Mississippi Medicaid
MEDICARE CROSSOVER FORM

MISSISSIPPI DIVISION OF MEDICAID

SUBMISSION DATE: _____

Section I: Payer Information

Medicare A ☐ Medicare B ☐ Medicare C/Advantage ☐

Payer Name: _____

Medicare C/Advantage Contract Number: _____

Section II: Member Information

Member Name (Last name, First name, MI): _____

Medicaid ID/HICN Number: _____

Section III: Provider Information

Billing Provider Number: _____

Provider Name: _____

Billing Contact Person Name: _____

Provider Phone Number: _____

Mail to: Mississippi Medicaid
PO Box 23076
Jackson, MS 39225-3076

Mississippi Medicaid
MEDICARE CROSSOVER FORM

MISSISSIPPI DIVISION OF MEDICAID

MS Medicaid Medicare Crossover Form Instructions

Providers are required to submit a separate MS Medicare Crossover form for each payer that has processed the claim prior to Mississippi Medicaid. An Explanation of Medicare Benefits (EOMB) from each payor should also be attached. Primary payers may be Medicare A, Medicare B, or Medicare C/Advantage.

SECTION I – PAYER INFORMATION

Check the appropriate box to indicate whether the primary payer is Medicare A, Medicare B, or Medicare C/Advantage. Check *one* box only. If more than one box is checked in Section I on the Medicare Crossover Coversheet, the claim will be returned to the provider unprocessed. Enter Payer name and Medicare C/Advantage contract number (if applicable).

SECTION II – MEMBER INFORMATION

Member Name: Enter the last name, first name, and middle initial of the member.

Member ID / HICN: Enter the Medicaid member ID or the Health Insurance Claim Number (HICN). This number must correspond to the member ID/HICN on all 1500 Health Insurance Claim Forms or UB-04 (CMS 1450) Claim Forms submitted.

SECTION III – PROVIDER INFORMATION

Provider ID: Enter the Billing Provider ID number.

Provider Name: Enter the Billing Provider name.

Provider Contact Person: Enter the Provider Contact Person name.

Provider Phone Number: Enter the Billing Provider telephone number.