

- Medicare Primary
- Medicaid Secondary

**Example 6a**  
**Outpatient**  
**Medicare Deductible**  
**and Coinsurance**

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
		03 20 08	08 1									

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 A1	AMOUNT 536.00	40 VALUE CODES A2	AMOUNT 260.00	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 4 OF 1	CREATION DATE	04 05 08	TOTALS	275400	0
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50 PAYER NAME MEDICARE MEDICAID	51 HEALTH PLAN ID	52 REL INFO Y Y	53 ASG BEN.	54 PRIOR PAYMENTS 1300.00	55 EST. AMOUNT DUE 0 796.00	56 NPI 1234567890 020024 HS990P
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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 GR	62	63	64	65	66	67	68	69	70	71	72	73
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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	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI

80 REMARKS	81CC a b c d
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RUN DATE: 04/04/08  
 RUN TIME: 1412  
 RUN USER: DBCOOPER

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Central Alaska Hospital  
 REMITTANCE REPORT

*Note: Your EOMB may be formatted differently.*

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

*Example 6b  
 Outpatient  
 Medicare Deductible  
 and Coinsurance*

NUMBER:	PROVIDER 020024	PAYER 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/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 0.00	536.00 0.00	260.00 796.00	0.00 0.00	0.00 0.00	1300.00
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		0.00				DRG CODE:
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	74.67			
0270		03/20/08	25600	136.53			
0350		03/20/08	97600	520.53			
0450		03/20/08	106300	398.14			
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 Deductible and Coinsurance

- 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. <b>Note:</b> the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 40a:	Enter Value Code "A2" and the recipient's Medicare coinsurance amount. <b>Note:</b> the Value Code used corresponds with Field 50A, where Medicare is primary.
4. Field 50: <i>Payer Name</i>	Enter the word "Medicare".
<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>• Medicaid is the secondary payer;</li> </ul>	Line B: 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>• Medicaid is the secondary payer;</li> </ul>	Line B: no entry needed.
6. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid <b>Note:</b> The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
7. 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>.