‹‹Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Pharmacy››

Page updated: December 2021

‹‹This section illustrates billing examples of Medicare/Medi-Cal crossover claims for pharmacy services on the *CMS-1500* and their correlating *Medicare Remittance Notice (MRN)/Remittance Advice* (RA) examples. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples.›› For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Note: A crossover claim reflects what was billed to Medicare, but only Medi-Cal-required fields are used for claims processing.

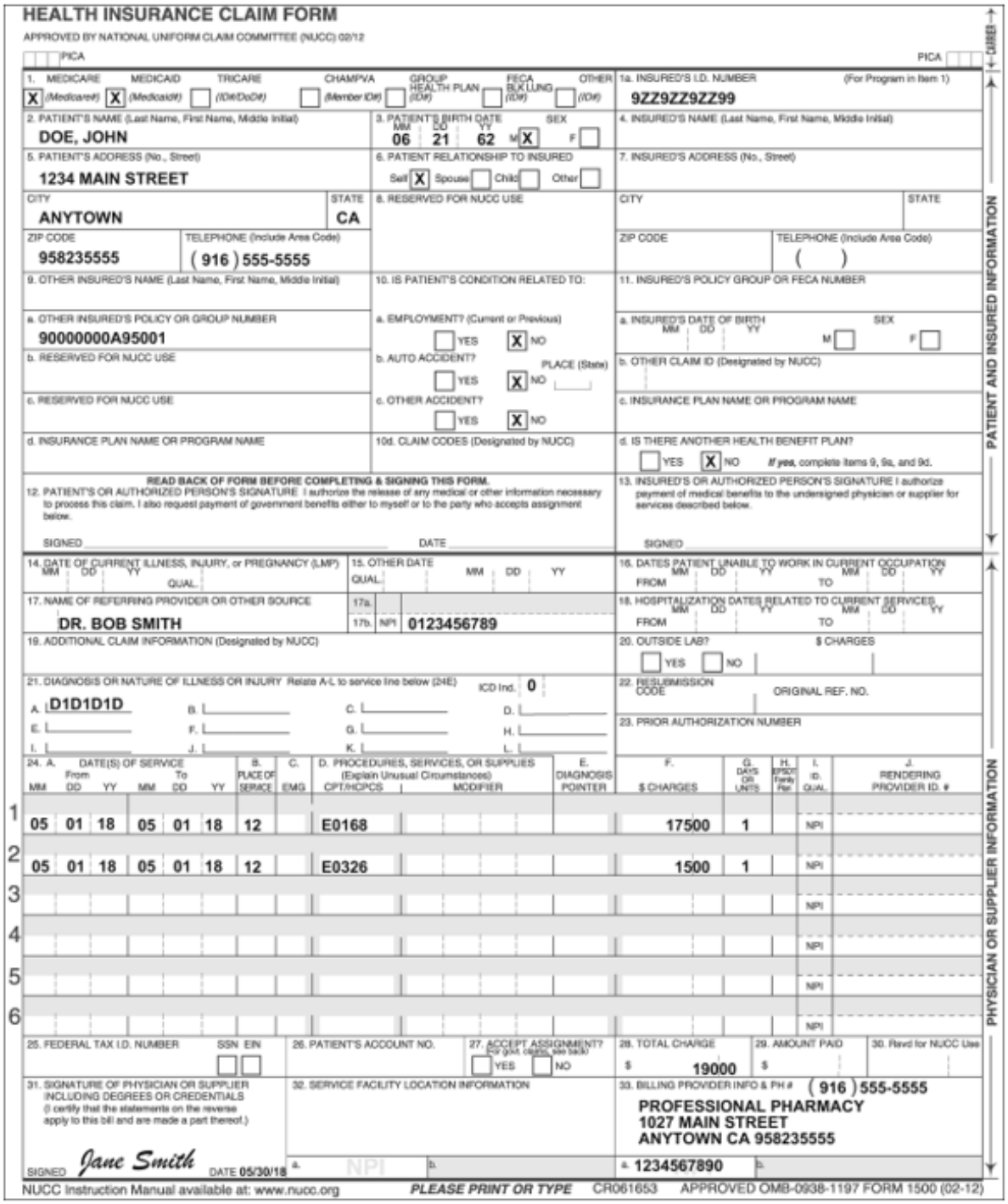
Billing Tips:

‹‹When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the *CMS-1500* type it on an 8½ x 11-inch sheet of paper and attach it to the claim.››

Hard Copy Billing Examples

The dollar amounts in the following payment examples are for illustration only and do not necessarily represent Medi-Cal or Medicare allowed amounts. The 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 Carrier: Non-Drug Crossover Claims.››
- ‹‹*Figures 2a and 2b*. Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Non-Drug Crossover Claims.››



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): 9ZZ9ZZ9ZZ99

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 [X]

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. D1D1D1D B. C. 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 05 01 18	05 01 18	12		E0168			17500	1		NPI	
2 05 01 18	05 01 18	12		E0326			1500	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 $ 19000

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 05/30/18

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

PROFESSIONAL PHARMACY
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 Carrier: Non-Drug Crossover Claims.››

Professional Pharmacy
1027 MAIN STREET
ANYTOWN, CA 95823-5555
0123456789

05/30/18

MEDICARE REMITTANCE NOTICE
NORIDIAN

BENEFICIARY NAME / MEDICARE ID/EX NO. CONTROL NUMBER	SERVICE DATES FROM MO-DAY	SERVICE DATES TO DAY-YR	PLACE TYPE	QTY/ NOS	PROCEDURE CODE-MODIF.	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTER
JOHN DOE	05 01 18	05 01 18	12	1	E0188	175.00	154.18		0.00	12.33	141.85	
9ZZ9ZZ9ZZ99	05 01 18	05 01 18	12	1	E0326	15.00	9.96		0.00	.80	9.16	
CLAIM TOTALS						190.00	164.14		0.00	13.13	151.01	0.00

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

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#)	MEDICAID (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)		
X	X						9ZZ9ZZ9ZZ99		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
DOE, JOHN			06 21 62	M X 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						
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
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. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
90000000A95001			YES X NO					M F	
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)		
			YES NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES NO 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	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	
03 21 18 QUAL.		FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	MM DD YY
DR. BOB SMITH	17b. NPI 0123456789	FROM	TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. D1D1D1D B. D2D2D2D C. D.			
E. F. G. H.		23. PRIOR AUTHORIZATION NUMBER	
I. J. K. L.			

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 05 01 18	05 01 18	21		A4340			10000	1		NPI	
2 05 01 18	05 01 18	21		A4244			4000	1		NPI	
3 05 01 18	05 01 18	21		A4357			2500	1		NPI	
4 05 01 18	05 01 18	21		A4209			3000	1		NPI	
5 05 01 18	05 01 18	21		A4310			2500	1		NPI	
6 05 01 18	05 01 18	21		A4647			10000	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
		YES NO	$ 32000	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (916) 555-5555
SIGNED Jane Doe DATE 05/30/18	a. NPI b.	PROFESSIONAL PHARMACY 1027 MAIN STREET ANYTOWN CA 958235555 a. 1234567890 b.

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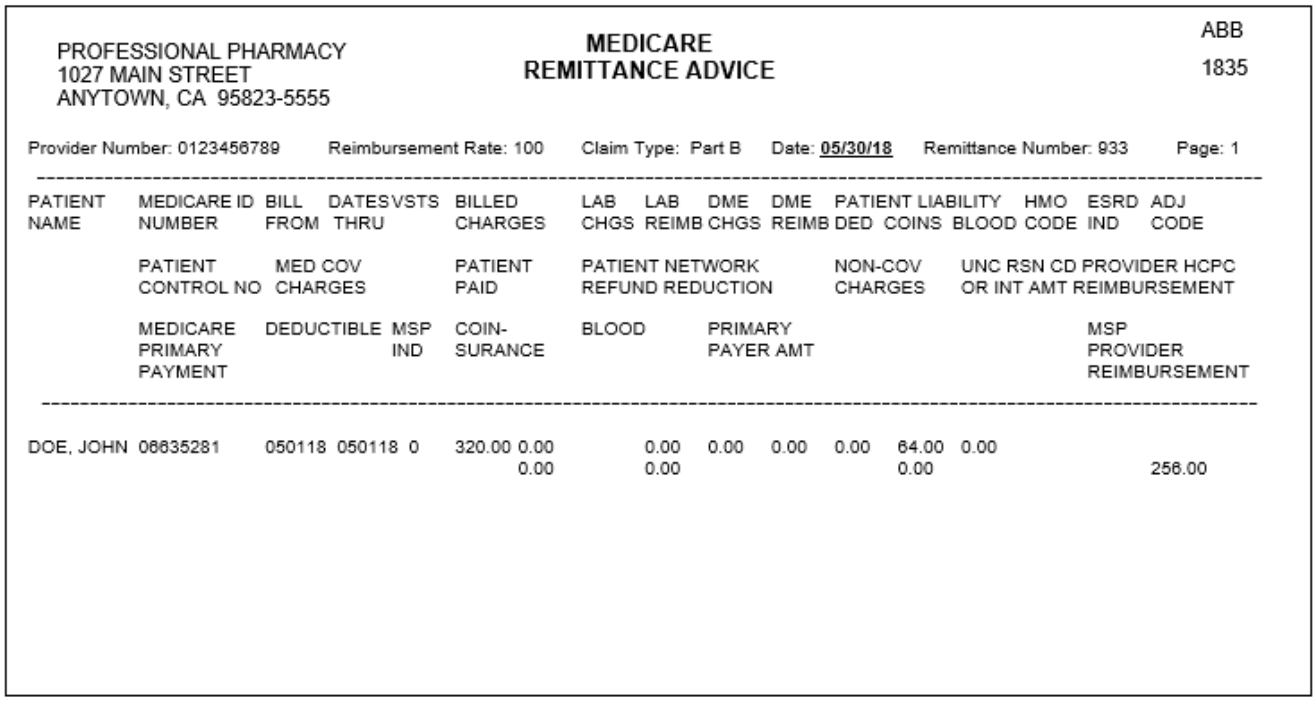
‹‹**Figure 2a:** Billing Medi-Cal for Part B Services Billed to a Part A Intermediary: Non-Drug Crossover Claims.››



PROFESSIONAL PHARMACY
1027 MAIN STREET
ANYTOWN, CA 95823-5555

MEDICARE
REMITTANCE ADVICE

ABB
1835

Provider Number: 0123456789 Reimbursement Rate: 100 Claim Type: Part B Date: 05/30/18 Remittance Number: 933 Page: 1

PATIENT NAME	MEDICARE ID NUMBER	BILL FROM	DATES THRU	VSTS	BILLED CHARGES	LAB CHGS	LAB REIMB	DME CHGS	DME REIMB	PATIENT DED	LIABILITY COINS	BLOOD	HMO CODE	ESRD IND	ADJ CODE
	PATIENT CONTROL NO	MED COV CHARGES			PATIENT PAID	PATIENT REFUND	NETWORK REDUCTION			NON-COV CHARGES		UNC RSN CD OR INT AMT	PROVIDER REIMBURSEMENT		HCPC
	MEDICARE PRIMARY PAYMENT	DEDUCTIBLE	MSP IND		COIN-SURANCE	BLOOD	PRIMARY PAYER AMT							MSP PROVIDER REIMBURSEMENT	
DOE, JOHN	06635281	050118	050118	0	320.00	0.00		0.00	0.00	0.00	0.00	64.00	0.00		
					0.00			0.00				0.00			256.00

‹‹**Figure 2b:** Medicare Remittance Advice Simplified Example.››

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.