Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Medical Services

Page updated: August 2020

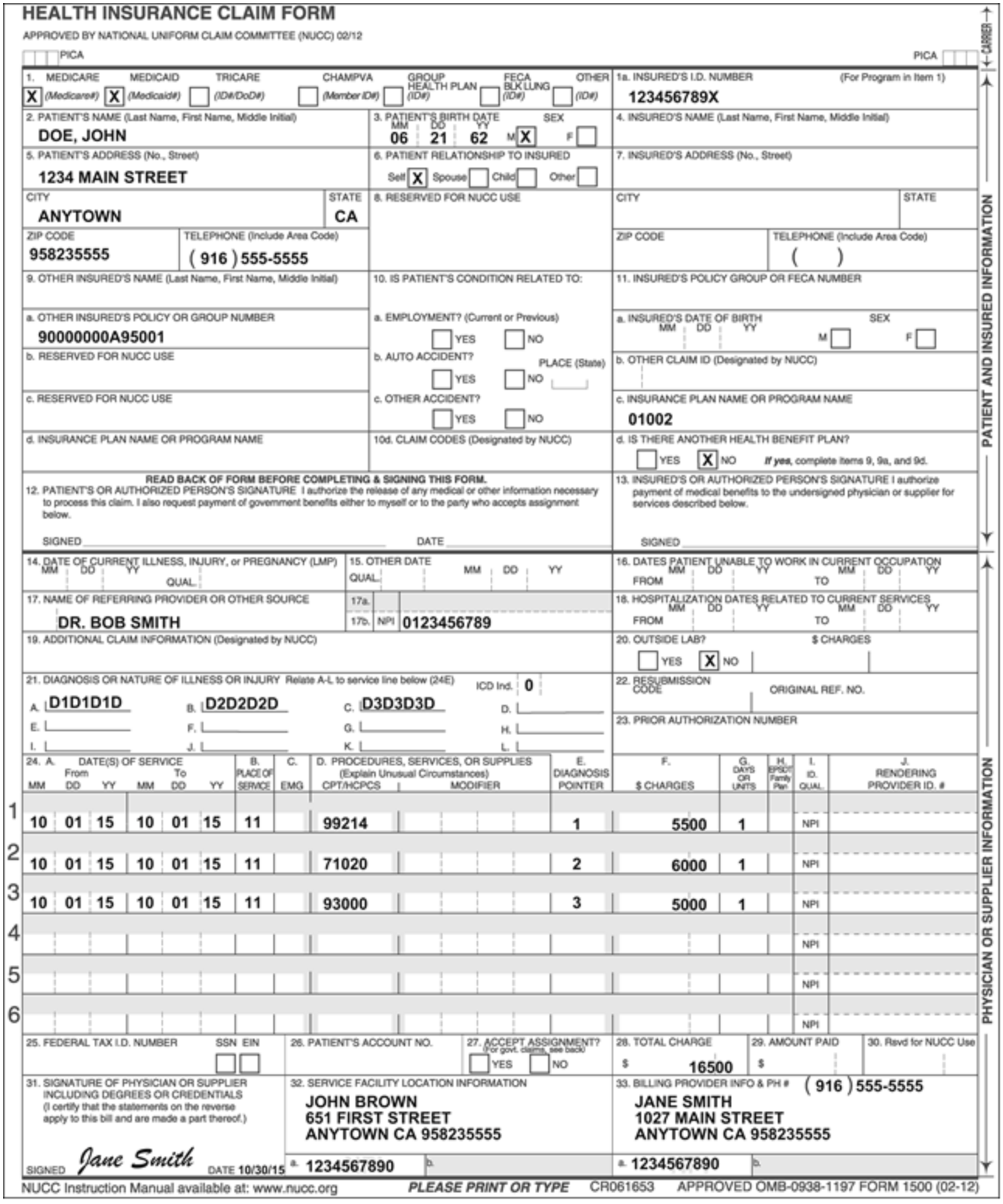
This section illustrates billing examples of Medicare/Medi-Cal crossover claims for medical services on the *CMS-1500* and correlating *Remittance Advice Details* (RAD) examples. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual for billing information.

The following examples do not necessarily reflect current Medicare or Medi-Cal policy.

Hard Copy Billing Examples

The following examples show how to bill hard copy Medicare/Medi-Cal crossover claims:

- *Figures 1a and 1b*. Billing Medi-Cal for Part B Services Billed to a Part B Contractor.
- *Figures 2a and 2b, 3a and 3b*. Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility for Blood Factor



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE: 06 21 62 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D3D3D3D D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15	10	01	15	11		99214		1	5500	1		NPI	
2	10	01	15	10	01	15	11		71020		2	6000	1		NPI	
3	10	01	15	10	01	15	11		93000		3	5000	1		NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 16500

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION
JOHN BROWN
651 FIRST STREET
ANYTOWN CA 958235555
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555
a. 1234567890 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1a: Billing Medi-Cal for Part B Services Billed to a Part B Contractor Example.

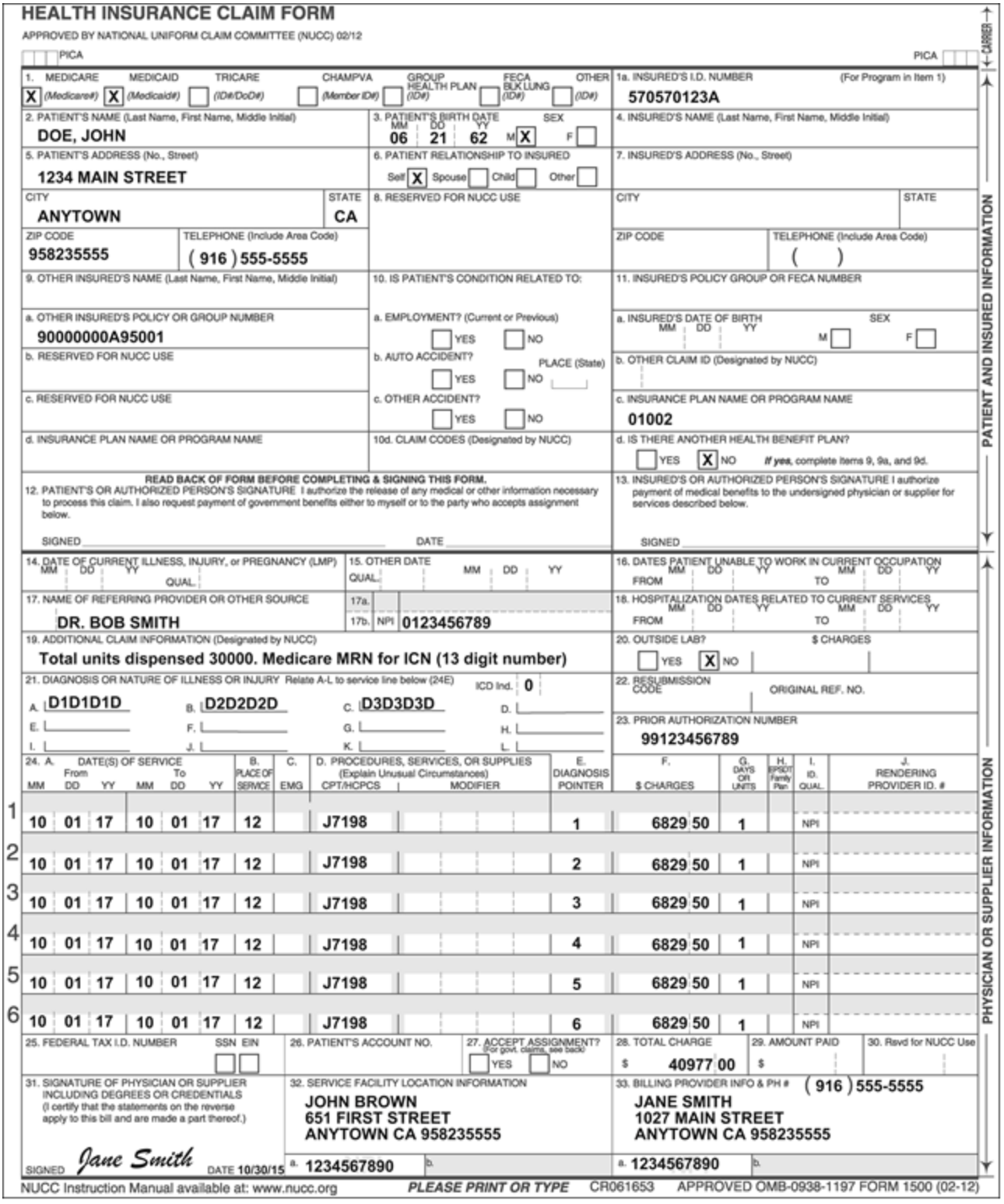
Jane Smith, M.D.
1027 Main Street
Anytown, CA 95823

10/01/15

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME / H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN DOE	**10-01-15**	**10-01-15**	11	99214	55.00	40.00		0.00	08.00	32.00	
570570A	**10-01-15**	**10-01-15**	11	71020	60.00	50.00		0.00	10.00	40.00	
	10-01-15	**10-01-15**		93000	50.00	45.00		0.00	09.00	36.00	
								0.00			
CLAIM TOTALS					165.00	133.00		0.00	27.00	108.00	0.00

Figure 1b: Simplified Medicare Remittance Notice (MRN) Example.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 570570123A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Total units dispensed 30000. Medicare MRN for ICN (13 digit number)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D3D3D3D D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 99123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	17	10	01	17	12		J7198		1	6829 50	1		NPI	
2	10	01	17	10	01	17	12		J7198		2	6829 50	1		NPI	
3	10	01	17	10	01	17	12		J7198		3	6829 50	1		NPI	
4	10	01	17	10	01	17	12		J7198		4	6829 50	1		NPI	
5	10	01	17	10	01	17	12		J7198		5	6829 50	1		NPI	
6	10	01	17	10	01	17	12		J7198		6	6829 50	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 40977 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION
JOHN BROWN
651 FIRST STREET
ANYTOWN CA 958235555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 2a: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility for Blood Factor

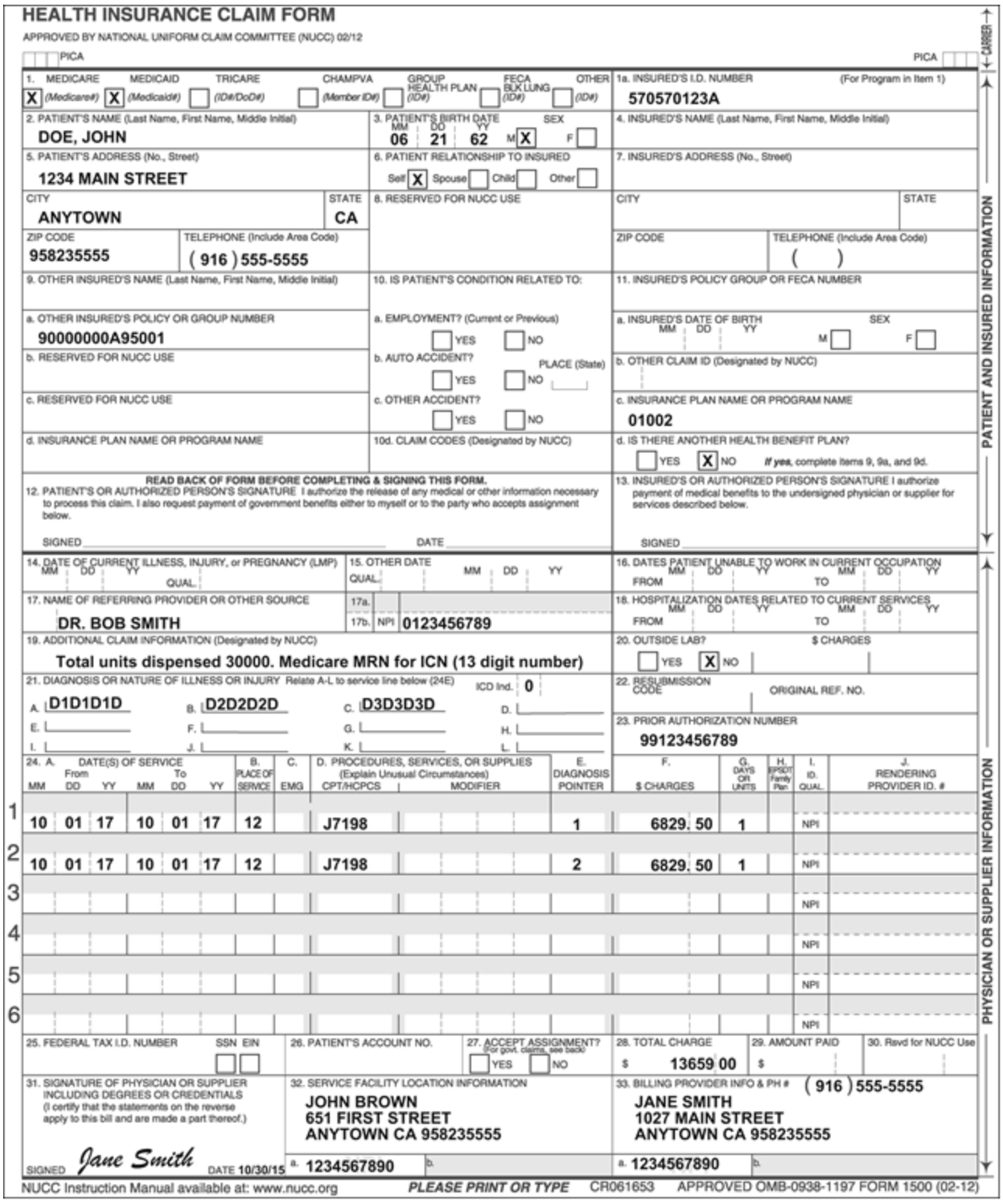
Jane Smith, M.D.
1027 Main Street
Anytown, CA 95823

10/01/17

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	 TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIBLE	COINSURANCE	PAYMENT
JOHN DOE	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
570570123A	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
ICN:	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
1234567891011	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
CLAIM TOTALS					54636.00	46044.96	0.00	9208.96	36099.28

Figure 2b: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility forBlood Factor



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 570570123A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Total units dispensed 30000. Medicare MRN for ICN (13 digit number)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D3D3D3D D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 99123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	17	10	01	17	12		J7198		1	6829.50	1		NPI	
2	10	01	17	10	01	17	12		J7198		2	6829.50	1		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 13659.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

JOHN BROWN
651 FIRST STREET
ANYTOWN CA 958235555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3a: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility for Blood Factor

Jane Smith, M.D.
1027 Main Street
Anytown, CA 95823

10/01/17

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME / H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIBLE	COINSURANCE	PAYMENT
JOHN DOE	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
570570123A	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
ICN:	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
1234567891011	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
	10-01-17	10-01-17	12	J7198	6829.50	5755.62	0.00	1151.12	4512.41
CLAIM TOTALS					54636.00	46044.96	0.00	9208.96	36099.28

Figure 3b: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility for Blood Factor

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.