

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 <u>mdh.eMedicaidMD@maryland.gov.</u>

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



Step	Process	
1	Log into Maryland's DHMH	
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2	Sign into eMedicaid with your User ID and Password. If you forgot your password, click on the <u>Forgot Your</u> <u>Password</u> link and follow the	Sign In User ID: Password: Sign In
	instructions.	Forgot Your Password?



Step	Process	
3	Signing in will take you to the eMedicaid home page. This page will provide the links for different services available under your User	Medical States of the state of the states of
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4	To begin submitting a	Health Homes eClaim(CMS 1500 PartB) Claim Lookup
	Medicare Part B Crossover	eClaim(1500) Recipient Eligibility Verification Presumptive Eligibility
	claim, click on the link at the	
	bottom of the page.	eClaim(CMS 1500 PartB)
	eClaim(CMS 1500 Part B)	
	Important Note: If the link	
	to choose eClaim (CMS 1500	
	PartB) is not available.	
	check with your Local	
	Administrator to request	
	alless.	



Step	Process	
5	The eClaim(CMS 1500 PartB) main page is	ecclaim (CMS 1500 PartB) Before starting, plasse ensure that you have your claim and the Medicare 509/tentitence report to onlive in all negoried claim data. In addition, have a soft ropy of the Medicare 509/tentitence report in order to uplaced after entering all reported data. Once you bagin admitting the claims and 609/tentitence report is unter in all negorier claim data. In addition, have a soft report data. Once you bagin admitting the claims and 609/tentitence report is onlive to be admit a few of the Medicare 509/tentitence report in order to uplaced 1.1. In other the part claims claim admitting of the claim of admitting againable. 3. To view the part claims claims claims placed.
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		<u> </u>
6	Click on New Claim to begin creating the Medicare Part B Crossover Claim.	Provider Name: PRESTON ST. MED. CTR. Provider Base Number: 1234567 Provider Location: (BSD, BALTIMORE, MD 212300000) New Claim
7	Complete the required fields of information from the Medicare filed claim. Important Note: The only required fields are the PATIENTS NAME (Field 2)	
	and OTHER INSURED'S POLICY OR GROUP NUMBER (Field 9a).	1304000 100 000 1000001 And 100000 1000001 And 100000 1000001 100000 1000001 1000000 1000001 1000000000000000000000000000000000000



EXPANDED VIEW OF SECTION ONE FORM:

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OTHER INSURED'S NAME	(Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			11. INSU	URED'S POLICY GROUP OR FECA NUMBER	
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INSURANCE PLAN NAME O	OR PROGRAM NAME		10d. CLAIM CODES(Designated by NUCC)			d. IS THE	ERE ANOTHER HEALTH BENEFIT PLAN?	
			Enter Claim Code: Lookup	Claim Code		VES (NO If yes, return to and complete item 9, 9a, and 9d.	
12. PATIENT'S OR AUTHOR	RIZED PERSON'S SIGNATURE I authorize	the release of any medical or other information r accepts assign	ecessary to process this claim. I also requer	it payment of government	t benefits either to myself or to the pa	arty who the under	JRED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical ensigned physician or supplier for services described below.	benefit to
SIGNED				DATE		SIGNE	D	
			Contin	Cancel				
 'a. Third Party Insurance – Rejection Reason Codes (field 11). If choice is Q, R, or S you must file a paper claim. 			d st	✓ Selea K-Se L-Coi M-Co N-Ini Q-Cli R-No S-Ot	t Rejection Rease rvice Not Covered verage Lapsed. overage Not in Eff dividual Not Cove aim Not Filed Tim Response from (her Rejection Rea	on d. rect on Se red. rely. (Requ Carrier Wi ason Not I	ervice Date. Jires documentation.) Ithin 120 Days(Requires documentati Defined Above(Requires documentati	ion.
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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.	
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.	ABC 10.00 1 NPI 1699774018 Clear Select the number of service lines to add 1 + Add More Service Lines 8. TOTAL CHARGE 29. AMOUNT PAID 30. RSVd for NUCC USE
98	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.	29. AMOUNT PAID \$ 0.00



EXPANDED VIEW OF SECTION TWO FORM:

HEALTH INSURANCE CLAIM FORM (2)					
LARTE CLARENT LLARES (Fire a sequencial a 15. DISCONDENSE) 15. DISCONDENSE DIS					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name)	17 a. 17 b. NP1		IB. HOSPITALIZATION DATES RELATED TO CURRENT SERVISES: (MM/DD/YY) FROM TO		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			VIS ONO SCHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-H to service line below (24E) A 244 B 250		C. 780 D.	22. RESUBNISSTION CODE ORIGINAL REF. NO.		
с.		G. H.	23. PRIOR AUTHORIZATION NUMBER 12A4565987		
24.A. DATE(S) OF SRVICE From (HHVDD/YYY) To (HHVDD/YYY)	B. PLACE OF SERVICE	c. D. PROCEDURES, SEVICES, OR SUPPLIES (Explain Unusual Circumstances) EMG CPT/HCPCS MODIFIER	LAE F. G. H. L. RENDERING POINTER SCHARGES UNITS PAIN QUAL PROVIDER ID. REDUCTING		
1 01 / 15 / 2015	11 Lookue	99213	ABC 160.00 1 NPI 1699774018 Clear		
2 01 / 15 / 2015	11 Lookud	90670	AB 220.00 1 NPI 1699774018 Clear		
3 01 / 15 / 2015	11 Lookup	G0009	AB 60.00 1 NF 1699774018 Clear		
4 01 / 15 / 2015	11 Leskue	36415	ABC 10.00 1 NPt 1699774018 Clear		
			Select the number of service lines to add 1 + Add More Service Lines.		
25.FEDERAL TAX 1.D. NUMBER	SSN EIN	26.PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims. see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Ravd for NUCC Use		
521234567 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	0	123456789 OYES NO 32. SERVICE FACILITY LOCATION INFORMATION	\$ 450.00 \$ 0.00		
(I certify that the satatements on the reverse apply to this bill and are made a part threof.)		Enter Facility Information?			
SIGNED DATE 10/13/2016			51100		
		Next Cancel			

10 When all required field filled in, click Next.	Next Cancel
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4.4		MEDIC	ARE INFORMATION FORM	1							
11	Fill In Medicare EOB	07	are Date Paid: (MM/DD	(YYYYY)							
	Information for each	Service Line #	DOS From & To	uos	Procedure code	\$ Billed	\$ Allowed	\$ Deductble	\$ Coinsurance	\$ Provider	Paid Amt
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To fill out this next section you will fill in fields from the <u>Detailed</u> or <u>Summary Medicare</u> 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.



EXPANDED VIEW OF SECTION THREE FORM:

eClaim (CMS 1500 PartB) -Adjustment reason code should not contain characters You must enter provider paid Amount. Deductible and Colinsurance enter in the PR field. For Deductible PR code - 1, Colinsurance PR code - 2 MEDICARE INFORMATION FORM Medicare Date Paid: (MM/DD/YYYY) 06 / 16 / 2015										ADJUSTM O NOT IN OR OA. or 237 O-45 or C	ERIC ENT CLUDE			
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		PR			_			со		_			OA	
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	2	\$ 23.03		\$		45	\$ 73.68		\$			\$		\$
		\$		\$		237	\$ 1.16		\$			\$		\$
		\$		\$		253	\$ 1.84		\$			\$		\$
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(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,	-	MEDIC	ARE INFO	RMATION FORM			
Aujustiment Reason Code I means Deductible	r	vieuic	are Date P		1111)		
and Code 2 means Co-Insurance**	C	06 /	16 / 20	15			
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				PR			
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PR, CO, OR OA.				\$		\$	
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Incorrect: CO-45 or CO-237				PR			
			Adjustment reason code	Amount	Adjustment reason code	Amount	
				\$		\$	
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Below is an example of the information needed from the Medicare EOB and where to populate the information on the Medicare Information Form.

Explanatio	n of Pay	yment					
Claims: 1							
(1)							
Patient Name				Patient ID		Claim Status	19
Subscriber Nan	ne			Payer Claim I	D	Claim Amount	\$222.00
Provider Name				Provider Clair	n ID	Paid Amount	\$106.28
Claim Stateme	nt			Received Date	e 08/20/2015	Pt Responsibility	\$23.03
Dates				Outpatient	MOA MA01		
				Adjudication	MA18		
Claim Status D PROGRAM OF	escription MD	: Processed as	Primary, F	orwarded to Ad	ditional Payer(s). For	warded to :	
Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments		
06/14/2015 - 06/14/2015	1	HC<99203	\$190.00	\$90.29	\$115.16 CO-45: \$73.68 PR-2: \$23.03	3 , CO-237: \$1.16 , CO-	253: \$1.84
		· .	REM: N700				
06/14/2015 -	1 H	IC<87880 <qw< td=""><td>\$32.00</td><td>\$15.99</td><td>\$16.32 CO-45: \$15.68</td><td>, CO-253: \$0.33</td><td></td></qw<>	\$32.00	\$15.99	\$16.32 CO-45: \$15.68	, CO-253: \$0.33	





13	Now you can upload	
	supporting Medicare EOB documentation. You can upload up to 5 attachments.	Claim (CMS 1500 PartB) Comments of the second seco
13a	 Uploading Requirements: At least one attachment must be uploaded. (Medicare EOB Report) Maximum of 5 attachments File size maximum (5 MB each) Formats allowed – (.PDF, .Png, .jpg) 	Step 4 of 5 Uploading Please upload the Medicare EOB. At least one attachment is Required. You may upload upto 5 attachments. The maximum size of each attachment is 5 MB. - if you uploaaded a wrong file, you can do it agin. - or go back to the previous screen and do it agin. - The following filetypes are allowed: PDF, Png, Jpg, Select a file to upload: Choose File No file chosen Select a file to upload: Choose File Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen Select a file to upload: Choose File No file chosen
14	Once files are chosen and uploaded, review to make sure all files are loaded.	Select a file to upload: Choose File ClaimPartBcounts.pdf Select a file to upload: Choose File no file selected Select a file to upload: Choose File no file selected Select a file to upload: Choose File no file selected Select a file to upload: Choose File no file selected Select a file to upload: Choose File no file selected Back cancel
15	Click Upload to ensure files are loaded and connected to claim that has been created.	Upload Back cancel



16	Review the entire claim.	eClaim(CMS 1500 Part8)
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	CHECK DOX DEFORE CIICKING	rules that are relevant to this electronic transaction. I am responsible for any
	Culture	misinformation or mistakes that are made.
	Submit.	 I understand that my electronic signature is as legally binding as my handwritten
		signature.
		 I agree that the Departmental electronic signature, if any, is an original signature as leastly blocking as a beadwritten signature.
		legally binding as a handwritten sightfure.
		 I drifting that the information I have provided in this electronic transaction is true and complete to the best of my knowledge and belief
		complete to the best of my knowledge and benefit
		Submit Cancel



18	Once submitted you will	
	see a Submission Date	eClaim(CMS 1500 PartB)
	and Claim Number for	Transaction Confirmation Please print this page for your records.
	your records.	CLAIM NUMBER: 162878000001
		Submission Date: 10/13/2010
18A	At the bottom of the	
	submitted claim you	Electronic Signature
	have the option to start	
	a new claim, go to the	 I have read and understand all warnings, restrictions, information, policies, and general rules that are relevant to this electronic transaction. I am responsible for any misinformation or misticing thet are relevant.
	Claim Home page or	 I understand that my electronic signature is as legally binding as my handwritten signature. I agree that the Departmental electronic signature, if any, is an original signature as legally
	Services Home page.	 I affirm that the information I have provided in this electronic transaction is true and complete to the best of my knowledge and belief.
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10	This is the officing (CMC	
19	1500 Part P) Homo page	o Claim (OHC 1500 Darth)
	1500 Part by home page.	Before starting, please ensure that you have your claim and the Medicare IDDI/Remittance report to entries in all required claim data. In addition, have a soft copy of the Medicare IDDI/Remittance report is more in all required claim. As in addition, have a soft copy of the Medicare IDDI/Remittance report is more in all required claim. As in addition, have a soft copy of the Medicare IDDI/Remittance report is more in all required claim. Back is an addition, have a soft copy of the Medicare IDDI/Remittance report is more in all required claim. Back is and mate complete each claim submission. 2.B work is soft and are claim, closed provide and the Claim of 2 additionable.
	If you wish to enter a	Provider Name - PRESTON ST. MED. CTR.
	new claim click New	Provider Base Number: 1234567 Provider Location: (BSD, BALTIMORE, MD 212300000)
	Claim and return to Step	(See Ode)
	6.	
		New Claim
*7a	Repeat patient	
	submissions are	
	simplified by entering	Veg are correctly signed into 26025110001 tester diministrator 20105 2010
	the 11-digit recipient ID	CUICITING STOUCH CONTROL Step 1 of 8 workshow to when the affect poly use the lookup function to autoff recipient information. - If the patient is allowed in the table behave an allowed.
	in this box. Patient	a.z A.Z 0.9 1 / 0 A / 0 A / 0 K Construction
	information will	11 digit Medical Assistance Number (MAID): 12345579900 Lanue
	automatically populate	Recipient Lookup/Auto Fill Recipient Information
	in required fields.	11 digit Medical Assistance Number (MAID): 12345678900



*7b	A new claim is created with the Patients information filled in	Straj Lati Zentralizzation Straj Lati Zentralizzation Straj Lati Zentralizzation Straj Lati Zentralizzation Only the detection billing of the table before year adverse.
	(Step 1 of 5).	Prese verb formation further year solution that drive a verb formation further year solution that drive a verb formation for the solution of the solution
	Begin new claim.	NUCLEM NUCLEM Description Descripion <thdescripion< th=""> <thdescrip< th=""></thdescrip<></thdescripion<>
		DF 0 ML ML0000 (Journa for Line) FF 0 ML FF 0
		* Named VALC dati
		In the Unit of the Annual Device of the Unit of the Unitof the Unit of the Unit of the Unitor Onit of the Unitor Onitor O

If you have any questions, email <u>mdh.eMedicaidMD@maryland.gov.</u>



APPENDIX EOB Reports

This shows examples of <u>Detailed</u> or <u>Summary</u> EOB reports you may receive. This will show how to fill in those fields from the information you receive on to the Medicare Information Form online.

**If you receive summary EOB reports, you should request a detailed report from the entity which sends you those.

Claim Adjustment Group Codes

PR = Patient Responsibility

CO = Contractual Obligation

OA = Other Adjustments

	PR					со			. 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
	\$		\$		\$		\$		\$		\$

Detailed EOB Report Example #1

			E	PAGE #:	01/26/201	6
CHECK/EFT #: 883879752						
REND-PROV SERV-DATE POS PD-PROC/MODS RARC	PD-NOS SUB-NOS	BILLED SUB-PROC	ALLOWED GRP/CARC	DEDUCT CARC-AMT	COINS ADJ-QTY	PROV-PD BS
NAME:1 HIC:	CNT: 4634	8227145	ICN:191601	2094180 ASG:	Y MOA:MA01	MA07
891857603 0102 010216 31 99308	1.000	77.31	76.39	0.00	15.28	58.69
1700 N701			CO-237	2.14	0.0000000000000000000000000000000000000	
NTL #: S27145K49342K9			CO-253	1.20		
PT RESP 15.28 CARC 3.34	CLAIM TOTALS	77.31	76.39	0.00	15.28	58.69
DJ TO TOTALS: PREV PD	INTEREST	0.00 LATE	FILING CHARGE	0.00	NET	58.69
LAIM INFORMATION FORWARDED TO: MD DE	P OF HEALTH & M	ENTAL HYGIEN				

CO/PR Codes: CO-237 (\$2.14), CO-253 (\$1.20) - Filled in below.

Service Line #	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coinsurance		\$ Provider	r Paid Amt
1	2015-05-05 to 2015-05-05 1			94180	\$77.31		76.39		76.39 15.28		15.28		58.69	
	PR							CO				0/	4	
	Adjustment reason code		Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
1	2	\$ 15.28		\$		237	\$ 2.14		\$			\$		\$
		\$		\$		253	\$ 1.20		\$			\$		\$
		\$		\$			\$		\$			\$		\$



Example #2

(1)							
Patient Name				Patient ID		Claim Status	19
Subscriber Nar	me -			Payer Claim ID	1015232357610	Claim Amount	\$222.00
Provider Name	9			Provider Claim ID	615888	Paid Amount	\$106.28
Claim Stateme	ent	-		Received Date	08/20/2015	Pt Responsibility	\$23.03
Dates				Outpatient	MOA MA01		
		-		Adjudication	MA18		
Claim Status D PROGRAM OF Serv Date	Description F MD : 002 Units	: Processed as 259 Serv Code	Primary, Fo	Adjudication rwarded to Addition Paid Allow	MA18 nal Payer(s). Forwa wed Adjustments	rded to : KIDNEY	DISEASE
Claim Status D PROGRAM OF Serv Date 06/14/2015 - 06/14/2015	Description F MD : 002 Units 1	: Processed as 259 Serv Code HC<99203	Primary, Fo Billed \$190.00	Adjudication rwarded to Addition Paid Allov \$90.29 \$115	MA18 nal Payer(s). Forwa wed Adjustments .16 CO-45: \$73.68 , PR-2: \$23.03	rded to : KIDNEY CO-237: \$1.16 , CO-	DISEASE
Claim Status D PROGRAM OF Serv Date 06/14/2015 - 06/14/2015	Description F MD : 002 Units 1	: Processed as 259 Serv Code HC<99203	Primary, Fo Billed \$190.00 REM: N700	Adjudication rwarded to Additior Paid Allov \$90.29 \$115	MA18 nal Payer(s). Forwa wed Adjustments .16 CO-45: \$73.68 , PR-2: \$23.03	rded to : KIDNEY CO-237: \$1.16 , CO-	DISEASE

CO/PR Codes: CO-45 (\$73.68), CO-237 (\$1.16), CO-253 (\$1.84), PR-2 (\$23.03)

CO/PR Codes: CO-45 (\$15.68), CO-253 (\$0.33) – Filled in below.

<u> </u>	-			<u>.</u>			· ·							
Service	DOS	From & To	"	os	Procedure code	\$8	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
Line #														
1	2015-05-05 to	0 2015-05-05	1			222	.00	131.49			23.03		106.28	
		PR						CO				0/	Α	
	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	\$ 23.03		\$		45	\$ 73.68		\$			\$		\$
		\$		\$]	237	\$ 1.16		\$			\$		\$
		\$		\$		253	\$ 1.84		\$			\$		\$
2	2015-05-05 to	o 2015-05-05	1		1					[
		PR						CO				0/	Α	
	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$		45	\$ 15.68		\$			\$		\$
		\$		\$		253	\$.33		\$			\$		\$
		\$		\$			\$		\$			\$		\$
			1			-								



Example #3



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

Service Line #	e DOS From & To UOS		os	Procedure code	\$ Billed		\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provider	Paid Amt	
1	2015-05-05 to 2015-05-05 1													
	PR							co				0/	ι	
	Adjustment reason code Amount code Amount		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		\$			\$		\$
		\$		\$			\$		\$			\$		\$

2 - CO/PR Codes: CO-94 (-\$51.20), CO-253 (\$1.68), PR-2 (\$24.60) - Filled in below.

Service Line #	ce DOS From & To UOS		os	Procedure code	\$ Billed		\$ Allowed		\$ Deductble	\$ Coinsurance		\$ Provider Paid		
1	2015-05-05 to 2015-05-05 1				-									
	PR							CO				0/	λ	
	Adjustment reason code Amount code Adjustment		Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount	
	2	\$ 24.60		\$		94	\$ -51.20		\$			\$		\$
	S		\$		253	\$ 1.68		\$			\$		\$	
	\$		\$			\$		\$			\$		\$	



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

Servie	005 From & To		U	os	Procedure code	\$ Billed		\$4	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to 2015-05-05 1		1			:								
	PR						co				0/	1		
	Adjustment reason code		Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
1	2	\$ 24.60		\$		45	\$ 14.40		\$			\$		\$
1		\$		\$		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	U	os	Procedure code	\$ B	illed	\$4	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1											
	PR						CO				0/	4		
	Adjustment reason code Amount		Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
1	2	\$ 37.80		\$]	45	\$ 67.20		\$			\$		\$
		\$		\$]	253	\$ 1.68		\$	1		\$		\$
		\$		\$			\$		\$			\$		\$
			1.											

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

					,,		`	,,		,				
Service	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1											
		PR						co				0/	1	
	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	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1											
		PR						co				0/	1	
	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
1	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	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1			1								
		PR						co				0/	4	
	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		\$			\$		\$
1		\$		\$	1		\$		\$			\$		\$

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	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provider	Paid Amt
1	2015-05-05 to	2015-05-05	1			1								
		PR						CO				0/	ι	
	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		\$			\$		\$



Example #4



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

Ser	vice e #	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1		2015-05-05 to	2015-05-05	1			- -								
			PR						co				0/	4	
		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
			\$		\$		45	\$ 20.20		\$			\$		\$
			5		\$	1	253	\$.78		\$	1		\$		\$
			\$		\$	1		\$		\$			\$		\$

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

Service	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1			-							[
		PR						CO				0/	Α	
	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$		45	\$ 81.09		\$			\$		\$
		\$		\$		253	\$.78		\$			\$		\$
		\$		\$			\$		\$			\$		\$



3 – CO/PR Codes: CO-253 (\$1.92) – Filled in below.

CO/PR Codes: CO-45 (\$173.24), CO-253 (\$1.84) – Filled in below.

Service Line #	DOS	From & To	U	05	Procedure code	\$8	illed	5 4	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1											
		PR						co				0/	A.	
	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		\$		253	\$ 1.92		\$			\$		\$
		\$		5	1		\$		\$			\$		\$
		\$		5	1		\$		\$	1		\$		\$
2	2015-05-05 to	2015-05-05	1		•									
		PR			1			CO				0/	A.	
	Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount
		\$		5	1	45	\$ 173.24		\$			\$		\$
		\$		\$		253	\$ 1.84		\$			\$		\$
		\$		\$	1		\$		\$	1		\$		\$
		3017 07 07			1									



#1

Medicare Part B Crossover Claim Submission User Guide

SUMMARY REPORT EXAMPLES

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

Ser	vice ne #	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coir	surance	\$ Provide	r Paid Amt
1		2015-05-05 to	2015-05-05	1			-								
			PR						CO				0/	ι	
		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment reason code	Amount	Adjustment reason code	Amount		Adjustment	Amount	Adjustment reason code	Amount
			\$		\$			\$		\$		23	\$ 24.63		\$
			\$		\$			\$		\$	L		\$		\$
			\$		\$			\$		\$			\$		\$

#2

PT: SYE			LOUI	ISE	HIC:	212360581D	ICN: 21	52790387	5307MDA AC	CCT: BON.	179	ASG	Ŷ		
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	C0118

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	DOS	From & To	U	os	Procedure code	\$ B	illed	\$ A	llowed	\$ Deductble	\$ Coi	nsurance	\$ Provide	r Paid Amt
1	2015-05-05 to	2015-05-05	1			-								
		PR						CO				0/	4	
	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		\$
		\$		\$			\$		\$			\$		\$
		\$		\$			\$		\$			\$		\$