MISSISSIPPI DIVISION OF MEDICAID

9.2 Forms

The forms on the following pages may be photocopied for your use.

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information	2 Beneficiary Information
1a Provider Number	***2a Name***
1b NPI	
1c Provider Name	***2b Recipient ID Number***
	2c Date(s) of Service
1d Provider Address	***2d Transaction Control Number (TCN)***
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change
- ☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender	***6b Mailing Date***

Mississippi Medicaid Use Only

Reason Code		***Initials***	***Date Stamp***
FCN		***Date***	
Claim Type	***TXN Code***	***COS***	

Appointment of Authorized Provider Representative or Agent Form

MISSISSIPPI DIVISION OF MEDICAID

Provider:	Provider Number: NPI:

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicaid the provider or supplier):

I appoint this individual or agent,_____, to act as my representative to submit claims and other billing documents at my direction to the Mississippi Division of Medicaid. This individual may also use my electronic signature, typed signature, stamped signature on my behalf, at my direction, to make such submissions. When using my electronic, typed, or stamped signature, this individual must also accompany my electronic, typed, or stamped signature with their own printed name, either in electronic or handwritten form.

Signature of Provider		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		

Section 2: Acceptance of Appointment

To be completed by the representative:

I,_____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS), licensure agency or Mississippi Department of Health (MSDH). I additionally certify that I have not been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including, but not limited to, fraud, forgery, counterfeiting, embezzlement, identity theft, tax evasion, money laundering, or any other crime related to dishonesty or concealment, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

I am a / an _____

(Professional title as it relates to the Provider)

Signature of Representative		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		

CLAIMS INQUIRY Form

Please complete this form and attach appropriate documentation.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23078
Jackson, Mississippi 39225

1 Provider Information

1a Billing Provider Number and/or Servicing Provider Number

1b NPI

1c Provider Name and Address

1d Point of Contact	***1e Provider Telephone***

2 Beneficiary Information

2a Name	***2b Recipient ID Number***
2c Date(s) of Service	***2d Transaction Control Number (TCN)***

3 Nature of Inquiry *(Please check one of the following if applicable, if not please explain in the space below)*

☐ 3a Claim Status ☐ 3b Explanation of denied Claim

Other Inquiry:

4 Signature Block

4a Signature	***4b Date***

Mississippi Medicaid Use Only

Reviewed by	***Date Stamp***
Action Taken	

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

(Page 1 of 5)

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

MISSISSIPPI DIVISION OF MEDICAID

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would otherwise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically. **Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.**

You may contact Mississippi's Provider Relations Unit at 1.800.884.3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

Attention! It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email address

Fax Number

Financial Institution Information

Financial Institution Name*

Financial Institution Address

Street

City

State

Zip

Financial Institution Routing Number*

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

(Page 2 of 5)

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

MISSISSIPPI DIVISION OF MEDICAID

Type of Account at Financial Institution*

O Checking
O Savings

Provider's Account Number with Financial Institution*

Account Number Linkage to Provider Identifier*
(**Must Match ERA Preference**)

O Provider Tax Identification Number (EIN/TIN)
O National Provider Identification Number (NPI)

Submission Information

Reason for Submission*

O New Enrollment
O Change Enrollment
O Cancel Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Medicaid agency to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Medicaid agency in order to change my bank account information immediately. I will not hold the Mississippi Medicaid agency liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Written Signature of Person Submitting Enrollment*

Printed Name of Person Submitting Enrollment

Submission Date

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

MISSISSIPPI DIVISION OF MEDICAID

INSTRUCTIONS
Required fields on this form are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title – Enter the title of the Provider Contact person.

Telephone Number – Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension – Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address – Enter the email address of the Provider Contact Person.

Fax Number – Enter the fax number of the Provider Contact Person.

Financial Institution Information

Financial Institution Name* - Enter the name of the financial institution that is to receive the provider's payments.

Financial Institution Address (Street) – Enter the street address of the financial institution.

Financial Institution Address (City) – Enter the city address of the financial institution.

Financial Institution Address (State) – Enter the two digit state abbreviation of the financial institution.

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

MISSISSIPPI DIVISION OF MEDICAID

INSTRUCTIONS
Required fields on this form are denoted with an asterisk (*).

Financial Institution Address (Zip) – Enter the zip code address of the financial institution.

Financial Institution Routing Number* - Enter the nine digit routing number of the financial institution.

Type of Account at Financial Institution* - Check the Checking radio button if the account at the financial institution is a checking account. Check the Savings radio button if the account is a savings account.

Provider's Account Number with Financial Institution* - Enter the provider's account number with the financial institution.

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is an atypical provider, otherwise check the National Provider Identification Number (NPI) radio button.

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for EFT. Check the Change Enrollment radio button if this application is to make a change to an existing provider's EFT information. If the Cancel Enrollment radio button is checked, the cancellation will be denied since an EFT is required to be on file for all active providers.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

MISSISSIPPI DIVISION OF MEDICAID

Missing or Late EFT Procedures

- The provider will contact the Xerox Call Center at (1-800-884-3222) to verify their banking information that is currently on file.
- The Call Center Agent will verify the banking account and routing numbers.
- If the account number is correct, the Call Center Agent will advise the provider to contact their financial institution's ACH department.
- If the banking account or routing number isn't correct, the Call Center Agent will direct the provider to update their banking account information via the Direct Deposit Authorization/Agreement form which is available on the Mississippi Medicaid website at http://msmedicaid.acs-inc.com under Provider→Provider Enrollment for online submission to be downloaded.

CLAIM FORM REORDER REQUEST Form

Please complete form.

Mail to: **Mississippi Medicaid Program**
Attention Claim Form Reorder Request
P.O. Box 23076
Jackson, Mississippi 39225

Provider Information

Medicaid Provider Number	***Provider Name***
NPI	
Provider Address/Ship To (Street, City, State and Zip)	

Order Information

Order only a 2-3 month supply, allowing 2-3 weeks for delivery. A change of address may require 3-5 weeks for delivery. Be sure to notify the Provider Relations unit at ACS of any address change to avoid unnecessary delay.

Form Number	Title	25	50	100	300	Other	Quantity Shipped
DOM 260	Certification for Nursing Facilities						
DOM 260 DC	Certification for Disabled Child						
DOM 260HCBS	Certification for HCBS						
DOM 260 MR	Certification for ICF/MR						
DOM 301 HCBS	HM Comm-Based SVS/PH						
DOM 340	Pharmacy Authorization Request – Clorazil						
DOM 350	Pharmacy Authorization Request – Sandimmune						
DOM 413	Level II PASRR Billing Roster						
HCBS 105	Admit/Discharge HCBS for LTC						
MA 1001	Sterilization Consent Form						
MA 1002	Hysterectomy Acknowledgement Statement						
MA 1034	Medical Necessity for Abortion Form						
MS/ADJ	Adjustment Void Form						
MA 1165	Hospice Membership Form						
MS/INQ	Claim Inquiry Form						
MS/XOVE	Medicare/Medicaid Crossover Form – Part A						
MS/XOVE	Medicare/Medicaid Crossover Form Part – B						
MS PHAR	Pharmacy Claim Form						

Provider or Authorized Signature	***Date***

Change of Address Form Instructions

Signature

- The individual provider's signature is required for all changes requested for an individual provider number.
- Signature of the authorized representative for the group/facility is required for changes to group/facility provider numbers.

General

- Incomplete forms will be returned to the provider.
- If you have any questions, please contact Xerox Provider Enrollment at (800) 884-3222.

MISSISSIPPI DIVISION OF
MEDICAID

CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: (888) 495-8169

Provider Information

Provider Name:

National Provider Identifier (NPI):

MS Medicaid Provider Number:

Contact Information

Contact Name: Phone Number:

Email Address:

Change of Address Information

Please check the appropriate box below for the address type you wish to change.

☐ Servicing Address		Street Address City / County / State / Zip Code
		Phone Number / Fax Number
☐ Billing Address		Street Address City / County / State / Zip Code
☐ Mail Other Address		Street Address City / County / State / Zip Code
☐ Remittance Advice Address		Street Address City / County / State / Zip Code
☐ 1099 Mailing Address	*W-9 Required	Street Address City / County / State / Zip Code

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

☐ **All Addresses**	*W-9 Required	Street Address City / County / State / Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature **Date**

Revised 6/3/2014

Xerox EDI Gateway, Inc. Provider Agreement

Please return to:

Mississippi Medicaid Program

Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

MISSISSIPPI DIVISION OF MEDICAID

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Xerox EDI GATEWAY TRADING PARTNER AGREEMENT

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between **SUBMITTER** ("Submitter") and **Xerox EDI GATEWAY, INC.** ("Trading Partner"), collectively "the Parties."

Whereas, Submitter desires to transmit Transactions to Trading Partner for the purpose of submitting data to the Mississippi Division of Medicaid;

Whereas, Trading Partner desires to receive such Transactions for this purpose; and

Whereas, Submitter is subject to the Transaction and Code Set Regulations with respect to the transmission of such Transactions.

Now, therefore, the Parties agree as follows:

1. Definitions

Trading Partner means Xerox EDI Gateway, Inc.

Submitter means the party identified as "Submitter" on the signature line of this Agreement who is a Health Care Provider as defined in 45 CFR 164.103.

Standard is defined in 45 CFR 160.103.

Transaction is defined in 45 CFR 160.103.

Transactions and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Submitter

A. The Parties agree, in regard to any electronic Transactions between them:

(1) They will exchange data electronically using only those Transaction types as selected by Submitter on the Xerox EDI Gateway Trading Partner Enrollment Form (TPEF).

(2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.

(3) They will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically.

(4) They will not add any data elements or segments to the Maximum Defined Data Set.

(5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.

(6) They will not change the meaning or intent of a Standard's implementation specification.

(7) Trading Partner will accept Transactions from Submitter according to the Xerox EDI Gateway TPEF but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the TPEF. Trading Partner may return a Submitter to a test status if Submitter repeatedly submits Transactions which do not meet the criteria set forth in a TPEF or if Submitter repeatedly submits inaccurate or incomplete Transactions to Trading Partner.

B. Submitter understands that Trading Partner or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Submitter will participate fully with Trading Partner in the testing, verification, and implementation of a modification to a Transaction affected by the change.

C. Trading Partner understands that DHHS may modify the Transaction and Code Set Regulations. Trading Partner will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Submitter and Trading Partner.

D. Neither Submitter nor Trading Partner accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Submitter and Trading Partner.

E. Submitter and Trading Partner will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Submitter and Trading Partner will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

F. Trading Partner may publish data clarifications ("Xerox Companion Guides") to complement each Implementation Guide. Submitter should use Xerox Companion Guides in conjunction with the HIPAA Implementation Guides available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

G. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will promptly transmit an electronic acknowledgment that conclusively constitutes evidence of properly received transactions. Each party will subject information to a virus check before transmission to the other party.

H. Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

3. Miscellaneous

A. This Agreement is effective on the date last signed below. This Agreement shall continue until such time as either party elects to give written notice of termination to the other party or termination of Transaction services provided by Trading Partner to Submitter, whichever is earlier.

B. This Agreement incorporates, by reference, any written agreements between the parties relating to the subject matter hereof.

C. This Agreement shall be interpreted consistently with all applicable federal and state privacy laws. In the event of a conflict between applicable laws, the more stringent law shall be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement shall be governed by and construed in accordance with Mississippi law, exclusive of conflicts of law principles. THE EXCLUSIVE JURISDICTION FOR ANY LEGAL PROCEEDING REGARDING THIS AGREEMENT SHALL BE IN THE COURTS OF THE STATE OF MISSISSIPPI AND THE PARTIES HEREBY EXPRESSLY SUBMIT TO SUCH JURISDICTION.

D. Unless otherwise prohibited by statute, the parties agree that this Agreement shall not be affected by any state's enactment or adoption of the Uniform Computer Information Transaction Act, Electronic Signature or any other similar state or federal law. Each party agrees to comply with all other applicable state and federal laws in carrying out its responsibilities under this Agreement.

E. This Agreement is entered into solely between, and may be enforced only by, Submitter and Trading Partner. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of Submitter or Trading Partner to any third party.

F. NO WARRANTIES, EXPRESS OR IMPLIED, ARE PROVIDED BY TRADING PARTNER UNDER THIS AGREEMENT. TRADING PARTNER'S MAXIMUM AGGREGATE LIABILITY FOR DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER ARISING OUT OF THIS AGREEMENT, REGARDLESS OF THE MANNER IN WHICH CLAIMED OR THE FORM OF ACTION ALLEGED, IS LIMITED TO THE AMOUNT(S) PAID TO TRADING PARTNER BY SUBMITTER UNDER THIS AGREEMENT.

G. Trading Partner may provide proprietary software to Submitter to allow Submitter to submit Transactions to Trading Partner. Submitter will protect the software as it protects its own confidential information and will not, directly or indirectly, allow access to or the use of the software or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than Submitter. Submitter may permit use of the software by contractors or agents of Submitter provided that any such contractors or agents are not competitors of Trading Partner and further provided that any such persons agree to protect the confidentiality of the software. Submitter and its contractors and agents are not permitted to use the software for any purpose other than submitting Transactions solely to Trading Partner.

H. This Agreement contains the entire agreement between the parties and may only be modified by an agreement signed by both parties.

f Submitter may elect to execute either a hard copy or an electronic copy of this Agreement. Hard Copy Execution: Submitter will sign a hard copy of this Agreement and mail to Trading Partner at the address indicated below. Trading Partner will return a copy of the fully executed Agreement to Submitter. The effective date of the hard copy Agreement is the date on which the Agreement is signed by Trading Partner. Electronic Copy Execution: Submitter should execute this Agreement by clicking on the "I AGREE" button that appears at the bottom of the Agreement. The effective date of the

MISSISSIPPI DIVISION OF MEDICAID

xerox

f electronic copy agreement is the date Trading Partner receives the electronic transmission of Submitter's acceptance to the terms of this Agreement.

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

SUBMITTER:

_____
Signature

_____
Printed Name and Title

_____
Date

_____
Signature

_____
Printed Name and Title

_____
Date

TPL EDIT OVERRIDE ATTACHMENT:
NO RESPONSE

This is to certify that a claim has been filed with the third party source named below with follow-up as required and that no response has been received in at least 60 days.

Name of Medicaid beneficiary: _____

Medicaid ID number: _____

TPL source name: _____

Address: _____

_____

Telephone number: _____

Policy number: _____

Date of original billing: _____

Date of follow-up: _____

I understand that the Division of Medicaid will research this matter. If no claim has been received by the TPL source, the Medicaid payment will be voided via the payment register with a message to bill the third party.

_____ _____

Signature of provider or billing clerk Date

_____

Phone Number

Medicaid Title XIX Pharmacy Invoice

Check One Box:
☐ Retro Eligibility
☐ TPN

State of Mississippi
Division of Medicaid
P.O. Box 23076
Jackson, MS 39225

PROVIDER INFORMATION

[1]Provider Name	[2]NPI	[3]Medicaid Number	[4]Phone # Fax #
[5]Street Address	[6]City	[7]State	[8]Zip Code

[9]Medicaid ID | Medicare #

BENEFICIARY INFORMATION

[10]Last Name	[11]First Initial	[12]DOB

1	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17]☐ New ☐ Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
2	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17]☐ New ☐ Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
3	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17]☐ New ☐ Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
4	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17]☐ New ☐ Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price
5	[13]Rx Number	[14]Prescriber NPI	[15]Prescriber Medicaid#	[16]Date of Service
[17]☐ New ☐ Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]National Drug Code	[23]	[24]TPL Amt	[25]U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ 27. Date: _____

28. Pharmacist's Name Printed: _____

Medicare Part A

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

1. Type of Bill

For Medicare Part C ONLY

2. Provider Name and Address	3a. Medicaid Provider Number	3c. Taxonomy Code	4. Recipient Name and Address
	3b. NPI Number		

5. Recipient Medicaid ID	6. Patient Account/Medical Record Number	Admission			10. Dates of Service	
		7. Date	8. Hour	9.Type	From	Thru

11. Covered Days	12.Diagnosis	
	Primary	Secondary
	3rd	4th

13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount

16. Total Medicare Deductible Amount	17. Total Medicare Co-insurance Amount	18. Total Medicare Blood Deductible Amount	19. Medicare Paid Date	20. Total Third Party Payment Amount

	21. Revenue Code	Procedure Code	22. Units	23. Medicare Billed Amount	24. Medicare Non-covered Amount
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

25. Provider Signature	26. Billing Date

Revised 6/16/10 rre

Medicare Part B

MISSISSIPPI CROSSOVER CLAIM FORM
State of Mississippi Medicaid Program

Revised 05/02/12

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	2c. Taxonomy Code	3. Recipient Name and Address
	2b. NPI Number	4. Recipient Medicaid ID	

5. Patient Acct. / Med Rec Num.	6. Diagnosis			
	Primary	Secondary	3rd	4th

	7. Service Dates From	Thru	8. Procedure Code	9. Modifier	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amounts
	13. Medicare Non-Covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-Insurance	18. Medicare Paid Date	19. Third Party Amount
1							
	8a. NDC						
2							
	8a. NDC						
3							
	8a. NDC						
4							
	8a. NDC						
5							
	8a. NDC						
6							
	8a. NDC						

I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted with the exception of authorized copayment.

20. Provider Signature	21. Billing Date