

# Job Aid

## **Professional Crossover Claim with TPL Submission**

This job aid provides step by step instructions to submit a Professional Crossover Claim with TPL in the MESA portal. Please read the instructions thoroughly and follow all directions.

Starting December 18, 2023, providers will have access to their portal account for up to 1 year from the date of termination. Claims for services provided before the termination effective date may be submitted for processing as well as adjustments or voids. Claims for services provided on or after the termination date will be denied.

#### When submitting a crossover claim make sure to follow these tips:

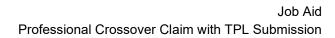
- > Only include the EOMB(s) needed to process the claim.
- > EOMBs must be completely legible.
- > Negative dollar amounts are not accepted and must be entered as zero.
- > All of the data on the EOMB must match the data entered on the portal submitted claim.

### Review the Steps to Submit a Professional Crossover Claim with TPL

Steps		Description									
Step 1	Login to the Portal. The <b>Portal Home</b> screen Displays.										
		Search Medicaid:									
	Home         Eligibility         Claims         Care Management         Patient Health History         Files Exchange         Resources         Contact Us										
	Home		Wednesday 11/30/2022 04:31 PM CST								
	Provider Name Location	Role IDs Taxonomy									
	User Details Welcome Group Mu Profile Manage Accounts Provider Name Provider ID Location ID Characteristics	Weicher Erschles System Assistance           Weicher Heafth Care Professional           Ware committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.	<ul> <li>Sign Up to Receive News</li> <li>Secure Correspondence</li> <li>Latest News</li> <li>Late Breaking News</li> <li>Provider Bulletins</li> <li>UM/QIO</li> <li>Report Fraud</li> </ul>								
	Provider Se     Member Focused Viewing     Search Payment History     Affiliated Providers     340B Program Information										



Steps	Description								
Step 2	<ul> <li>The following steps will review how to submit a Professional Crossover Claim in MESA:</li> <li>Hover over the <b>Claims</b> tab on the menu bar. A list of claim types displays below.</li> <li>Select <b>Submit Claim Prof</b>.</li> </ul>								
	Home         Eligibility         Claims         Care Management         Patient Health History         Files Exchange         Resources         Contact Us           Search Claims         Submit Claim Dental         Submit Claim Inst         Submit Claim Prof         Submit Claim Pharm         Search Payment History								
Step 3	<ul> <li>The Portal displays the "Submit Professional Claim": Step 1 page.</li> <li>Select Claim Type Crossover Professional.</li> </ul>								
	Submit Professional Claim: Step 1  * Indicates a required field.  Claim Type Crossover Professional								
Step 4	Complete the <b>Provider Information</b> section. <b>NOTE</b> : There will be information already generated in this section. Complete additional fields if applicable to the claim being submitted.								
	Provider Information								
	Billing Provider ID ID Type NPI Name								
	Taxonomy Performing Provider ID ID Type NPI Name Taxonomy								
	Referring Provider ID     Q     ID Type     NPI     Name       Taxonomy								
	Taxonomy _								
Step 5	<ul> <li>Complete the Member Information section.</li> <li>NOTE: Once the Member ID is entered, the system will generate the remaining fields in this section.</li> <li>Verify the fields populate correctly.</li> </ul>								
	Member Information         *Member ID         Last Name         Birth Date         Address         Address Line 2         City         State         V								





Desc	ription
-	
Claim Information	
Date Type  Accident Related  Patient Number	Date of Current  Admission Date  Authorization Number
*Transport Certification O Yes  No	
*Does the provider have a signature on file?	○ Yes ● No
*Does the provider accept assignment for claim processing?	○Yes  No Clinical Lab Services Only
*Are benefits assigned to the provider by the patient or their authorized representative?	○ Yes
*Does the provider have a signed statement from the patient releasing their medical information?	⊖ Yes® No
Include Other Insurance 💿	Total Charged Amount \$0.00
Review all sections on Submit Professional C correct select <b>Continue</b> to move on to Step 2.	Claim: Step 1 page. If all the information entered is
Claim Information	
Date Type	Date of Current () () () () () () () () () () () () ()
*Does the provider have a signature on file?	● Yes ○ No
*Does the provider accept assignment for claim processing?	● Yes ○ No ○ Clinical Lab Services Only
*Are benefits assigned to the provider by the patient or their authorized representative?	● Yes ○ No ○ N/A
*Does the provider have a signed statement from the patient releasing their medical information?	● Yes ○ No
Include Other Insurance	Total Charged Amount \$0.00
	Continue Cancel
	<ul> <li>Complete the Claim Information section.</li> <li>NOTE: The "Include Other Insurance" box is grader in the insurance in the provider accept assignment for the provider have a signature on file?</li> <li>* Does the provider accept assignment for claim processing?</li> <li>* Are benefits assigned to the provider by the patient or their authorized representative?</li> <li>* Does the provider have a signed statement from the patient releasing their medical information?</li> <li>Include Other Insurance information</li> <li>Claim Information</li> <li>Claim Information</li> <li>* Review all sections on Submit Professional C correct select Continue to move on to Step 2.</li> <li>Claim Information</li> <li>Date Type information</li> <li>* Transport Certification in the patient or the patient or the patient releasing their medical information?</li> <li>* The transport Certification in the patient or the patient number in the patient number in the patient or the patient or the patient or the patient or the patient or the patient releasing it patient patie</li></ul>



Steps			Description			
Step 8	<ul><li>The Portal displays the "Sub entered in step 1 will display</li><li>Review the previously sup</li></ul>	at the top of the	page in step 2.	The previous inf	ormation tl	hat was
	Submit Professional Claim: Step 2					2
	* Indicates a required field.					<u> </u>
		Claim Type Cross	sover Professional			
	Provider Information					
	Billing Provider ID	1	D Type NPI	Name		
	Taxonomy Patient and Claim Information					
	Member ID					
	Member Birth Date		Gender			
	Birtii Date		Total Charged Amount			
Step 9	• Enter the <b>Diagnosis Co</b> Everything with a <b>Red</b> asteri		•		-	
	Diagnosis Codes					-
	Select the row number to edit the row. Click the Please note that the 1st diagnosis entered is co					
	# Diagnosis Type		Diagnosis Code			Action
	1					
	1 *Diagnosis Type ICD-10-CM V	*Diagnosis Co	ode Ə			
	Add Reset					
Step 10	Scroll down to the Other Ins	urance Detail p	anel.			
	<b>NOTE:</b> If there is other insur button under the <b>Action</b> colu		already populated that	it is out of date,	select the	Remove
	<ul> <li>Select the plus sign to a</li> </ul>		irance. Steps are show	vn below to add	Medicare	and other
	insurance outside of Me				mouldid	
	1					
	Other Insurance Details					
	Enter the carrier and policy holder information	below.				
	Enter other carrier Remittance Advice details h Details section.	nere for the claim or with eacl	n service line. Enter adjusted payment o	details, such as reason code	s, in the Claim Adj	ustment
	NOTE: Please click Remove to discard any un	related "Other Insurance", pr	ior to submitting claim.			
			1		Refresh Other I	insurance
	# Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	mittance Date	Action
	Click to add a new other insurance.					



Steps				Description						
Step 11	To add Medicare Part A, B, or C follow these steps. Using the Claim Filing Indicator dropdown, select 16 (Medicare Part C), MA (Medicare Part A), or MB (Medicare Part B). No additional fields are necessary for these selections. For this example, MB-Medicare Part B was selected from the Claim Filing Indicator dropdown. Click Add Insurance to save the selection. Other Insurance Details displays Medicare Part B on line #1. Other Insurance Details Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim.									
			,	-		Refresh Other	Insurance			
	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action			
		lick to collapse.								
		*Claim Filing Indicator MB	-Medicare Part B	~						
		Add Insurance	cel Insurance							
Step 12	Othe Enter Enter Detai	Select the plus sign r Insurance Details the carrier and policy holder inform other carrier Remittance Advice de Is section.	nation below.	service line. Enter adjusted payment	details, such as reason	codes, in the Claim A				
	#	Carrier Name	Carrier Code	Group #	COB Payer Paid	Remittance Date	Action			
	1	Claim Filing Indicator: 'Medicare P	art B'		Amount		Remove			
		lick to add a new other insurance.								



			Description			
•	Medicare A (MA), I	ance that is applicabl Medicare B (MB), or M ne selection is made. that line.	ledicare C (Claim fili	ing indicator = 16	), then addition	onal field
-	Click to collapse.					
	*Claim Filing	Indicator				~
			Non-Federal Program	ms		
	Add Ins	12-Prefer	red Provider Organiz of Service (POS)			
Co	ondition Codes	14-Exclus	sive Provider Organiz nnity Insurance	ation (EPO)		
CI	ick the <b>Remove</b> link	17-Denta	n Maintenance Organ I Maintenance Organ		dicare Risk	
	#	BL-Blue C	nobile Medical Cross/Blue Shield			
	1		ercial Insurance Co.			
1	*Conditio		al Employees Program			
		CC LM-Liabili		nization		
	Add		care Part A care Part B			
	100		Federal Program			-
•	Complete the addi Link to Carrier Coo					6
Ot Eni De	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	<u>des</u>	ch service line. Enter adjusted pay	rment details, such as reason Everything w must b	codes, in the Claim Ac rith a red aster e completed. Refresh Other	isk *
Ot Eni De NG	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. DTE: Please click Remove to disco Carrier Name	des nformation below. ce details here for the claim or with ea	ch service line. Enter adjusted pay	rment details, such as reason Everything w	vith a red aster e completed.	isk *
Ot Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. DTE: Please click Remove to disco Carrier Name Click to collapse.	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk * Insurance
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	des nformation below. ce details here for the claim or with ea ard any unrelated "Other Insurance", s	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk * Insurance
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section.	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group #	ment details, such as reason Everything w must b COB Pyer Paid	vith a red aster e completed. Refresh Other	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [ *First Name ]	ment details, such as reason Everything w must b COB Pyer Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to disci Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [ *First Name ]	ment details, such as reason Everything w must b COB Pyer Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please click Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code @ *Subscriber ID *Group #	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [ *First Name ]	ment details, such as reason Everything w must b COB Pyer Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code @ *Subscriber ID *Group # Group Name	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code [ *First Name ] State [ Country ]	ment details, such as reason Everything w must b COB Driver Paid mount	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility	hormation below.  te details here for the claim or with ea ard any unrelated "Other Insurance", ;  Carrier Code  BL-Blue Cross/Blue Shield  DUID	ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [ *First Name ]	COB Diver Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility	hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code	ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country	ment details, such as reason Everything w must b COB Driver Paid mount	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility *COB Payer Paid Amount Remaining Patient Liability	hormation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code BL-Blue Cross/Blue Shield BL-Blue Cross/Blue Shield	ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country	COB Diver Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *
Ott Eni De NO	Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility *COB Payer Paid Amount	hormation below.  te details here for the claim or with ea ard any unrelated "Other Insurance", ;  Carrier Code  BL-Blue Cross/Blue Shield  DUID	ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country	COB Diver Paid	rith a red aster e completed. Refresh Other Remittance Date	isk *



52	MISSISSIPPI DIVISION OF
-	MEDICAID

Steps			Description
	•	Select the appropriate Pay	or Responsibility. If not known, select Unknown.
		*Payer Responsibility	
		*COB Payer Paid Amount	D Driver
		Remaining Patient Liability	P-Primary S-Secondary
		*Release of Information	T-Tiertiary U-Unknown
		Assignment of Benefits	A-Payer Responsibility Four
		_	- C-Paver Responsibility Six -
		Outpatient Adjudication Inform	D-Payer Responsibility Seven     E-Payer Responsibility Eight
		Reimbursement Rate	F-Payer Responsibility Nine G-Payer Responsibility Ten
		Remark CoMS 1	H-Payer Responsibility Eleven
		Remark COPIS 1	
	•	Everything with a Red aste	erisk * must be completed if the section is applicable to the claim.
	•		entered select Add Insurance.
	Ou	tpatient Adjudication Information	
		Reimbursement Rate	Claim HCPCS Payable
			Amount
		Remark CoMS 1 Remark Code 2	
		Remark Code 3	
		Remark Code 4	
		Remark Code 5	Non-payable Professional Component Amount
	C	laim ESRD Payment Amount	
		Add Insurance Cancel Insura	ance
	•		
	_		
	Scr	oll down to see all other i	nsurance details panels.



Steps				Description							
Step 14	i	nsurance just added		added, select the nun							
		<b>NOTE</b> : Users can only view the Other Insurance Reasons sub-panel if the Claim Filing Indicator is anything other than Medicare A, B, or 16.									
	*The	*The user MUST click on the other insurance hyperlink after adding insurance to add additional information.									
	Othe	r Insurance Details					-				
		the carrier and policy holder inforr									
		Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.									
	NOT	NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim.									
						Refresh Othe	r Insurance				
	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action				
	1	Claim Filing Indicator: 'Medicare F					<u>Remove</u>				
	2 + C	test lick to add a new other insurance.	test	test	\$0.00	11/30/2022	Remove				
01 15											
Step 15			Insurance Reason urance Reasons sect								
		-		completed if the section	n is applicable	e to the clair	n.				
			to save the information	on to the reason.							
		er Insurance Reasons can enter up to five unique group	codes. You can repeat six combinati	ions of reason code and adjustment an	ount with each group	code.	_				
	Click	the <b>Remove</b> link to remove the e	ntire row.								
	#	Group Code		Reason	Amount	Units of Service	Action				
		Click to collapse.									
		*Group Code *Reason 9		~							
		*Amount	0.00	Units of Service							
		Add Reason Cance	el Reason								
		Once the <b>Other Insu</b>	rance Reasons are	added, select Save In	surance to m	ove to the r	next				
		er Insurance Reasons									
			odes. You can repeat six combinatio	ons of reason code and adjustment amo	ount with each group co	de.					
	Click	the <b>Remove</b> link to remove the e	ntire row.								
	#	Group Code		Reason	Amount	Units of Service	Action				
	1	PR-Patient Responsibility	36-Balance does not exceed	co-payment amount.	\$1.	00	Remove				
	•	Click to add a new claim reason.									
		Save Insurance	cel Insurance								





Steps						Descript	ion		
Step 16	was •	<ul> <li>The Portal displays the "Submit Professional Claim": Step 3 page. The previous information that was entered in step 1 and step 2 is displayed at the top of the page on step 3.</li> <li>Scroll down to view the additional sections on this page.</li> <li>NOTE: Select the plus and minus for each section to expand and collapse the section.</li> </ul>							
	Submit Professional Claim: Step 3 ?								?
					Claim Type C	rossover Profession	al		
	Prov	ider Inform	ation						
			illing Provider ID			ID Type NPI	Name		
			Taxonomy						
	Patio	ent and Clai	m Information						
			Member ID Member				Gender		
			Birth Date			Total (	Charged Amount		
	Med	icare Crosso	over Details						
		Allowed	Medicare Amount	\$0.00			Co-insurance Amount \$0.00		
			eductible Amount			P	sychiatric Services Amount \$0.00		
		Medicare	Payment Amount Copay Amount				Medicare Payment Date		
								Evnan	d All   Collapse All
	Diag	nosis Codes	;						
	Pleas	e note that t	he 1st diagnosis ent	ered is considered	I to be the princi	pal (primary) Diagn	osis Code.		
		#		)iagnosis Type			Diagnosis Cod		
		1		ICD-10-CM			R071-CHEST PAIN ON B	REATHING	
	Othe	er Insurance	e Details						
	#		Carrier Name	•	Carri	ier Code	Group #	COB Payer Paid Amount	Remittance Date
	1		Indicator: 'Health N	1aintenance Orga		1edicare Risk'			
	2	test			test		test	\$0.00	12/09/2022



Steps				Description					
Step 17	<ul> <li>Fill out the required information for the Service Details section.         <ul> <li>Complete the Medicare Crossover Details section.</li> <li>Complete the NDCs for Svc. # panel if applicable.</li> </ul> </li> <li>Once all information has been completed, select Add.     The data entered must match the submitted EOMB or the system could deny.     </li> <li>Ex: EOMB shows the member has a copay of \$20. The Copay field must have \$20 entered. If \$ is entered in the Coinsurance field that will cause the claim to deny.     </li> <li>Ex: EOMB shows Medicare Payment Date of 10/01/2024 but the date entered was 09/30/2024. Th will cause the claim to deny,</li> </ul>								
	Service Details		w. Click the <b>Remove</b> link to remove th	he entire row.					
	Svc # From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action		
	# 1 *From Date 0 1 *From Date 0 Charge Amount Clia Number Referring Provider ID Performing Provider ID Ordering Provider ID Medicare Crosson Allowed N De	02/02/2025 99215-OFFICE \$100.00 \$100.0	To Date 0       02/02/2025         O/P1       Modifiers 0         *Units       60.000         Authorization Number         ID Type       NPI         ID Type       NPI	Place of 10-Telehealth Provided in Service   Unit Type   *Unit Type   Minutes   EPSDT   Taxonomy	Patient's Home *Diagnosis 1 Pointers t \$10.00 t \$0.00				
	Note: Repeat	this step	for each detail on the	claim.					



Step 18       • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section.         Step 18       • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section.         Step 18       • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section.         Step 18       • Clock the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section.         Step 18       • Total to Date       • Preceder Code         Step 19       • Total total       • Other Insurance Details for each detail in the Svc # column total	Steps				Description								
Select the row number to edit the row. Click the Remove link to remove the entire row.         Svc       From Date       To Date       Place of Service       Procedure Code       Charge Amount       Units       Action         1       02/02/2023       02/02/2023       10-Telshealth Provided in Patient's       99213-OFFICE O/P EST HI 40 MIN       \$100.00       60.000       Remove         2	Step 18				mn to view the Other Insura	ance Details f	or each	detail in					
Svc       From Date       To Date       Place of Service       Procedure Code       Charge Amount       Units       Action         1       02/02/2025       02/02/2025       10-Telehealth Provided in Patient's       99215-OFFICE 0/P EST HI 40 MIN       \$100.00       60.000       Minutes         2		Service Details						_					
# From Date       To Date       Place of Service       Procedure Code       Charge Amount       Units       Action         1       02/02/2025       02/02/2025       10-Telehealth Provided in Patient's       99215-OFFICE 0/P EST HI 40 MIN       \$100.00       60.000       Minutes         2       *       *       To Date 0       If *       Place of        Y       EHG         2       *       *       To Date 0       If *       Place of        Y       Y         2       *       *       Modifiers 0       If *       Place of        Y       Y         2       *       Modifiers 0       If *       *       Place of        Y       Y       Y         Charge Amount       *       Units       *       *       Unit Type Unit       EPSDT        Pointers         Charge Amount       *       Units       *       *       Unit Type Unit       EPSDT           Clia Number		Select the row numb	per to edit the rov	v. Click the <b>Remove</b> link to remove th	e entire row.								
1       02/02/2025       02/02/2025       Home       99215-OFFICE 0/P EST HI 40 MIN       \$100.00       Minutes       Remove         2		From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action					
2 *From Date @ R To Date @ R *Place of Service *Procedure Modifiers @ Pointers Code @ Pointers Charge Amount Units Unit Type Unit EPSDT Clia Number Referring I D Type NPI Taxonomy Displays a list of Service Details. Provider ID Performing I D Type NPI Taxonomy _ Provider ID Ordering I D Type NPI Taxonomy _ Provider ID Medicare Crossover Details Allowed Medicare Amount \$0.00 Deductible Amount \$0.00 Medicare Payment Anount \$0.00 Copay Amount \$0.00 NDCS for Syc. # 2		1 02/02/2025	02/02/2025		99215-OFFICE O/P EST HI 40 MIN	\$100.00		<u>Remove</u>					
• Procedure         Code				🛒 To Date 🛛	*Place of		✓ E	MG 🔽					
Charge Amount  Units  Units  Unit Type Unit  EPSDT Clia Number Authorization Number Referring ID Type NPI Taxonomy Displays a list of Service Details. Provider ID Performing ID Type NPI Taxonomy Provider ID ID Type NPI Taxonomy Provider ID Medicare Crossover Details Allowed Medicare Amount \$0.00 Deductible Amount \$0.00 Deductible Amount \$0.00 Co-insurance Amount \$0.00 Deductible Amount \$0.00 Co-psychiatric Services Amount \$0.00 Medicare Payment Amount \$0.00 Medicare Payment Amount \$0.00 Medicare Payment Amount \$0.00				Modifiers 🛛 🗌			<b>~ ~</b> [	<b>&gt;</b>					
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Select the row number to edit the row. Click the Remove link to remove the entire row.         Set       From Date       To Date       Place of Service       Procedure Code       Charge Amount       Unit       Active         1       02/02/2025       02/02/2025       02/02/2025       10-Telehealth Provided In Patient's       99215-OFFICE 0/P EST H1 40 MIN       \$100.00       60.000       Minutes         1       "From Date 0       02/02/2025       To Date 0       02/02/2025       *Place of 10-Telehealth Provided In Patient's Horn       V       V       Pointers         1       "From Date 0       62/02/2025       *Place of 10-Telehealth Provided In Patient's Horn       V       V       Pointers         1       "From Date 0       62/02/2025       *Place of 10-Telehealth Provided In Patient's Horn       V       V       Pointers         1       "From Date 0       62/02/2025       *Unit Yape       Minutes       V       V       Pointers         1       "Date 0       *Unit Yape       Minutes       EPSDT       Pointers       Pointers         1       Date 0       *Unit Yape       Minutes       EPSDT       Pointers       Pointers         1       Date 0       Web/case Cassover Data 0       Date 0       Pointers       Pointers       Poin		Everything with a <b>Red</b> asterisk * must be completed if the section is applicable to the claim.										
Sec #       From Date       To Date       Place of Service       Procedure Code       Charge Amount       Units       Action Action         1       02/02/2025       02/02/2025       10 <sup>-</sup> Telebeath Provided in Reserct's       59215-OFFICE O/P ESTHI 40 MIN       \$100.00       6												
1       02/02/2023       02/02/2023       02/02/2023       92213-OFFICE ()P EST H1 40 MN       \$100.00       Minute       Remaining         1       *From Date 0       02/02/2023       If to bate 0       02/02/2023       If the bate in the second is to be in the second is the second is to be intered in the second is to be intered		Svc From Date To Date Place of Service Procedure Code Charge Amount Units Action										
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Provider ID       Performing       ID Type NPI       Taxonomy         Provider ID       Deductible Amount \$75.00       Co-insurance Amount \$50.00         Deductible Amount \$10.00       Psychiatric Services Amount \$50.00       Medicare Payment Date®         McGrare Payment Amount \$50.00       Medicare Payment Date®       0/(01/2025) Tr         Copay Amount \$50.00       Remaining Patient Bundled       Emiliance         MDCs for Svc. # 1       Click the row number to edit the row. Click the Remove link to remove the entire row.       Image: State S		Clia Number Authorization Number										
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Allowed Medicare Amount \$75.00       Co-insurance Amount \$10.00         Deductible Amount       \$50.00         Psychiatric Services Amount       \$50.00         Medicare Payment Amount       \$50.00         Copay Amount       \$50.00         MDCs for Svc. # 1       Medicare Payment Date®         Other Insurance Details for Svc. # 1       Click the row number to edit the row. Click the Remove link to remove the entire row.         #       Carrier Code       Modifiers         COB Payer Paid       Remittance       Paid Units         @ Click to collapse.       ************************************		Ordering ID Type NPI Taxonomy										
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Click the row number to edit the row. Click the Remove link to remove the entire row.           # Carrier Code       Procedure Code       Modifiers       COB Payer Paid Amount       Remaining Patient Date       Bundled Liability       Action         Click to collapse. <ul> <li>Click to collapse.</li> <li>*Other Carrier</li> <li>*Other Carrier</li> <li>Modifiers @</li> <li>Modifiers @</li> <li>COB Payer Paid Amount</li> <li>\$0.00</li> <li>*Remittance Date @</li> <li>*Paid Units</li> <li>0.00</li> <li>*Paid Units</li> <li>0.00</li> <li>*Remittance Date @</li> <li>*Paid Units</li> <li>0.00</li> <li>*Add Insurance</li> <li>Cancel Insurance</li> <li>Cancel Insurance</li> <li>Cancel Insurance</li> <li>Concel In</li></ul>												
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#       Carrier Code       Procedure Code       Modifiers       Amount       Date       Paid Units       Liability       Line       Action            Click to collapse.           *Other Carrier              Bundled into Line #		Click the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.										
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Save Reset Cancel		Add Insurance Cancel Insurance										
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Steps	Description								
	Select the Other Carrier from the drop-down list.								
	Other Insurance Details for Svc. # 1								
	#     Carrier Code     Procedure Code     Modifiers     COB Payer Paid Amount     Remittance Date     Paid Units     Remaining Patient Liability     Bundled Line     Action								
	Click to collapse.								
	*Other Carrier *Procedure Code Modifiers 1000111-First Choice Bundled into Line # 0								
	COB Payer Paid Amount S0.00 Remntance Date 9 *Paid Units 0.00								
	Add Insurance Cancel Insurance								
	<ul> <li>Add all information about the detail as applicable.</li> <li>Any Red asterisk * fields are required.</li> </ul>								
	Click the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.								
	#     Carrier Code     Procedure Code     Modifiers     COB Payer Paid Amount     Remittance Date     Paid Units     Remaining Patient Liability     Bundled Line     Action								
	Click to collapse.								
	*Other Carrier       1000111-First Choice       ✓       Bundled into Line #       0         *Procedure Code₀       99215-OFFICE O/P EST HI 40 MIN           Modifiers₀								
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	Add Insurance Cancel Insurance								
	Save Reset Cancel								
	• Once the <b>Add Insurance</b> is clicked, it is added to the detail and will look like the panel below.								



Steps						Descr	iption				
	Ser	vice Details									-
	Sele	ct the row numb	er to edit the row	. Click the Remo	ve link to rer	move the entire ro	w.				
	Svc #	From Date	To Date	Place	of Service		Procedure	Code	Charge Amount	Units	Action
	1	02/02/2025	02/02/2025	10-Telehealth P	rovided in Pa Iome	tient's 992	15-OFFICE O/P E	EST HI 40 MIN	\$100.00	60.000 Minutes	Remove
	1 *From Date 0 02/02/2025				02/02/20	TABLE .	in Patient's Home	✓ E	MG 🔽		
		*Procedure [ Code e	99215-OFFICE C	)/PI Modifiers	θ		Service *Di			<b>~</b>	~ ~
	Ch	arge Amount	\$100.00	*Uni	ts 60.000	*Unit Ty	pe Minutes N	EPSDT	)		
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		Ordering Provider ID		] ID Тур	e NPI	Taxonomy	m				
	Me	edicare Crossov	er Details								
		Allowed M	edicare Amoun	<b>it</b> \$75.00			Co	-insurance Amou	unt \$10.00		
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			Copay Amoun	it \$5.00							
	N	DCs for Svc. # 1	L								Đ
		1	Details for Svc.								
					ove link to re	emove the entire ro	Nol.				
	#	Carrier Cod	e Procedur	e Code Mo	odifiers	COB Payer Paid Amount	Remittance Date	Paid Units	Remaining Patient Liability	Bundled Line	Action
	1	1000111	99215-OFF EST HI 4			\$50.00	04/01/2025	60.00	\$25.00	0	<u>Remove</u>
	Ŀ	Click to add a n	ew other insuran	ice.							
		Save	Reset C	ancel							
Step 20	Nex	t to add C	)ther Insu	rance Rea	asons c	lick the ro	w number	in front of	the Other Ins	urance	Details
0100 20		Svc. #.					i namber	in none of			Details
			etails for Svc. #	# 1							=
					<b>ve</b> link to rer	move the entire ro	w.				_
	#	Carrier Code	Procedure	Code Mo	difiers	COB Payer Paid Amount	Remittance Date	Paid Units	Remaining Patient Liability	Bundled Line	Action
	1	1000111	99215-OFFI EST HI 40			\$50 <b>.</b> 00	04/01/2025	60.00	\$25.00	0	Remove
	± (	Click to add a ne	w other insuranc	e.							

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Description													
• The panel will expand and show the Other Ins	urance Reasons a	rea.											
Other Insurance Details for Svc. # 1													
Click the row number to edit the row. Click the Remove link to remove the entire row.													
Carrier Code     Procedure Code     Modifiers     COB Payer Paid     Amount     Remittance     Date     Paid	d Units	ndled Action											
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Modifierse													
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Remaining Patient \$25.00													
Liability Other Insurance Reasons													
You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustr	nent amount with each group code.												
Click the <b>Remove</b> link to remove the entire row.													
# Group Code Reason	Amount Units Service	Action											
Click to collapse.													
*Group Code													
*Reason ( *Amount \$0.00 Units of Service													
Add Reason Cancel Reason													
Save Insurance Cancel Insurance													
Click to add a new other insurance.													
• Select the Group Code from the dropdown lis	- Select the Crown Code from the drandown list.												
Select the Group Code from the dropdown list:													
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<ul> <li>Group Code CO-Contractual C *Reason 0 *Amount CO-Contractual C *Amount CO-Contractual C *Amount CR-Correction an OA-Other adjustr PI-Payer Initiated PR-Patient Respo- urance Cancer Insurance</li> <li>Next, choose the Reason for the code-named *Group Code CO-Contractual Obligations *Reason 0 *Amount 1-Deductible Amount *Amount 1-Deductible Amount *Amount 1-Deductible Amount *Amount 1-Deductible Amount *Amount 1-Deductible Amount *Amount 1-Deductible Amount *Amount 1-Deductible Amount Segment (loop 2110 Service Payment Information REF) 100-Payment made to patient/insured/responsible part 101-Predetermination: anticipated payment upon comp 102-Major Medical Adjustment. 103-Provider promotional discount (e.g., Senior citizen 104-Managed care withholding. other insurance. 105-Tax withholding.</li> </ul>	bligations bligations d Reversals ments d Reductions nsibility reason above: , if present. y. letion of services or claim adjudica	core roiny rocommension											
<ul> <li>Group Code CO-Contractual C *Reason 0 *Amount CO-Contractual C *Amount CO-Contractual C *Amount CO-Contractual C eason Cane CR-Correction an OA-Other adjustr PI-Payer Initiated PR-Patient Respo- urance Cancer Insurance     </li> <li>Next, choose the Reason for the code-named *Group Code CO-Contractual Obligations         *Reason 0 *Amount 1-Deductible Amount         Segment (loop 2110 Service Payment Information REF) 100-Payment made to patient/insured/responsible part 101-Predetermination: anticipated payment upon comp 102-Major Medical Adjustment.         103-Provider promotional discourt (e.g., Senior citizen 104-Managed care withholding.     </li> </ul>	bligations bligations d Reversals ments d Reductions nsibility reason above: reason above: consequences or due ocorrection , if present. y. letion of services or claim adjudica discount).												



				Desci	ription					
		he amount for				if applica	ble.			
	Click Add Reason to add it to the service detail.									
0	)ther Insurance Re	asons								
Y	You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code. Click the <b>Remove</b> link to remove the entire row.									
C										
+	# Gro	oup Code		Reaso	on		Amount	Units of Service	Actio	
E	Click to collapse.   Scroup Code CO-Contractual Obligations  Reason  1-Deductible Amount									
		*Reason (1-De *Amount \$10.			Units of Servio	ce 🗌				
-	Add R	eason Cancel Rea	ason							
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÷	Click to add a new o	ther insurance.								
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		Once all changes have been made to the service detail, click <b>Save</b> .											
		Select the row number to edit the row. Click the Remove link to remove the entire row.											
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Steps		Descripti	on							
Step 21	<ul> <li>Select the <b>plus sign</b> in the Attachments section to attach a copy of the EOMB.</li> <li>Note: Crossover Claims require the Explanation of Medicare Benefits (EOMB) to be attached.</li> <li>If Other insurance information was added, then the Explanation of Benefits (EOB) for that carrier must be attached as well.</li> <li>Attachments must be in PDF format.</li> </ul>									
	Attachments Click the Remove link to remove the entire row	v.								
	# Transmission Method	File	Control #	Attachment Type	Action					
	Click to add attachment.									
	Back to Step 1 Back to Step	p 2		Submit Cancel						
Step 22	Complete the additional in Everything with a red asteristic everything e	required fields for this sect		cable to the claim.						
	Attachments		11							
	Click the <b>Remove</b> link to remove the entire rov	v.								
	#         Transmission Method <ul> <li>Click to collapse.</li> </ul>	File	Control #	Attachment Type	Action					
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	Back to Step 1 Back to Step	92		Submit Cancel						
	• Select <b>Add</b> to save the a	ttachment to the claim.								
Step 23	The attachments display in the Review the information	ne Attachments section. on entered for Step 3 and	select <b>Submit</b> .							



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	Description									
	Attack	hments								
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	1 FT-File Transfer		Medicare EOMB.pdf (36K)	20221202122716197843	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)	Remo				
	2	FT-File Transfer	Other Carrier EOMB.pdf	123	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)	Remove				
	+ Cli	ick to add attachment.								
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24	The P	ortal displays the <b>Con</b>	firm Professional Claim	page.						
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		ed for this claim.	p-g-,	, <u>,</u> , .,						
	0	Confirm Professional Claim								
			you want to assure you view the claim as you e	ntered it After confirmation Pri	nt Preview may reflect changes as the cl	_				
		een saved on the payer system.	you mane to assure you then the claim as you e		ne rreview may relieve endinges as are a					
			Claim Type Crossover Profession	ıal						
	P	rovider Information								
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Steps							Descript	ion					
		Are benefits assigned to the provider by the patient or their authorized No representative? Does the provider have a signed statement from the patient releasing No their medical information? Total Charged Amount \$0.00											
	Medicare Crossover Details           Allowed Medicare Amount \$0.00         Co-insurance Amount \$0.00           Deductible Amount \$0.00         Psychiatric Services Amount \$0.00           Medicare Payment Amount \$0.00         Medicare Payment Date												
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Step 25	NC EC	<b>DTE</b> : DMB.	The confirr	mation pag	je disp	plays. <b>A</b>	Professional LL Crossov						to verify the
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### Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	12/14/2022	Gainwell	Initial publication
1.1	06/02/2023	Gainwell	Updated providers display to show CCO information based on CR1925.
1.2	12/06/2023	Gainwell	Updated portal access to inactive providers date of termination based on CR 2278.
1.3	4/19/2024	Gainwell	Updated an image and some verbiage in steps 6, 14, 15 and 16.
1.4	07/22/2024	Gainwell	Updated per CR2113
1.5	8/13/2024	Gainwell	Updated the Other Insurance information for clearer instructions.
1.6	11/13/2024	Gainwell	Added tips to introduction
1.7	06/05/2025	Gainwell	Updated steps per Claims Resolution feedback