2.3 Medicare Part C Only - Mississippi Medicaid Part B Claim Form Instructions

The Mississippi Medicaid Part B Crossover Claim form located in this section is a state specific form, and must be used when billing for Medicare Part C Advantage Plans only. Medicare Advantage Plans claims are for dually eligible beneficiaries enrolled in Medicare and eligible for Medicaid coverage. The following are instructions for completing the Medicare Part B crossover billing form when billing Medicare Part C Advantage Plan claims. An additional requirement is that a copy of the Medicare EOMB for the billed services **must** be attached for all paper Crossovers. This claim form and instructions are available on DOM's website at http://www.medicaid.ms.gov. Select the Resources link then choose the Forms link.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- Claims received on an incorrect claim form or without the appropriate EOMB can not be processed for payment.
- Indicate that the claim is a Medicare Part C Advantage Plan claim by writing the words **Advantage Plan** on the bottom of the claim form.

Paper Claims with Attachments

When submitting attachments with the Mississippi Medicaid Part B Crossover claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Billing Tip 

Often the contractual amount sometimes referred to as "co-pay/co-insurance", "co-pay/deductible", 'co-pay/co-insurance/deductible", or "member-patient responsibility" will be indicated on the Medicare Part C Advantage Plan EOMB. However, if not specifically stated use the criteria below to enter amount in appropriate field(s).

The following are examples of Medicare Part C Advantage Plan EOMB scenarios for TPL Payment.

Scenario 1: If EOMB states co-pay/co-insurance only, enter amount on claim in Field 17.

Scenario 2: If EOMB states co-pay/deductible only, enter amount on claim in Field 17.

Scenario 3: If EOMB states co-pay only, enter amount on claim in Field 17.

Scenario 4: If EOMB states amounts separately for co-pay/co-insurance/deductible enter amount for deductible on claim in Field 16 and combined amounts for both co-pay/co-insurance on claim in Field 17.

Scenario 5: If EOMB states amounts separately for co-pay, no amount for co-insurance and amount for deductible, enter amount on claim in Field 16 for deductible and Field 17 for co-insurance.

Scenario 6: If EOMB states member-patient responsibility only, enter amount on claim in Field 17.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (03/16)
1	Required	**Provider Name and Address**: Enter the full name and address of the provider/facility submitting the claim.
2a	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care provider.
2b	Required	**National Provider Identifier (NPI):** Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
2c	Required if applicable	**Taxonomy Code:** Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
3	Required	**Beneficiary Name and Address:** Enter the full name (last name, first name) and the address of the beneficiary receiving services.
4	Required	**Beneficiary Medicaid ID Number:** Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
5	Optional	**Patient Account/Medical Record Number:** Enter the internal account number or medical record number of the beneficiary.
6	Required	**Diagnosis Code:** Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
7	Required	**Service Dates:** Enter the from and thru date of service for this billing in MM/DD/CCYY format.
8	Required	**Procedure Code:** **Outpatient Services:** Enter the HCPCS code for laboratory, radiology and dialysis services provided. **Professional services**: Enter the appropriate CPT code for the services provided.
8a	Required	**National Drug Code**: Enter the appropriate NDC for the services provided.
9	Required	**Procedure Modifier**: Enter the applicable modifier for the procedure rendered.
10	Required	**Service Units:** Enter the number of units provided on each detail line.
11	Required	**Medicare Billed Charges:** Enter the total charges (dollars.cents) billed to Medicare for each detail line.
12	Required	**Medicare Allowed Amount:** Enter the amount payable for each service (dollars.cents) as determined by Medicare.
13	Required	**Medicare Non-Covered Amount:** Enter the charge (dollars.cents) for any non-covered service, such as take-home drugs.
14	Required	**Medicare Blood Deductible Amount:** Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid by Medicaid.
15	Required	**Medicare Paid Amount:** Enter the total amount (dollars.cents) Medicare paid on the claim for each detail line.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (03/16)
16	**Required**	**Medicare Deductible:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
17	**Required**	**Medicare Co-insurance:** Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	**Required**	**Medicare Paid Date:** Enter the date of Medicare payment in MM/DD/CCYY format.
19	**Required if Applicable**	**Third Party Payment Amount:** Enter the amount (dollars.cents) of payment made by any third party source applied toward the claim for each detail.
20	**Required**	**Provider Signature:** The provider or an authorized representative must sign the claim form. Rubber stamp signatures are acceptable.
21	**Required**	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Medicare Part B

Revised 03/14/16

MISSISSIPPI CROSSOVER CLAIM FORM
State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	2c. Taxonomy Code	3. Beneficiary Name and Address
	2b. NPI Number	4. Beneficiary 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 Amount
	13. Medicare Non-covered Amount	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Payment 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