 OTHER NPI	QUAL		79 OTHER NPI	QUAL	
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*Example 4b
 Outpatient
 Medicare
 Coinsurance Only*

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 131

NUMBER:	PROVIDER	PAYER
NAME:	020024	C24
ADDRESS:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
CITY/ST/ZIP:	1000 HOSPITAL DR.	PO BOX 6720
	ANYTOWN, AK 99500-0000	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
DOE, JANE E. 00047960	0812345 12345678901234	574500000A 0	03/20/08	03/20/08			2754.00	0.00	250.00	367.20	0.00	0.00	1468.80
CAPITAL PMT:	0.00	HSP:	0.00										
HOLD HARM:	0.00	IME-ADJ:	0.00					0.00					DRG CODE:
COVERD CHARGES:	2754.00	CLAIM STATUS CODE:	0										

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
0258		03/20/08	14000	74.67			
0270		03/20/08	25600	136.53			
0350		03/20/08	97600	520.53			
0450		03/20/08	106300	566.94			
0460		03/20/08	31900	170.13			

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims with J (drug) Code

Scenario: Outpatient Claim Form, with Medicare Coinsurance Only

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional 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 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>	Line a: enter Value Code "A2" and the recipient's Medicare coinsurance amount. Note: the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 50: <i>Payer Name</i>	Enter the word "Medicare".
<ul style="list-style-type: none"> • Medicare is the primary payer; • Medicaid is the secondary payer; 	Line A: enter all information pertaining to Medicare. Line B: enter all information pertaining to Medicaid.
4. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> • Medicare is the primary payer; • Medicaid is the secondary payer; 	Line A: enter the Medicare Paid Amount. Line B: no entry needed.
5. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid. Note: The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
6. 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>.