



## Medicare Part B Crossover Claim Submission User Guide

Thank you for using MDH's newest web application to process your Medicare Part B Crossover Claims. Each claim you file is official and will supersede any paper claim you may have filed within the past year.

DHMH's goals for giving Medicaid providers on-line access to file the Medicare Part B Crossover claims are to:

- Let providers manage the Medicare Part B Crossover claim requests at your location thereby reducing possible errors
- Pay claims promptly, usually within two weeks from the time the claim is submitted.
- Reduce the need to submit paper claims

When you prepare to submit a Medicare Part B Crossover claim, the following are required:

- A copy of the Medicare Part B Crossover claim
- A copy of the Medicare Explanation of Benefits (EOB) sheet
- A soft copy (.pdf) of the Medicare Explanation of Benefits (EOB) sheet to upload to DHMH

This is a step by step guide to enter Medicare Part B Crossover Claims, upload supporting documents and review the status of the submitted claims.

### **\*\*IMPORTANT TO NOTE\*\* -**

- **Medicare Part B Crossover claim submission date must be on or before one calendar year from the Date of Service (DOS)**  
**Or**  
**The Medicare Paid Date must be less than or equal to 120 days from Medicare Part B Crossover claim submission date.**
- **If the claim has no co-insurance or deductible, then DO NOT attempt to file a Medicare Part B Crossover Claim.**
- **If the patient has Third Party Insurance and you received a rejection reason code of Q, R, or S, you must file a paper claim.**

The key areas to note for filing this type of claim successfully are:

- Submitting Medicare EOB information- Be sure your documentation is clear to note PR (Patient Responsibility) or CO (Contractual Obligation) codes and charges.
- Upload supporting documents - This will give you control of the paperwork needed to complete your claim.

If you have any questions or concerns, contact [mdh.eMedicaidMD@maryland.gov](mailto:mdh.eMedicaidMD@maryland.gov).

**DO NOT USE YOUR BROWSER BACK BUTTON TO GO BACK. USE THE KEYS AT THE BOTTOM OF EACH PAGE TO GO BACK IF NECESSARY.**



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Step	Process	
1	<p>Log into Maryland’s DHMH eMedicaid site:</p> <p><a href="http://www.emdhealthchoice.org">www.emdhealthchoice.org</a></p>	
2	<p>Sign into eMedicaid with your User ID and Password.</p> <p><i>If you forgot your password, click on the <a href="#">Forgot Your Password</a> link and follow the instructions.</i></p>	

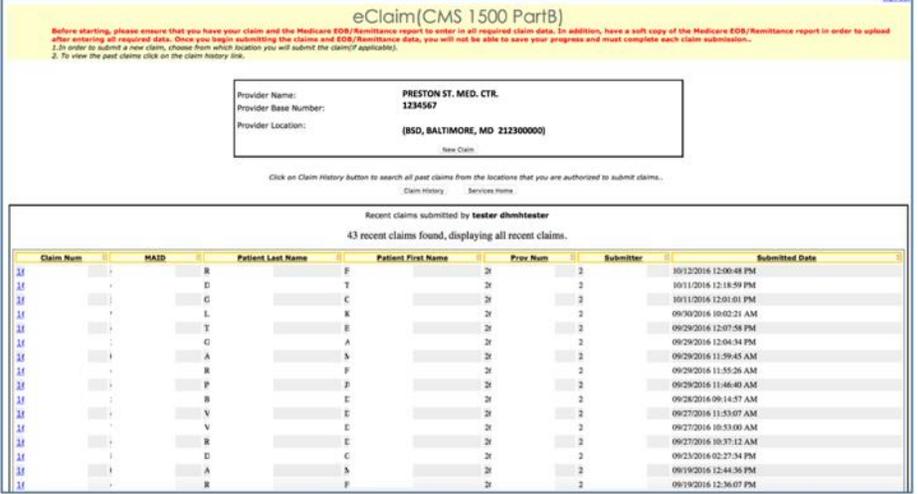
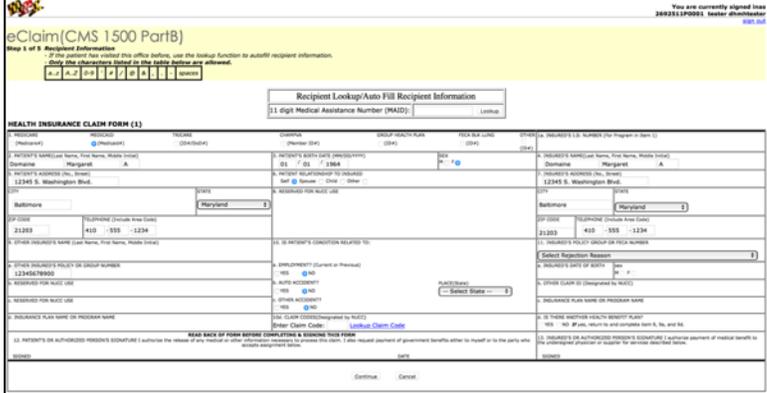


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Step	Process	
3	<p>Signing in will take you to the eMedicaid home page. This page will provide the links for different services available under your User ID.</p>	<p>The screenshot shows the Maryland Medical Programs Web Services interface. At the top, there is a logo for 'Maryland MEDICAL PROGRAMS Web Services' with the tagline '... brought to you by the Maryland Department of Health and Mental Hygiene'. A green banner in the top right corner reads 'NEW FEATURE! Direct Claim Submission' and provides details about the new feature for CMS 1500 claims. Below the banner is a table titled 'Remittance Advice (EOB)' with columns for Provider Number, Practice Address, Most Recent Check Amount, and Remittance Advice Date for this Check. The table lists several entries for provider number 960. At the bottom of the page, there is a navigation menu with links for Health Homes, eClaim(CMS 1500 PartB), Claim Lookup, eClaim(1500), Recipient Eligibility Verification, and Presumptive Eligibility.</p>
4	<p>To begin submitting a Medicare Part B Crossover claim, click on the link at the bottom of the page.</p> <p><a href="#">eClaim(CMS 1500 Part B)</a></p> <p><b>Important Note: If the link to choose eClaim (CMS 1500 PartB) is not available, check with your Local Administrator to request access.</b></p>	<p>The close-up screenshot shows the navigation menu with the following links: Health Homes, eClaim(CMS 1500 PartB), Claim Lookup, eClaim(1500), Recipient Eligibility Verification, and Presumptive Eligibility. A red arrow points to the 'eClaim(CMS 1500 PartB)' link.</p> <p style="text-align: center;"><a href="#">eClaim(CMS 1500 PartB)</a></p>



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Step	Process	
5	The eClaim(CMS 1500 PartB) main page is displayed	 <p>The screenshot shows the eClaim(CMS 1500 PartB) main page. At the top, it displays the provider information: PRESTON ST. MED. CTR., Provider Base Number: 1234567, and Provider Location: (BSD, BALTIMORE, MD 212300000). Below this is a table of recent claims submitted by the provider, with 43 claims found. The table columns include Claim Num, MAID, Patient Last Name, Patient First Name, Prior Num, Submitter, and Submitted Date.</p>
6	Click on New Claim to begin creating the Medicare Part B Crossover Claim.	 <p>The screenshot shows the 'New Claim' button on the eClaim(CMS 1500 PartB) main page. The button is highlighted with a red arrow, indicating that it should be clicked to begin creating a new claim.</p>
7	Complete the required fields of information from the Medicare filed claim.  <b>Important Note: The only required fields are the PATIENTS NAME (Field 2) and OTHER INSURED'S POLICY OR GROUP NUMBER (Field 9a).</b>	 <p>The screenshot shows the 'HEALTH INSURANCE CLAIM FORM (1)' in the eClaim(CMS 1500 PartB) system. The form is divided into several sections, including Recipient Information, Patient Information, and Insurance Information. The form is partially filled out, showing fields for Patient Name, Address, and Insurance Policy/Group Number.</p>



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EXPANDED VIEW OF SECTION ONE FORM:

You are currently signed in as  
**2692511P0001 tester dhmhtester**  
[sign out](#)

**eClaim(CMS 1500 PartB)**

**Step 1 of 5 Recipient Information**  
- If the patient has visited this office before, use the lookup function to autofill recipient information.  
- Only the characters listed in the table below are allowed.  
a..z A..Z 0-9 - # / @ & . , - spaces

Recipient Lookup/Auto Fill Recipient Information

11 digit Medical Assistance Number (MAID):

**HEALTH INSURANCE CLAIM FORM (1)**

<input type="radio"/> MEDICARE (Medicare#) <input checked="" type="radio"/> MEDICAID (Medical#) <input type="radio"/> TRICARE (ID#/DoD#) <input type="radio"/> CHAMPVA (Member ID#) <input type="radio"/> GROUP HEALTH PLAN (ID#) <input type="radio"/> FECA BLK LUNG (ID#) <input type="radio"/> OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Domname Margaret A		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Domname Margaret A	
3. PATIENT'S BIRTH DATE (MM/DD/YYYY) 01 / 01 / 1964		7. INSURED'S ADDRESS (No. Street) 12345 S. Washington Blvd.	
5. PATIENT'S ADDRESS (No. Street) 12345 S. Washington Blvd.		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/>		9. RESERVED FOR NUCC USE	
7. INSURED'S ADDRESS (No. Street) 12345 S. Washington Blvd.		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="radio"/> YES <input checked="" type="radio"/> NO b. AUTO ACCIDENT? <input type="radio"/> YES <input checked="" type="radio"/> NO c. OTHER ACCIDENT? <input type="radio"/> YES <input checked="" type="radio"/> NO 10d. CLAIM CODES (Designated by NUCC) Enter Claim Code: <input type="text"/> <input type="button" value="Lookup Claim Code"/>	
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="radio"/> YES <input checked="" type="radio"/> NO <i>If yes, return to and complete item 9, 9a, and 9d.</i>	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="radio"/> YES <input checked="" type="radio"/> NO b. AUTO ACCIDENT? <input type="radio"/> YES <input checked="" type="radio"/> NO c. OTHER ACCIDENT? <input type="radio"/> YES <input checked="" type="radio"/> NO 10d. CLAIM CODES (Designated by NUCC) Enter Claim Code: <input type="text"/> <input type="button" value="Lookup Claim Code"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="radio"/> YES <input checked="" type="radio"/> NO <i>If yes, return to and complete item 9, 9a, and 9d.</i>	
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="radio"/> YES <input checked="" type="radio"/> NO <i>If yes, return to and complete item 9, 9a, and 9d.</i>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	

7a.	<p>Third Party Insurance – Rejection Reason Codes (field 11).</p> <p style="color: red;">If choice is Q, R, or S you must file a paper claim.</p>	<div style="border: 1px solid gray; padding: 5px;"> <ul style="list-style-type: none"> <li>✓ Select Rejection Reason</li> <li>K-Service Not Covered.</li> <li>L-Coverage Lapsed.</li> <li>M-Coverage Not in Effect on Service Date.</li> <li>N-Individual Not Covered.</li> <li>Q-Claim Not Filed Timely.(Requires documentation.)</li> <li>R-No Response from Carrier Within 120 Days(Requires documentation.)</li> <li>S-Other Rejection Reason Not Defined Above(Requires documentation.)</li> </ul> </div>
8	<p>When all required fields are filled in, click Continue.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid gray; border-radius: 10px; padding: 5px 20px; background-color: #f0f0f0;">Continue</div> <div style="border: 1px solid gray; border-radius: 10px; padding: 5px 20px; background-color: #f0f0f0;">Cancel</div> </div> <div style="text-align: right; margin-top: 10px;"> </div>



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9 Fill in Health Insurance Claim Form (2).

**Important Note: The Date(s) of Service (DOS) fields MUST be filled out in this format: (MM/DD/YYYY).**

*Medicare Part B Crossover claim submission date must be on or before one calendar year from the DOS*  
*Or*  
*The Medicare Paid Date must be less than or equal to 120 days from Medicare Part B Crossover claim submission date.*

The screenshot shows a 'HEALTH INSURANCE CLAIM FORM (2)'. It includes fields for patient name, date of birth, sex, and address. There are also fields for service dates (DOS) and charges. The form is partially filled out with example data.

9A If you need to add more Service Lines to the claim, select the number of lines you need and click Add More Service Lines box.

The screenshot shows a form with a table of service lines. The first row has 'ABC' in the first column, '10.00' in the second, '1' in the third, and 'NPI 1699774018' in the fourth. Below the table, there is a red box around a dropdown menu showing '1' and a button labeled 'Add More Service Lines'.

9B Box 29. Enter the total of all TPL/Commercial Insurance paid amounts. This excludes ALL Medicare paid amounts including Medicare Advantage, Medicare Replacement, Medicare HMO, etc.

The screenshot shows a box labeled '29. AMOUNT PAID' with a text input field containing '\$ 0.00'.



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EXPANDED VIEW OF SECTION TWO FORM:

**HEALTH INSURANCE CLAIM FORM (2)**

14. DATE OF CURRENT: (MM/DD/YYYY) <input type="text" value="01/15/2015"/>		15. ILLNESS (First symptom), OR INJURY (Accident), OR PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: (MM/DD/YYYY) FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name)		17 a. <input type="text" value="NPI"/>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: (MM/DD/YYYY) FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
20. OUTSIDE LAB? <input type="radio"/> YES <input checked="" type="radio"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-H to service line below (24E)					
22. RESUBMISSION CODE ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER 12A4565987					
24.A. DATE(S) OF SERVICE From (MM/DD/YYYY) To (MM/DD/YYYY)		B. PLACE OF SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
1 01 / 15 / 2015		11 Lockup		99213	
2 01 / 15 / 2015		11 Lockup		90670	
3 01 / 15 / 2015		11 Lockup		G0009	
4 01 / 15 / 2015		11 Lockup		36415	
25. FEDERAL TAX I.D. NUMBER 521234567		SSN ESN <input checked="" type="radio"/>		26. PATIENT'S ACCOUNT NO. 123456789	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="radio"/> YES <input type="radio"/> NO		28. TOTAL CHARGE \$ 450.00		29. AMOUNT PAID \$ 0.00	
30. RAV for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof)		32. SERVICE FACILITY LOCATION INFORMATION Enter Facility Information( No 2)	
SIGNED		DATE 10/13/2016		33. BILLING PROVIDER INFO & PH # 51100	

Next Cancel

10	When all required fields are filled in, click Next.	 
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11 Fill in Medicare EOB Information for each Service Line billed.

**Important Note: The Medicare Date Paid at the upper left MUST be filled out in this format: (MM/DD/YYYY).**

**MEDICARE INFORMATION FORM**  
Medicare Date Paid: (MM/DD/YYYY)  
07 / 15 / 2015

Service Line #	DOS From & To	UOS	Procedure code	\$ Billed	\$ Allowed	\$ Deductible	\$ Coinsurance	\$ Provider Paid Amt
1	2015-01-15 to 2015-01-15	1	99213	160.00	38.51			38.51
		PR			CO			OA
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$	45	\$ 121.49	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$
2	2015-01-15 to 2015-01-15	1	99870	220.00	99.00			99.00
		PR			CO			OA
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$	45	\$ 121	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$
3	2015-01-15 to 2015-01-15	1	G9909	60.00	58.09			58.09
		PR			CO			OA
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$	237	\$ 1.91	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$
		\$		\$		\$	\$	\$

**IMPORTANT: SUBMIT ONLY THE NUMERIC VALUE OF THE ADJUSTMENT REASON CODE. DO NOT INCLUDE THE VALUES CO, PR, OR OA.**

**Correct : 45 or 237**  
**Incorrect : CO-45 or CO-237**

To fill out this next section you will fill in fields from the Detailed or Summary Medicare EOB report you received. In the Appendix section at the end of this document are examples of how to fill in those fields from various formatted Medicare EOB reports.

**\*\*REMINDER\*\* - If the claim has no co-insurance or deductible then DO NOT attempt to file a claim.**



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EXPANDED VIEW OF SECTION THREE FORM:

**eClaim(CMS 1500 PartB)**

**Step 3 of 5 Medicare Service Information**  
-Adjustment reason code should not contain characters. You must enter provider paid Amount.  
Deductible and CoInsurance enter in the PR field. For Deductible PR code - 1, CoInsurance PR code - 2

**SUBMIT ONLY THE NUMERIC VALUE OF THE ADJUSTMENT REASON CODE. DO NOT INCLUDE PR, CO, OR OA.**  
**Correct: 45 or 237**  
**Incorrect: CO-45 or CO-237**

**MEDICARE INFORMATION FORM**  
Medicare Date Paid: (MM/DD/YYYY)  
06 / 16 / 2015

Service Line #	DOS From & To	UOS	Procedure code	\$ Billed	\$ Allowed	\$ Deductible	\$ Coinsurance	\$ Provider Paid Amt
1	2015-06-14 to 2015-06-14	1	76830	190.00	115.16		23.03	90.29
	PR			CO			OA	
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
2	\$ 23.03	\$	45	\$ 73.68	\$			\$
	\$	\$	237	\$ 1.16	\$			\$
	\$	\$	253	\$ 1.84	\$			\$
2	2015-06-14 to 2015-06-14	1	76856	32.00	16.32			15.99
	PR			CO			OA	
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	\$	\$	45	\$ 15.68	\$			\$
	\$	\$	253	\$ .33	\$			\$
	\$	\$		\$	\$			\$

Next Previous

(See appendix below for examples of where to find PR (Patient Responsibility) or CO (Contractual Obligation) on sample billing detail documents)

\*\*In the PR (Patient Responsibility) section, Adjustment Reason Code 1 means Deductible and Code 2 means Co-Insurance\*\*

**SUBMIT ONLY THE NUMERIC VALUE OF THE ADJUSTMENT REASON CODE. DO NOT INCLUDE PR, CO, OR OA.**  
**Correct: 45 or 237**  
**Incorrect: CO-45 or CO-237**

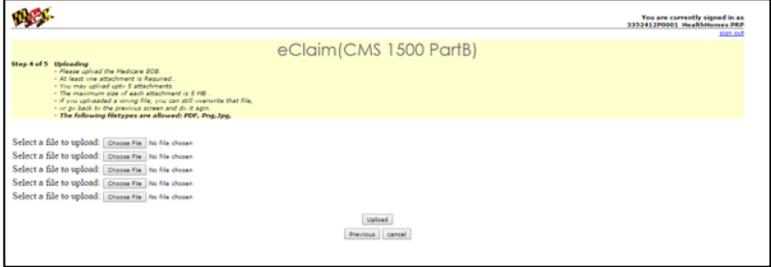
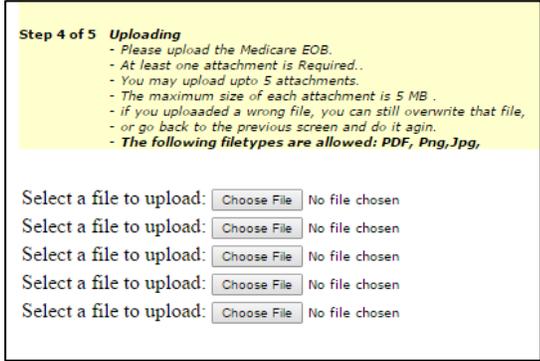
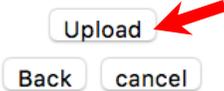
**MEDICARE INFORMATION FORM**  
Medicare Date Paid: (MM/DD/YYYY)  
06 / 16 / 2015

Service Line #	DOS From & To	UOS
1	2015-06-14 to 2015-06-14	1
	PR	
	Adjustment reason code	Amount
2	\$ 23.03	\$
	\$	\$
	\$	\$
2	2015-06-14 to 2015-06-14	1
	PR	
	Adjustment reason code	Amount
	\$	\$
	\$	\$
	\$	\$





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<p>13</p>	<p>Now you can upload supporting Medicare EOB documentation. You can upload up to 5 attachments.</p>	
<p>13a</p>	<p>Uploading Requirements:</p> <ul style="list-style-type: none"> <li>• At least one attachment must be uploaded. (Medicare EOB Report)</li> <li>• Maximum of 5 attachments</li> <li>• File size maximum (5 MB each)</li> <li>• Formats allowed – (.PDF, .Png, .jpg)</li> </ul>	
<p>14</p>	<p>Once files are chosen and uploaded, review to make sure all files are loaded.</p>	
<p>15</p>	<p>Click Upload to ensure files are loaded and connected to claim that has been created.</p>	





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18	Once submitted you will see a Submission Date and Claim Number for your records.	
18A	At the bottom of the submitted claim you have the option to start a new claim, go to the Claim Home page or Services Home page.	
19	This is the eClaim (CMS 1500 Part B) Home page.  If you wish to enter a new claim, click New Claim and return to Step 6.	
*7a	Repeat patient submissions are simplified by entering the 11-digit recipient ID in this box. Patient information will automatically populate in required fields.	



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\*7b A new claim is created with the Patients information filled in (Step 1 of 5).  
  
Begin new claim.

eClaim(CMS 1500 PartB)  
Step 1 of 5 - Recipient Information  
If the patient has visited this office before, use the lookup function to auto-fill recipient information.  
Only the information defined in the table below may be entered.

Form has been auto-filled based on the information found in one of your authorized locations.  
Please verify information before you submit the claim.

Recipient Lookup/Auto Fill Recipient Information  
11 digit Medicare Assistance Number (MAID):  Lookup

**HEALTH INSURANCE CLAIM FORM (1)**

1. PATIENT'S NAME (Last, First, Middle Initial) DOMANE MARGARET A	2. PATIENT'S DATE OF BIRTH (MM/DD/YYYY) 08 / 02 / 1964	3. PATIENT'S SEX F	4. PATIENT'S MARITAL STATUS A
5. PATIENT'S ADDRESS (Street, City, State, ZIP Code) 12345 S. WASHINGTON BLVD BALTIMORE Maryland 21203	6. PATIENT'S PHONE NUMBER (Area Code, Number) 410 - 555 - 1234	7. PATIENT'S EMPLOYMENT STATUS NO	8. PATIENT'S ACCOUNT TYPE NO
9. PATIENT'S POLICY OR GROUP NUMBER 1234567890	10. PATIENT'S CONDITION RELATED TO THIS CLAIM NO	11. PATIENT'S POLICY GROUP OR PLAN NUMBER 1234567890	12. PATIENT'S SIGNATURE (Print Name, Title, Date) MARGARET A. DOMANE

13. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)  
14. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

15. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

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79. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

80. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

81. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

82. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

83. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

84. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

85. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

86. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

87. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

88. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

89. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

90. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

91. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

92. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

93. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

94. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

95. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

96. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

97. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

98. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

99. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

100. AUTHORIZED PERSON'S SIGNATURE (Print Name, Title, Date)

If you have any questions, email [mdh.eMedicaidMD@maryland.gov](mailto:mdh.eMedicaidMD@maryland.gov).









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3 - CO/PR Codes: CO-45 (\$14.40), CO-253 (\$1.68), PR-2 (\$24.60) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 24.60		\$	45	\$ 14.40		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$		\$		\$		\$		\$

4 - CO/PR Codes: CO-45 (\$67.20), CO-253 (\$1.68), PR-2 (\$37.80) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 37.80		\$	45	\$ 67.20		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$		\$		\$		\$		\$

5 - CO/PR Codes: CO-45 (\$14.40), CO-253 (\$1.68), PR-2 (\$24.60) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 24.60		\$	45	\$ 14.40		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$		\$		\$		\$		\$

6 - CO/PR Codes: CO-45 (\$14.40), CO-253 (\$1.68), PR-2 (\$24.60) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 24.60		\$	45	\$ 14.40		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$		\$		\$		\$		\$

7 - CO/PR Codes: CO-45 (\$14.40), CO-253 (\$1.68), PR-2 (\$24.60) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 24.60		\$	45	\$ 14.40		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$		\$		\$		\$		\$

8 - CO/PR Codes: CO-45 (\$67.20), CO-253 (\$1.68), PR-2 (\$37.80), CO-92 (\$30.00) – Filled in below.

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt
1	2015-05-05 to 2015-05-05		1									
	PR				CO				OA			
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
	2	\$ 37.80		\$	45	\$ 67.20		\$		\$		\$
		\$		\$	253	\$ 1.68		\$		\$		\$
		\$		\$	92	\$ 30.00		\$		\$		\$



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Example #4

Claim # 1014302009550	Processed and forwarded to additional payer		
Claim Total \$65.00	\$35.12		\$8.96
99212 \$65.00	\$35.12	10-07-2014	MC
①	Contractual Obligation # 45	\$20.20	Exceeds fee sch
	Contractual Obligation # 253	\$0.72	
	Patient Responsibility		
Claim # 1014302009910	Processed as Primary		
Claim Total \$120.00	\$38.13		
G0101 \$120.00	\$38.13	10-16-2014	MC
②	Contractual Obligation # 45	\$81.09	Exceeds fee sch
	Contractual Obligation # 253	\$0.78	
70070			
Claim # 1014302009330	Processed and forwarded to additional payer		
Claim Total \$408.00	\$184.05		\$46.95
99205 \$120.00	\$94.08	09-24-2014	MC
③	Contractual Obligation # 253	\$1.92	
	Patient Responsibility		
58100	\$89.97	09-24-2014	MC
	Contractual Obligation # 45	\$173.24	Exceeds fee sch
	Contractual Obligation # 253	\$1.84	
	Patient Responsibility		

1 – CO/PR Codes: CO-45 (\$20.20), CO-253 (\$0.72) – Filled in below.

Service Line #	DOS From & To	UOS	Procedure code	\$ Billed	\$ Allowed	\$ Deductible	\$ Coinsurance	\$ Provider Paid Amt	
1	2015-05-05 to 2015-05-05	1							
				CO			OA		
				Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
				45	\$ 20.20				
				253	\$ .78				

2 – CO/PR Codes: CO-45 (\$81.09), CO-253 (\$0.78) – Filled in below.

Service Line #	DOS From & To	UOS	Procedure code	\$ Billed	\$ Allowed	\$ Deductible	\$ Coinsurance	\$ Provider Paid Amt	
1	2015-05-05 to 2015-05-05	1							
				CO			OA		
				Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount
				45	\$ 81.09				
				253	\$ .78				





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SUMMARY REPORT EXAMPLES

#1

PERF	PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME				HIC:		ACNT:		710013			
ICN: 2											
		0403 040315	11 1	1.00	G0470	190.00	0.00	0.00	33.61	190.00	131.76
										CO/45 CO/253 PR/2	
		0403 040315	11 1	1.00	90834	175.00	0.00	0.00	0.00	175.00	0.00
										CO/97	
PT RESP		33.61		CLAIM TOTALS		365.00	0.00	0.00	33.61	365.00	131.76

For claims where the EOB summary does not include specific amounts for specific reason codes, enter 23 in the OA section for reason code and the amount (Billed – (Patient Responsibility (PR))-Provider Payment (PD)). In this case \$190.00 – \$33.61 – \$131.76 = \$24.63

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt	
1	2015-05-05 to 2015-05-05		1										
	PR				CO				OA				
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$		\$		\$		23	\$ 24.63		\$
		\$		\$		\$		\$			\$		\$
		\$		\$		\$		\$			\$		\$

#2

PT: SYB	LOUISE	HIC: 212360581D	ICN: 21527903875307MDA	ACCT: BON.179	ASG Y								
MMDD-MMDDYY	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINSUR	INTEREST	OTHER	PT PAID	ADJUST	PROV PD	ACTS
0901-090115	65 1	90999		1500.00	231.12	0.00	46.22	0.00	0.00	0.00	1273.07	180.71	CO118

Enter 23 in the OA section for reason code and the amount (Billed – (Patient Responsibility (PR))-Provider Payment (PD)). In this case \$1500.00 – \$46.22 – \$180.71 = \$1273.07

Service Line #	DOS From & To		UOS	Procedure code	\$ Billed		\$ Allowed		\$ Deductible	\$ Coinsurance		\$ Provider Paid Amt	
1	2015-05-05 to 2015-05-05		1										
	PR				CO				OA				
	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$		\$		\$		23	\$ 1273.07		\$
		\$		\$		\$		\$			\$		\$
		\$		\$		\$		\$			\$		\$