

**Instructions for Mississippi Medicaid Part B Crossover Claim Form (06/10)  
For Part C Claims ONLY**

<b>Field</b>	<b>Requirement</b>	<b>Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (06/10)</b>
<b>1</b>	<b>Required</b>	<b>Provider Name and Address:</b> Enter the full name and address of the provider/facility submitting the claim.
<b>2a</b>	<b>Optional</b>	<b>Medicaid Provider Number:</b> Enter the 8 digit Medicaid number of the health care provider.
<b>2b</b>	<b>Required</b>	<b>National Provider Identifier (NPI):</b> Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
<b>2c</b>	<b>Required if Applicable</b>	<b>Taxonomy Code:</b> Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
<b>3</b>	<b>Required</b>	<b>Beneficiary Name and Address:</b> Enter the full name (last name, first name) and the address of the beneficiary receiving services.
<b>4</b>	<b>Required</b>	<b>Beneficiary Medicaid ID Number:</b> Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
<b>5</b>	<b>Optional</b>	<b>Patient Account/Medical Record Number:</b> Enter the internal account number or medical record number of the beneficiary.
<b>6</b>	<b>Required</b>	<b>Diagnosis Code:</b> Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
<b>7</b>	<b>Required</b>	<b>Service Dates:</b> Enter the from and thru date of service for this billing in MM/DD/CCYY format.
<b>8</b>	<b>Required</b>	<b>Procedure Code:</b> <b>Outpatient Services:</b> Enter the HCPCS code for laboratory, radiology and dialysis services provided. <b>Professional services:</b> Enter the appropriate CPT code for the services provided.
<b>9</b>	<b>Required</b>	<b>Procedure Modifier:</b> Enter the applicable modifier for the procedure rendered.
<b>10</b>	<b>Required</b>	<b>Service Units:</b> Enter the number of units provided on each detail line.
<b>11</b>	<b>Required</b>	<b>Medicare Billed Charges:</b> Enter the total charges (dollars.cents) billed to Medicare for each detail line.
<b>12</b>	<b>Required</b>	<b>Medicare Allowed Amount:</b> Enter the amount payable for each service (dollars.cents) as determined by Medicare.
<b>13</b>	<b>Required</b>	<b>Medicare Non-covered Amount:</b> Enter the charge (dollars.cents) for any non-covered service, such as take-home drugs.
<b>14</b>	<b>Required</b>	<b>Blood Deductible Amount:</b> Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid

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		by Medicaid.
15	<b>Required</b>	<b>Medicare Paid Amount:</b> Enter the total amount (dollars.cents) Medicare paid on the claim for each detail line.
16	<b>Required</b>	<b>Medicare Deductible:</b> Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
17	<b>Required</b>	<b>Medicare Coinsurance:</b> Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	<b>Required</b>	<b>Medicare Paid Date:</b> Enter the date of Medicare payment in MM/DD/CCYY format.
19	<b>Required if Applicable</b>	<b>Third Party Payment Amount:</b> Enter the amount (dollars.cents) of payment made by any third party source applied toward the claim for each detail.
20	<b>Required</b>	<b>Provider Signature:</b> The provider or an authorized representative must sign the claim form. Rubber stamp signatures are acceptable.
21	<b>Required</b>	<b>Billing Date:</b> Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.