3.2 Medicare Part C Only - Mississippi Medicaid Part A Claim Form Instructions

The Mississippi Medicaid Part A Crossover Claim form located in this section is a state specific form and must be used when billing for Medicare Part C Advantage Plans only. Medicare Advantage Plans claims are for dually eligible beneficiaries enrolled in Medicare and eligible for Medicaid coverage. The following are instructions for completing the Medicare Part A crossover billing form when billing services for Medicare Part C Advantage Plans. An additional requirement is that a copy of the Medicare EOMB for the billed services **must** be attached for all paper Crossovers. This claim form and instructions are available on the Division of Medicaid's website at http://www.medicaid.ms.gov. Select the Provider link then choose the Forms link.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc. print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- Claims received on an incorrect claim form or without the appropriate EOMB can not be processed for payment.
- Indicate that the claim is a Medicare Part C Advantage Plan claim by writing the words **Advantage Plan** on the bottom of the claim form.
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Paper Claims with Attachments

When submitting attachments with the Mississippi Crossover Part A claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Billing Tip 

Some Medicare Part C Advantage Plans have a co-pay/co-insurance field or a co-pay/deductible field on their Explanation of Medicare Benefits (EOMB). The Division of Medicaid will only pay co-insurance and/or deductible. Claims submitted with these types of EOMBs will be returned to the provider and may be resubmitted with written documentation from the health plan verifying the coinsurance or deductible amount(s). Medicaid does not pay co-pay for these claim types.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

Instructions for Mississippi Medicaid Part A Crossover Claim Form For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part A Crossover Claim Form (06/10)
1	Required	**Type of Bill:** Enter a valid code for the type of claim being submitted – (inpatient, interim billing, hospice, etc.)
2	Required	**Provider Name and Address**: Enter the full name and address of the provider/facility submitting the claim.
3a	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care.
3b	Required	**National Provider Identifier (NPI):** Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
3c	Required if applicable	**Taxonomy Code:** Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
4	Required	**Beneficiary Name and Address:** Enter the full name (last name, first name) and the address of the beneficiary receiving services.
5	Required	**Beneficiary Medicaid ID Number:** Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
6	Optional	**Patient Account/Medical Record Number:** Enter the internal account number or medical record number of the beneficiary.
7	Required	**Admission Date:** Enter the date of beneficiary's admission in MM/DD/CCYY format.
8	Required	**Admission Hour:** Enter the hour of beneficiary's admission to the facility (00-23) per the UB-04 Uniform Billing Instructions.
9	Required	**Admission Type**: Enter the nature of the admission using the applicable codes (0-9) per the UB-04 Uniform Billing Instructions.
10	Required	**Dates of Service:** Enter the from and thru date of service for this billing in MM/DD/CCYY format.
11	Required	**Covered Days:** Enter the number of covered days for this billing. Note: date of death and date of discharge are not counted as covered days.
12	Required	**Diagnosis Code:** Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
13	Required	**Total Medicare Billed Charges:** Enter the total charges (dollars.cents) billed to Medicare for all services.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part A Crossover Claim Form (06/10)
14	**Required**	**Total Medicare Allowed Amount:** Enter the total amount payable for the claim (dollars.cents) as determined by Medicare.
15	**Required**	**Total Medicare Paid Amount:** Enter the total amount (dollars.cents) Medicare paid on the claim.
16	**Required**	**Total Medicare Deductible Amount:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
17	**Required**	**Total Medicare Coinsurance Amount:** Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	**Required**	**Total Medicare Blood Deductible Amount:** Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid by Medicaid.
19	**Required**	**Medicare Paid Date:** Enter the date of Medicare payment in MM/DD/CCYY format.
20	**Required if applicable**	**Total Third Party Payment Amount:** Enter the amount (dollars.cents) of payment made by any third party source which applies toward the claim.
21	**Required** **Required if applicable**	**Revenue Code:** Enter the appropriate revenue code from the Uniform Billing Manual. **Procedure Code:** Enter the HCPCS code for laboratory, radiology, and dialysis services provided.
22	**Required**	**Units:** Enter the number of days or units of service provided for each detail line.
23	**Required**	**Medicare Billed Amount:** Enter the total charges (dollars.cents) billed to Medicare for each detail service.
24	**Required if applicable**	**Medicare Non-covered Amount:** Enter the charge (dollars.cents) for any non-covered service such as take-home drugs.
25	**Required**	**Provider Signature:** The provider or an authorized representative must sign the claim form. Original rubber stamp signatures are acceptable.
26	**Required**	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Medicare Part A

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

1. Type of Bill

For Medicare Part C ONLY

2. Provider Name and Address	3a. Medicaid Provider Number	3c. Taxonomy Code	4. Beneficiary Name and Address
	3b. NPI Number		

5. Beneficiary Medicaid ID	6. Patient Account/Medical Record Number	Admission			10. Dates of Service	
		7. Date	8. Hour	9.Type	From	Thru

11. Covered Days	12.Diagnosis	
	Primary	Secondary
	3rd	4th

13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount

16. Total Medicare Deductible Amount	17. Total Medicare Co-insurance Amount	18. Total Medicare Blood Deductible Amount	19. Medicare Paid Date	20. Total Third Party Payment Amount

	21. Revenue Code	22. Procedure Code	23. Units	24. Medicare Billed Amount	25. Medicare Non-covered Amount
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I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

26. Provider Signature	27. Billing Date

Revised 03/14/16