

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Medical Services

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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.

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.

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																	
<small>PICA</small> <small>PICA</small>																	
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789X																
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 <input checked="" type="checkbox"/> F <input type="checkbox"/>				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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)								
CITY ANYTOWN			STATE CA			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE					
ZIP CODE 95823			TELEPHONE (Include Area Code) (916) 555-5555			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			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) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME 01002					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
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 (First symptom OR INJURY (Accident) OR PREGNANCY (LMP)) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. BOB SMITH						17a. NPI 0123456789			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO								
19. RESERVED FOR LOCAL USE						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by Line)																	
1. 41400			3. 4011			2. 4280			4.			24. A. DATE(S) OF SERVICE From MM DD YY To DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCP/PCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EP/SDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					
1. 06 01 07 06 01 07 11			99214			1			5500 1			NPI					
2. 06 01 07 06 01 07 11			71020			2			6000 1			NPI					
3. 06 01 07 06 01 07 11			93000			3			5000 1			NPI					
4.			NPI			NPI			NPI			NPI					
5.			NPI			NPI			NPI			NPI					
6.			NPI			NPI			NPI			NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (If gov. claims, see 0490) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 16500		29. AMOUNT PAID \$		30. BALANCE DUE \$ 16500	
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.) <i>Jane Smith</i> SIGNED _____ DATE 06/21/07						32. SERVICE FACILITY LOCATION INFORMATION JOHN BROWN 651 FIRST STREET ANYTOWN CA 958235555						33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555					
a. 1234567890						b.						a. 1234567890 b.					
NUCC Instruction Manual available at: www.nucc.org																	
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)																	

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

Jane Smith, M.D.
 1027 Main Street
 Anytown, CA 95823

6/21/07

Medicare Remittance Notice Medicare Contractor (12345)											
BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE		PLACE TYPE	PROCEDURE	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
	FROM MO-DAY	TO DAY-YR		CODE-MODIFIER							
JOHN DOE 570570A	6 01 07	6 01 07	11	99214	55.00	40.00		0.00	08.00	32.00	
	6 01 07	6 01 07	11	71020	60.00	50.00		0.00	10.00	40.00	
	6 01 07	6 01 07		93000	50.00	45.00		0.00	09.00	36.00	
CLAIM TOTALS					165.00	133.00		0.00	27.00	108.00	0.00

Figure 1b. Simplified Medicare Remittance Notice (MRN) Example.