- *Medicare Primary*
- *Medicaid Secondary*

Example 5a
Outpatient
Medicare Deductible Only

1 CENTRAL ALASKA HOSPITAL
1000 HOSPITAL DR.
ANYTOWN, AK 99500-0000
(907) 333-3333

3a PAT. CNTL # 0812345
b. MED. REC. #
4 TYPE OF BILL 0131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 032008 THROUGH 032008

8 PATIENT NAME a DOE, JANE E.
9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 03 20 08 | 13 HR 08 | 14 TYPE 1 | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18–28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE 50 DATE 04 04 08 (1)

39 VALUE CODES: CODE A1 AMOUNT 250.00 (2)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0258	N400026064871UN1234.567	J1480		1	14000		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		
0001	PAGE 1 OF 1 (3)	CREATION DATE	04 05 08	TOTALS (4)	275400	0	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
MEDICARE		Y		1500.00		57 020024
MEDICAID		Y		0	250.00 (5)	OTHER HS99OP

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
DOE, JANE E.		574500000A		
DOE, JANE E.		0600611111		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: 78650 | 5990 | 79099 | 78720 | 4019

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB042C NUBC TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

RUN DATE: 04/04/08
RUN TIME: 1412
RUN USER: DBCOOPER

6

Central Alaska Hospital
REMITTANCE REPORT

Example 5b Outpatient Medicare Deductible Only

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 131

Note: Your EOMB may be formatted differently.

	PROVIDER	PAYER
NUMBER:	020024	C24
NAME:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
ADDRESS:	1000 HOSPITAL DR.	PO BOX 6720
CITY/ST/ZIP:	ANYTOWN, AK 99500-0000	FARGO ND 58108-6720

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCPC AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
DOE, JANE E.	0812345	574500000A	03/20/08	03/20/08			2754.00	0.00	250.00	0.00	0.00		1500.00

MEDICAL RECORD NUMBER	INTERNAL CONTROL NO	COST DAYS	COV DAYS	NONCOV DAYS	C O	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE-DUCTABLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED
00047960	12345678901234	0	0				0.00	0.00	0.00	1836.00	0.00	0.00

CAPITAL PMT: 0.00 HSP: 0.00 FSP: 0.00 DSH ADJ: 0.00 DRG CODE:
HOLD HARM: 0.00 IME-ADJ: 0.00 EXCEPTIONS: 0.00
COVERD CHARGES: 2754.00 CLAIM STATUS CODE: 0 TYPE OF BILL: 131

CLAIM LEVEL

Reason Codes	Reason Amts	Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0258		03/20/08	14000	0.00			
0270		03/20/08	25600	0.00			
0350		03/20/08	97600	0.00			
0450		03/20/08	106300	0.00			
0460		03/20/08	31900	0.00			

Example 5c Outpatient Medicare Deductible Only

Completing the UB-04 Claim Form for Institutional Medicare Crossover paper claims with J (drug) code

Scenario: Outpatient Claim Form, with Medicare Deductible Only

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional Requirements for Institutional Medicare Crossover Claims:

1. Field 31: *Occurrence Code/Date*	Enter the Occurrence Code "50" and the Medicare paid date in *mm/dd/yy* format.
2. Field 39a: *Value Codes/Amount*	Enter Value Code "**A**1" and the recipient's Medicare deductible amount. **Note:** the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 50: *Payer Name*	Enter the word "Medicare".
• Medicare is the primary payer;	Line A: enter all information pertaining to Medicare.
• Medicaid is the secondary payer;	Line B: enter all information pertaining to Medicaid.
4. Field 54: *Prior Payments*	
• Medicare is the primary payer;	Line A: enter the Medicare Paid Amount.
• Medicaid is the secondary payer;	Line B: no entry needed.
5. Field 55**B**: *Est. Amount Due*	Enter the Estimated Amount Due from Medicaid. **Note:** The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
6. The Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: https://medicaidalaska.com/providers/Billing.asp.