

- Medicare Primary
- Medicaid Secondary

Example 5a
Outpatient
Medicare Deductible
Only

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2		3a PAT. CNTRL.# 0812345		4 TYPE OF BILL 0131	
8 PATIENT NAME a DOE, JANE E.				9 PATIENT ADDRESS a			
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
				03 20 08		08	
14 TYPE		15 SRC		16 DHR		17 STAT	
1							
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
50 04 04 08							
35 CODE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38	
39 CODE		40 VALUE CODES AMOUNT		41 CODE		42 VALUE CODES AMOUNT	
A1		250.00					

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	TO	275400	0
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56 PAYER NAME MEDICARE MEDICAID		51 HEALTH PLAN ID	52 REL INFO Y Y	53 ASG BEN.	54 PRIOR PAYMENTS 1500.00 0	55 AMOUNT DUE 250.00	56 NPI 1234567890 020024 HS99OP
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58 INSURED'S NAME DOE, JANE E. DOE, JANE E.		59 P.REL.	60 INSURED'S UNIQUE ID 574500000A 0600611111	61 GROUP NAME		62 FINANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	

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	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI
80 REMARKS	81CC a			
	b			
	c			
	d			

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

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Central Alaska Hospital
 REMITTANCE REPORT

*Example 5b
 Outpatient
 Medicare Deductible
 Only*

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

NUMBER:	PROVIDER	PAYER
	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

*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			03/20/08	03/20/08	2754.000.00	250.00	0.00	0.00	1500.00	
CAPITAL PMT:	0.00	HSP:	0.00			FSP: 0.00	DSH ADJ:		0.00				DRG CODE:
HOLD HARM:	0.00	IME-ADJ:	0.00			EXCEPTIONS:0.00							
COVERD CHARGES:	2754.00	CLAIM STATUS CODE:	0			TYPE OF BILL: 131							

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	0.00			
	0270		03/20/08	25600	0.00			
	0350		03/20/08	97600	0.00			
	0450		03/20/08	106300	0.00			
	0460		03/20/08	31900	0.00			

Completing the UB-04 Claim Form for Institutional Medicare Crossover paper claims with J (drug) code

Scenario: Outpatient Claim Form, with Medicare Deductible 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>	Enter Value Code "A1" and the recipient's Medicare deductible 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; 	Line A: enter all information pertaining to Medicare.
<ul style="list-style-type: none"> • Medicaid is the secondary payer; 	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; 	Line A: enter the Medicare Paid Amount.
<ul style="list-style-type: none"> • Medicaid is the secondary payer; 	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>.