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

Page updated: August 2020 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 MEDICARE 1a. INSURED'S I.D. NUMBER FECA BLK LUNG ((D#) GROUP HEALTH PLAN X (Medicare#) X (Medicaid#) (ID#/DoD#) Momber (D#) (ID#) 123456789X 3. PATIENT'S BIRTH DATE 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 06 21 62 MX DOE, JOHN 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 1234 MAIN STREET Self X Spouse Child Other 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION ANYTOWN CA ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 958235555 (916)555-5555 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. INSURED'S DATE OF BIRTH a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) 90000000A95001 YES b. RESERVED FOR NUCC USE b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES NO . c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES 01002 NO d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING A SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information ne to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigning INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15, OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DO OUAL TO QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DO YY FROM то DR. BOB SMITH 17b. NPI 0123456789 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES X NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION CODE ICD Ind. 0 ORIGINAL REF. NO. A LD1D1D1D B. [D2D2D2D c. [D3D3D3D D. L 23. PRIOR AUTHORIZATION NUMBER H. L D. PROCEDURES, SERVICES, OR SUPPLIES DATE(S) OF SERVICE PLACE OF SUPPLIER INFORMATION RENDERING DIAGNOSIS (Explain Unusual Circumstances) MM DD MM CPT/HCPCS MODIFIER \$ CHARGES PROVIDER ID. POINTER 10 01 15 10 01 15 99214 5500 1 NPI 10 01 15 10 01 15 11 71020 6000 1 3 10 01 15 10 01 15 11 93000 5000 NPI 4 OR NPI PHYSICIAN 5 6 NPI 25. FEDERAL TAX LD. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 30. Reyd for NUCC Use YES NO 5 16500 33. BILLING PROVIDER INFO & PH# (916) 555-5555 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION JANE SMITH JOHN BROWN (I certify that the statements on the reverse 1027 MAIN STREET ANYTOWN CA 958235555 651 FIRST STREET ANYTOWN CA 958235555

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

1234567890

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Jane Smith DATE 10/30/15 * 1234567890

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Jane Smith, M.D. 1027 Main Street										<u>10/01</u>	/13
Anytown, CA 958	23										
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Figure 1b: Simplified Medicare Remittance Notice (MRN) Example.

Page updated: August 2020 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 CHAMPVA 1a. INSURED'S I.D. NUMBER MEDICARE FECA BUX LUNG (IDV) GROUP HEALTH PLAN X (Medicare#) X (Medicaid#) (ID#/DoD#) (Member IDII) (ID#) 570570123A 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN 06 21 62 MX 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 1234 MAIN STREET Self X Spouse Child Other 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION ANYTOWN CA ZIP CODE TELEPHONE (Include Area Co ZIP CODE TELEPHONE (Include Area Code) 958235555 (916) 555-5555 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 a. EMPLOYMENT? (Current or Previous) SEX 90000000A95001 YES b. AUTO ACCIDENT? b. RESERVED FOR NUCC USE b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES NO L c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES NO 01002 d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO # 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. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. DATE 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD QUAL. TO QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a. 17b. NPI 0123456789 DR. BOB SMITH 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES Total units dispensed 30000. Medicare MRN for ICN (13 digit number) YES X NO 22. RESUBMISSION CODE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ORIGINAL REF. NO A LD1D1D1D B. [D2D2D2D c. D3D3D3D D. L 23. PRIOR AUTHORIZATION NUMBER E. l g. L 99123456789 B. PLACE OF D. PROCEDURES, SERVICES, OR SUPPLIES DATE(S) OF SERVICE OR SUPPLIER INFORMATION RENDERING (Explain Unusual Circumstances) SERVICE EMG CPT/HCPCS MM DO MM DD MODIFIER POINTER \$ CHARGES PROVIDER ID. # 10 01 17 J7198 6829 50 NPI J7198 10 01 17 10 01 17 12 2 6829 50 NPI 10 01 17 10 01 17 12 J7198 3 6829 50 NPI 10 01 17 10 01 17 12 J7198 6829 50 1 NPI PHYSICIAN 10 01 17 | 10 01 17 | 12 J7198 6829 50 5 NPI 10 01 17 | 10 01 17 | 12 J7198 6829 50 1 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 27. ACCEPT ASSIGNMENT? For govt. claims, see back YES NO 40977 00 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (916) 555-5555 INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOHN BROWN JANE SMITH

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

1027 MAIN STREET

a. 1234567890

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ANYTOWN CA 958235555

651 FIRST STREET

ANYTOWN CA 958235555

Jane Smith DATE 10/30/15 a. 1234567890

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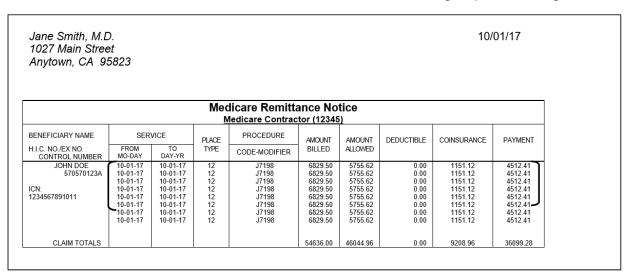


Figure 2b: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility forBlood Factor

		Page upo	dated: August 202		
HEALTH INSURANCE CLAIM FORM			†		
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First	t Name, Middle Initial)		
DOE, JOHN	06 21 62 MX F				
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)			
1234 MAIN STREET	Self X Spouse Child Other 8. RESERVED FOR NUCC USE	CITY	STATE		
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958235555 (916) 555-5555			()		
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			J		
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	YES NO	s 13659 00 s			
INCLUDING DEGREES OR CREDENTIALS	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #	(916) 555-5555		
(I certify that the statements on the reverse JOHN BI	ROWN ST STREET	JANE SMITH 1027 MAIN STREET			
	VN CA 958235555	ANYTOWN CA 95823	5555		
gane Smith 1234567	890	a. 1234567890			

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

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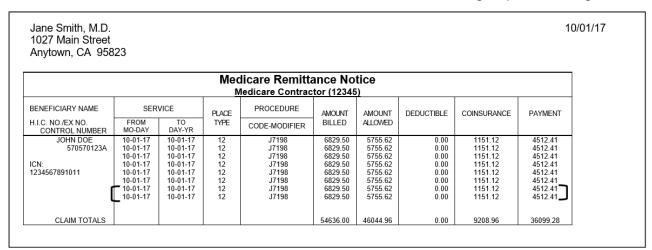


Figure 3b: Billing Medi-Cal for Medicare, Medi-Cal and GHPP Eligibility for Blood Factor

«Legend»

«Symbols used in the document above are explained in the following table.»

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