CAUTION: Read the ICD-9 Policy Holding Library page about policy in this document.

Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples

This section illustrates billing examples of Medicare/Medi-Cal crossover claims for outpatient services on the *CMS-1500* or *UB-04* claim and correlating Medicare *Remittance Advice* (RA) examples. Billing examples for Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs), Part B dialysis and split billing also appear in this section.

Refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section in this manual for detailed billing and policy information. Refer to the *UB-04 Completion: Outpatient Services* 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-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

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.
- *Figures 2a* and *2b.* Outpatient Hospital Provider Billing Medi-Cal for Part B Services Billed to a Part A Contractor With Coinsurance and Deductible.
- *Figure 3.* Billing Medi-Cal for Rural Health Clinics and Federally Qualified Health Centers.
- *Figures 4a and 4b.* Billing Medi-Cal for Part B Dialysis Services.
- *Figures 5a, 5b, 5c and 5d.* Billing for More Than 15 Line Items for Part B Services Billed to a Part A Contractor With Coinsurance.
- *Figures 6a, 6b, 6c and 6d.* Billing Medi-Cal for Part B Dialysis Services for More Than 15 Lines.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

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 06 DD 21 YY 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE JOHN

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. PATIENT STATUS: Single [ ] Married [ ] Other [X] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 95823 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 [X] NO

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [X] 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? [ ] YES [X] NO ***If yes***, return to and complete item 9 a-d.

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 SIGNATURE ON FILE DATE 11/15/07

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 414.0
2. 428.0
3.
4.

22. MEDICAID 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	11	19	07	11	19	07	22		99214					1	55 00	1		NPI	1234567890
2	11	19	07	11	19	07	22		71020					1	60 00	1		NPI	1234567890
3	11	19	07	11	19	07	22		93000					1	50 00	1		NPI	1234567890
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ]

26. PATIENT'S ACCOUNT NO.: 193638

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. BALANCE DUE $ 165 00

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 11/30/07

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

JANE SMITH
1420 SECOND STREET
ANYTOWN CA 958235555

a. 2345678901 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

JANE SMITH
1027 MAIN STREET
ANYTOWN, CA 95823-5555

12/21/07

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN DOE	11 19 07	11 19 07	22	99214	55.00	40.00		0.00	8.00	32.00	
123456789X	11 19 07	11 19 07	22	71020	60.00	50.00		0.00	10.00	40.00	
90000000A95001	11 19 07	11 19 07	22	93000	50.00	45.00		0.00	9.00	36.00	
CLAIM TOTALS					165.00	135.00		0.00	27.00	108.00	0.00

Figure 1b. Simplified Medicare Remittance Notice Example.

medi cr op ex
4

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 122907 THROUGH 122907

7

8 PATIENT NAME a b DOE JANE

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE 08241980
11 SEX F
12 ADMISSION DATE 122907
13 HR 15
14 TYPE 3
15 SRC
16 DHR 12
17 STAT 01
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	50	011508													
b															

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A1	10000	A2	12717		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	300	DESCRIPTION	36415	122907	1	2410		
2	301	DESCRIPTION	80053	122907	1	18575		
3	301	DESCRIPTION	83880	122907	1	21600		
4	301	DESCRIPTION	84484	122907	1	10210		
5	305	DESCRIPTION	85025	122907	1	8055		
6	305	DESCRIPTION	85379	122907	1	10550		
7	324	DESCRIPTION	71020	122907	1	18300		
8	450	DESCRIPTION	9928325	122907	1	131500		
9	730	DESCRIPTION	93005	122907	1	13000		
10	921	DESCRIPTION	93970	122907	1	98700		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	332900		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A	MEDICARE	01001			23017	332900	57	A
B	O/P MEDI-CAL					22719	OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	JANE DOE		123456789X			A
B			90000000A95001			B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 490 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
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 1234567890 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 OMB APPROVAL PENDING
© 2005 NUBC
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 2a. Hospital Outpatient Provider Billing Medi-Cal for Part B Services Billed to a Part A Contractor.

```
==========================================================================================
                Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center                 FPE:      03/30/08      Medicare Contractor
140 Second Street                     PAID:     01/15/08      1234 B Street
Anytown, CA 95823-5555                CLM#:     166           Anytown, CA  98765-5555
0123456789                            TOB:      131           555-555-5555
==========================================================================================
PATIENT: DOE, JANE                                                   PCN: 123456789
    HIC: 123456789X                       SVC FROM:  12/29/2007      MRN: 000193638
PAT STAT:    CLAIM STAT: 19                   THRU:  12/29/2007      ICN: 12345678901234
==========================================================================================
CHARGES:                            PAYMENT DATA:     =DRG                  0.370 =REIM RATE
    3329.00 =REPORTED                 0.00 =DRG AMOUNT                       0.00 =MSP PRIM PAYER
       0.00 =NCVD/DENIED              0.00 =DRG/OPER/CAP                     0.00 =PROF
COMPONENT
       0.00 =CLAIM ADJS            2871.64 =LINE ADJ AMT                     0.00 =ESRD AMOUNT
    3329.00 =COVERED                  0.00 =OUTLIER (C)                    104.03 =PROC CD
AMOUNT
DAYS/VISITS:                          0.00 =CAP OUTLIER                    230.17 =ALLOW/REIM
          0 =COST REPT              100.0 =CASH DEDUCT                       0.00 =G/R AMOUNT
          0 =COVD/UTIL                0.00 =BLOOD DEDUCT                     0.00 =INTEREST
          0 =NON-COVERED            127.19 =COINSURANCE                      0.00 =CONTRACT ADJ
          0 =COVD VISITS              0.00 =PAT REFUND                       0.37 =PER DIEM AMT
          0 =NCOV VISITS              0.00 =MSP LIAB MET                   230.17 =NET REIM AMT
REMARK CODES:        MA01
==========================================================================================
REV   DATE    HCPCS   APC/HIPPS  MODS   QTY   CHARGES ALLOW/REIM  GC   RSN    AMOUNT   REMARK CODES
0300  12/29   36415                      1     24.10       3.00  CO   42      21.10
0301  12/29   80053                      1    185.75      14.77  CO   42     170.98
0301  12/29   83880                      1    216.00      47.43  CO   42     168.57
0301  12/29   84484                      1    102.10      13.75  CO   42      88.35
0305  12/29   85025                      1     80.55      10.86  CO   42      69.69
0305  12/29   85379                      1    105.50      14.22  CO   42      91.28
0324  12/29   71020   00260              1    183.00      25.07  CO   45     137.42
                                                                 PR   2       20.51
0450  12/29   99283   00611      25      1   1315.00       4.07  CO   45    1173.36
                                                                 PR   1     100.00
                                                                 PR   2       37.57
0730  12/29   93005   00099              1    130.00      18.05  CO   45     107.44
                                                                 PR   2        4.51
0921  12/29   93970   00267              1    987.00      78.95  CO   45     843.45
                                                                 PR   2       64.60
==========================================================================================
```

Figure 2b. Medicare *Remittance Advice* Example.

medi cr op ex
6

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 711

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a
b DOE JANE

9 PATIENT ADDRESS a
b c d e

10 BIRTHDATE 08241980

11 SEX F

12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT

ADMISSION

CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28

29 ACDT STATE 30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	CROSSOVER CLAIM	02	110307	1	75 00		
23	001 PAGE _____ OF _____	CREATION DATE		TOTALS	75 00		

50 PAYER NAME: O/P MEDI-CAL
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE: 75 00
56 NPI: 0123456789
57 OTHER PRV ID

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID: 90000000A95001
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 4118 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c 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 1234567890 QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 3. Billing Medi-Cal for Rural Health Clinics/Federally Qualified Health Centers.

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL # 123456789
b. MED. REC. #
4 TYPE OF BILL 721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 110207 THROUGH 112407
7

8 PATIENT NAME a
b DOE JANE
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE 08241980
11 SEX F
12 DATE 13 HR 14 TYPE 15 SRC ADMISSION
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
a 50 121507
b
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	DESCRIPTION	A4657	110207	21	10 50		
2	635	DESCRIPTION	J0886	110307	13	3045 12		
3	636	DESCRIPTION	J1580	110307	4	3 80		
4	636	DESCRIPTION	J2916	111007	40	198 00		
5	636	DESCRIPTION	90740	111207	1	113 91		
6	771	DESCRIPTION	G0010	112207	1	7 88		
7	821	DESCRIPTION	90999G4	112407	13	1496 63		
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	4875 84		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A	MEDICARE	01001			3892 45	4875 84	57 OTHER PRV ID
B	O/P MEDI-CAL					974 74	
C							

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			123456789X		
B			90000000A95001		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX 58532 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c 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 1234567890 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81 CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING
© 2005 NUBC
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 4a. Billing Medi-Cal for Part B Dialysis Services.

medi cr op ex
8

```
==========================================================================================
                Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center                 FPE:      11/30/07     Medicare Contractor
140 Second Street                     PAID:     12/15/07     1234 B Street
Anytown, CA 95823-5555                CLM#:     166          Anytown, CA  98765-5555
0123456789                            TOB:      721          555-555-5555
==========================================================================================
PATIENT: DOE, JANE                                                   PCN: 123456789
    HIC: 123456789X                       SVC FROM:  11/02/2007      MRN: 000193638
PAT STAT:     CLAIM STAT: 1                   THRU:  11/30/2007      ICN: 12345678901234
==========================================================================================
CHARGES:                            PAYMENT DATA:     =DRG                  1.000 =REIM RATE
     4875.84 =REPORTED                0.00 =DRG AMOUNT                       0.00 =MSP PRIM PAYER
        0.00 =NCVD/DENIED             0.00 =DRG/OPER/CAP                     0.00 =PROF
COMPONENT
        0.00 =CLAIM ADJS              2.15 =LINE ADJ AMT                     0.00 =ESRD AMOUNT
     4873.69 =COVERED                 0.00 =OUTLIER (C)                    334.09 =PROC CD
AMOUNT
DAYS/VISITS:                          0.00 =CAP OUTLIER                   3892.45 =ALLOW/REIM
           0 =COST REPT                0.0 =CASH DEDUCT                       0.00 =G/R AMOUNT
           0 =COVD/UTIL               0.00 =BLOOD DEDUCT                      0.00 =INTEREST
           0 =NON-COVERED           974.74 =COINSURANCE                       0.00 =CONTRACT ADJ
           0 =COVD VISITS             0.00 =PAT REFUND                        0.00 =PER DIEM AMT
           0 =NCOV VISITS             0.00 =MSP LIAB MET                   3892.45 =NET REIM AMT
==========================================================================================
REV   DATE   HCPCS   APC/HIPPS  MODS   QTY   CHARGES ALLOW/REIM   GC   RSN    AMOUNT   REMARK CODES
0270  11/02  A4657                     21    10.50       8.40   PR   2        2.10
0635  11/03  J0886                     13  3045.12    2436.10   PR   2      609.02
0636  11/03  J1580                     4      3.80       3.04   PR   2        0.76
0636  11/10  J2916                     40   198.00     158.40   PR   2       39.60
0636  11/12  90740                     1    113.91      91.13   PR   2       22.78
0771  11/22  G0010                     1      7.88       6.30   PR   2        1.58
0821  11/24  90999             G4      13  1496.63    1189.08   CO   97       6.50
                                                                 45       2.15
                                                                 PR   2      298.90
==========================================================================================
```

Figure 4b. Medicare *Remittance Advice* Example.

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 110107 THROUGH 111607

7

8 PATIENT NAME a
b DOE JANE

9 PATIENT ADDRESS a
b c d e

10 BIRTHDATE 08241980
11 SEX F
12 DATE 13 HR 14 TYPE 15 SRC
ADMISSION
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28
CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
a 50 122107
b
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
a A2 40 99
b
c
d
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	420	DESCRIPTION	G0283GP	110107	1	101 00		1
2	420	DESCRIPTION	G0283GP	110207	1	101 00		2
3	420	DESCRIPTION	G0283GP	110307	1	101 00		3
4	420	DESCRIPTION	G0283GP	110807	1	101 00		4
5	420	DESCRIPTION	G0283GP	110907	1	101 00		5
6	420	DESCRIPTION	G0283GP	111107	1	101 00		6
7	420	DESCRIPTION	G0283GP	111607	1	101 00		7
8	420	DESCRIPTION	97018GP	110107	1	66 50		8
9	420	DESCRIPTION	97018GP	110207	1	66 50		9
10	420	DESCRIPTION	97018GP	110107	1	83 00		10
11	420	DESCRIPTION	97035GP	110107	1	83 00		11
12	420	DESCRIPTION	97135GP	110207	1	83 00		12
13	420	DESCRIPTION	97110GP	110307	1	109 00		13
14	420	DESCRIPTION	97110GP	110807	1	109 00		14
15	420	DESCRIPTION	97110GP	110907	1	109 00		15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	001	PAGE 1 OF 2	CREATION DATE		TOTALS	1416 00		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A MEDICARE	01001			163 78	1416 00	57
B O/P MEDI-CAL					40 99	OTHER
C						PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		123456789X		
B		90000000A95001		
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX 71590 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c 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 1234567890 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
SPLIT BILLED - CLAIM 1 OF 2 DEDUCTIBLE = 0
TOTAL 2509.00 MEDICARE 422.18 COINS 105.59
CLAIM 1 1416.00 163.78 40.99
CLAIM 2 1093.00 258.40 64.60

81CC a
b
c
d

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 5a. Billing for More Than 15 Line Items for Part B Services Billed to Part A Contractors. Split Bill Claim 1 of 2 *(see also Figure 5c).*

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 110107 THROUGH 111607

7

8 PATIENT NAME a. b. DOE JANE

9 PATIENT ADDRESS a. b. c. d. e.

10 BIRTHDATE 08241980

11 SEX F

12 ADMISSION DATE 13 HR 14 TYPE 15 SRC

16 DHR

17 STAT

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE
a 50 122107
b

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT
a A2 64 60
b
c
d

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	420	DESCRIPTION	97110GP	111107	1	109 00		1
2	420	DESCRIPTION	97110GP	111607	2	218 00		2
3	420	DESCRIPTION	97140GP	110307	2	191 50		3
4	420	DESCRIPTION	97140GP	110807	2	191 50		4
5	420	DESCRIPTION	97140GP	110907	2	191 50		5
6	420	DESCRIPTION	97140GP	111107	1	109 00		6
7	420	DESCRIPTION	97140GP	111607	1	82 50		7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	001	PAGE 2 OF 2	CREATION DATE		TOTALS	1093 00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A	MEDICARE	01001			258 40	1093 00	57	A
B	O/P MEDI-CAL					64 60	OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A			123456789X			A
B			90000000A95001			B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 71590 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1234567890 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
SPLIT BILLED - CLAIM 2 OF 2 DEDUCTIBLE = 0
TOTAL 2509.00 MEDICARE 422.18 COINS 105.59
CLAIM 1 1416.00 163.78 40.99
CLAIM 2 1093.00 258.40 64.60

81CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
© 2005 NUBC

Figure 5b (continued from 5a). Billing for More Than 15 Line Items for Part B Services Billed to Part A Contractors. Split Bill Claim 2 of 2 *(see also Figure 5d).*

Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center	FPE:	11/30/07	Medicare **Contractor**
140 Second Street	PAID:	12/21/07	1234 B Street
Anytown, CA 95823-5555	CLM#:	23	Anytown, CA 98765-5555
0123456789	TOB:	131	555-555-5555

PATIENT: DOE, JANE — PCN: 123456789
HIC: 123456789X — SVC FROM: 11/01/2007 — MRN: 000193638
PAT STAT: CLAIM STAT: 1 — THRU: 11/16/2007 — ICN: 12345678901234

CHARGES:		PAYMENT DATA: =DRG			
2509.00	=REPORTED	0.00	=DRG AMOUNT	0.290	=REIM RATE
133.00	=NCVD/DENIED	0.00	=DRG/OPER/CAP	0.00	=MSP PRIM PAYER
COMPONENT				0.00	=PROF
0.00	=CLAIM ADJS	0.00	=LINE ADJ AMT	0.00	=ESRD AMOUNT
2374.00	=COVERED	0.00	=OUTLIER (C)	0.00	=PROC CD
AMOUNT					
DAYS/VISITS:		0.00	=CAP OUTLIER	422.18	=ALLOW/REIM
0	=COST REPT	0.00	=CASH DEDUCT	0.00	=G/R AMOUNT
0	=COVD/UTIL	0.00	=BLOOD DEDUCT	0.00	=INTEREST
0	=NON-COVERED	105.59	=COINSURANCE	1765.23	=CONTRACT ADJ
0	=COVD VISITS	0.00	=PAT REFUND	0.00	=PER DIEM AMT
0	=NCOV VISITS	0.00	=MSP LIAB MET	422.18	=NET REIM AMT

REMARK CODES: MA01

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT	REMARK CODES
0420	11/01	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/02	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/03	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/08	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/09	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/11	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/16	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/01	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	11/02	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	11/01	97018		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	11/02	90735		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	11/03	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/08	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/09	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/11	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/16	97110		GP	2	218.00	49.73	CO	42	155.84	
								PR	2	12.43	
0420	11/03	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/08	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/09	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/11	97140		GP	1	109.00	22.98	CO	42	80.28	

Claim

1 of 2

medi cr op ex

12

```
                                                                  PR   2        5.74
0420  11/16  97140            GP      1      82.50      22.98   CO   42      52.78
                                                                  PR   2        5.74
==================================================================================================
```

Figure 5c. Medicare *Remittance Advice* Example Split Bill Claim 1 of 2.

Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center	FPE:	11/30/07	Medicare **Contractor**
140 Second Street	PAID:	12/21/07	1234 B Street
Anytown, CA 95823-5555	CLM#:	23	Anytown, CA 98765-5555
00454	TOB:	131	555-555-5555

PATIENT: DOE, JANE — PCN: 123456789
HIC: 123456789X — SVC FROM: 11/01/2007 — MRN: 000193638
PAT STAT: CLAIM STAT: 1 — THRU: 11/16/2007 — ICN: 12345678901234

CHARGES:		PAYMENT DATA: =DRG			
2509.00	=REPORTED	0.00	=DRG AMOUNT	0.290	=REIM RATE
133.00	=NCVD/DENIED	0.00	=DRG/OPER/CAP	0.00	=MSP PRIM PAYER
COMPONENT				0.00	=PROF
0.00	=CLAIM ADJS	0.00	=LINE ADJ AMT	0.00	=ESRD AMOUNT
2374.00	=COVERED	0.00	=OUTLIER (C)	0.00	=PROC CD
AMOUNT					
DAYS/VISITS:		0.00	=CAP OUTLIER	422.18	=ALLOW/REIM
0	=COST REPT	0.00	=CASH DEDUCT	0.00	=G/R AMOUNT
0	=COVD/UTIL	0.00	=BLOOD DEDUCT	0.00	=INTEREST
0	=NON-COVERED	105.59	=COINSURANCE	1765.23	=CONTRACT ADJ
0	=COVD VISITS	0.00	=PAT REFUND	0.00	=PER DIEM AMT
0	=NCOV VISITS	0.00	=MSP LIAB MET	422.18	=NET REIM AMT

REMARK CODES: MA01

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT	REMARK CODES
0420	11/01	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/02	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/03	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/08	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/09	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/11	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/16	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	11/01	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	11/02	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	11/01	97018		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	11/02	90735		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	11/03	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/08	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/09	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/11	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	11/16	97110		GP	2	218.00	49.73	CO	42	155.84	
								PR	2	12.43	
0420	11/03	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/08	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/09	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	11/11	97140		GP	1	109.00	22.98	CO	42	80.28	

Claim

2 of 2

```
                                                                  PR   2        5.74
0420  11/16  97140             GP      1      82.50      22.98   CO   42      53.78
                                                                  PR   2        5.74
==================================================================================================
```

Figure 5d. Medicare *Remittance Advice* Example Split Bill Claim 2 of 2.

1 A1 DIALYSIS
100 FIRST STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 721

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 110207 THROUGH 113007

7

8 PATIENT NAME a b DOE JANE

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE 08241980

11 SEX F

12 DATE 13 HR 14 TYPE 15 SRC

16 DHR

17 STAT

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE
a 50 121507
b

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT
a A2 74493
b
c
d

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	INJECTION ADMIN SUPPLIES	A4657	110207	21	1050		1
2	635	EPOETIN ALFA ESRD	Q4081	110207	13	304512		2
3	636	INJECTION GARAMYCIN	J1580	110507	1	95		3
4	636	INJECTION GARAMYCIN	J1580	111207	1	95		4
5	636	INJECTION GARAMYCIN	J1580	111907	1	95		5
6	636	INJECTION GARAMYCIN	J1580	112607	1	95		6
7	636	INJECTION GLUCONATE	J2916	110507	10	4950		7
8	636	INJECTION GLUCONATE	J2916	111207	10	4950		8
9	636	INJECTION GLUCONATE	J2916	111907	10	4950		9
10	636	INJECTION GLUCONATE	J2916	112607	10	4950		10
11	636	HEP B VACCINE DIA PATIENT	90740	110207	1	11391		11
12	771	ADMIN OF HEP B	G0010	110207	1	788		12
13	821	UNLISTED DIALYSIS PROCED.	90999G4	110207	1	11513		13
14	821	UNLISTED DIALYSIS PROCED.	90999	110507	1	11513		14
15	821	UNLISTED DIALYSIS PROCED.	90999	110707	1	11513		15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	001	PAGE 1 OF 2	CREATION DATE		TOTALS	372460		23

50 PAYER NAME
A MEDICARE
B O/P MEDI-CAL
C

51 HEALTH PLAN ID
A 01001
B
C

52 REL. INFO

53 ASG. BEN.

54 PRIOR PAYMENTS
A 297967
B
C

55 EST. AMOUNT DUE
A 372460
B 74493
C

56 NPI 0123456789

57 OTHER PRV ID

58 INSURED'S NAME

59 P REL

60 INSURED'S UNIQUE ID
A 123456789X
B 90000000A95001
C

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX 5856 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c 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 1234567890 QUAL
LAST FIRST

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
SPLIT BILLED - CLAIM 1 OF 2 DEDUCTIBLE = 0
TOTAL 4875.90 MEDICARE 3900.67 COINS 975.23
CLAIM 1 3724.60 2979.67 744.93
CLAIM 2 1151.30 921.00 230.30

81 CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
© 2005 NUBC

Figure 6a. Billing Medi-Cal for Part B Dialysis Services for More Than 15 Lines.
Split Bill Claim 1 of 2 *(see also Figure 6c).*

1 A1 DIALYSIS
100 FIRST STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #

4 TYPE OF BILL 721

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 110207 THROUGH 113007

7

8 PATIENT NAME a. b. DOE JANE

9 PATIENT ADDRESS a. b. c. d. e.

10 BIRTHDATE 08241980

11 SEX F

12 ADMISSION DATE 13 HR 14 TYPE 15 SRC

16 DHR

17 STAT

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE
a 50 121507
b

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT
a A2 23030
b
c
d

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	821	UNLISTED DIALYSIS PROCED.	90999	110907	1	11513		1
2	821	UNLISTED DIALYSIS PROCED.	90999	111207	1	11513		2
3	821	UNLISTED DIALYSIS PROCED.	90999	111407	1	11513		3
4	821	UNLISTED DIALYSIS PROCED.	90999	111607	1	11513		4
5	821	UNLISTED DIALYSIS PROCED.	90999	111907	1	11513		5
6	821	UNLISTED DIALYSIS PROCED.	90999	112107	1	11513		6
7	821	UNLISTED DIALYSIS PROCED.	90999	112307	1	11513		7
8	821	UNLISTED DIALYSIS PROCED.	90999	112607	1	11513		8
9	821	UNLISTED DIALYSIS PROCED.	90999	112807	1	11513		9
10	821	UNLISTED DIALYSIS PROCED.	90999	113007	1	11513		10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	001	PAGE 2 OF 2	CREATION DATE		TOTALS	115130		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A	MEDICARE	01001			92100	115130	57	A
B	O/P MEDI-CAL					23030	OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A			123456789X			A
B			90000000A95001			B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 5856 Y A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c

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 1234567890 QUAL
LAST FIRST

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
SPLIT BILLED - CLAIM 2 OF 2 DEDUCTIBLE = 0
TOTAL 4875.90 MEDICARE 3900.67 COINS 975.23
CLAIM 1 3724.60 2979.67 744.93
CLAIM 2 1151.30 921.00 230.30

81CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
© 2005 NUBC

Figure 6b (continued from 6a). Billing Medi-Cal for Part B Dialysis Services for More Than 15 Lines. Split Bill Claim 2 of 2 *(see also Figure 6d).*

```
==========================================================================================
                Medicare National Standard Intermediary Remittance Advice

A1 Dialysis                          FPE:      11/30/07     Medicare Contractor
100 First Street                     PAID:     12/15/07     5555 55th Street
Anytown, CA 95823-5555               CLM#:     166          City CA 90000-9000
0123456789                           TOB:      721          555-555-5555
==========================================================================================
PATIENT: DOE, JANE                                                  PCN: 123456789
    HIC: 123456789X                     SVC FROM:  11/02/2007       MRN: 000193638
PAT STAT:    CLAIM STAT: 1                  THRU:  11/30/2007       ICN: 12345678901234
==========================================================================================
CHARGES:                            PAYMENT DATA:     =DRG                  0.290 =REIM RATE
    4875.00 =REPORTED                 0.00 =DRG AMOUNT                       0.00 =MSP PRIM PAYER
       0.00 =NCVD/DENIED              0.00 =DRG/OPER/CAP                     0.00 =PROF
COMPONENT
       0.00 =CLAIM ADJS               0.00 =LINE ADJ AMT                     0.00 =ESRD AMOUNT
    4875.00 =COVERED                  0.00 =OUTLIER (C)                      0.00 =PROC CD
AMOUNT
DAYS/VISITS:                          0.00 =CAP OUTLIER                   3900.67 =ALLOW/REIM
          0 =COST REPT                0.00 =CASH DEDUCT                      0.00 =G/R AMOUNT
          0 =COVD/UTIL                0.00 =BLOOD DEDUCT                     0.00 =INTEREST
          0 =NON-COVERED            975.23 =COINSURANCE                      0.00 =CONTRACT ADJ
          0 =COVD VISITS              0.00 =PAT REFUND                       0.00 =PER DIEM AMT
          0 =NCOV VISITS              0.00 =MSP LIAB MET                  3900.67 =NET REIM AMT
==========================================================================================
REV   DATE    HCPCS   APC/HIPPS  MODS    QTY CHARGES  ALLOW/REIM   GC   RSN    AMOUNT   REMARK CODES

0270  11/02   A4657                     21    10.50        8.40   PR   2        2.10
0635  11/02   Q4081                     13  3045.12     2436.10   PR   2      609.02
0636  11/05   J1580                     1       .95         .76   PR   2        0.19
0636  11/12   J1580                     1       .95         .76   PR   2        0.19
0636  11/19   J1580                     1       .95         .76   PR   2        0.19
0636  11/26   J1580                     1       .95         .76   PR   2        0.19
0636  11/05   J2916                     10    49.50       39.60   PR   2        9.90
0636  11/12   J2916                     10    49.50       39.60   PR   2        9.90
0636  11/19   J2916                     10    49.50       39.60   PR   2        9.90
0636  11/26   J2916                     10    49.50       39.60   PR   2        9.90
0636  11/02   90740                     1    113.91       91.13   PR   2       22.78
0771  11/02   G0010                     1      7.88        6.30   PR   2        1.58
0821  11/02   90999             G4      1    115.13       92.10   PR   2       23.03
0821  11/05   90999                     1    115.13       92.10   PR   2       23.03
0821  11/07   90999                     1    115.13       92.10   PR   2       23.03

0821  11/09   90999                     1    115.13       92.10   PR   2       23.03
0821  11/12   90999                     1    115.13       92.10   PR   2       23.03
0821  11/14   90999                     1    115.13       92.10   PR   2       23.03
0821  11/16   90999                     1    115.13       92.10   PR   2       23.03
0821  11/19   90999                     1    115.13       92.10   PR   2       23.03
0821  11/21   90999                     1    115.13       92.10   PR   2       23.03
0821  11/23   90999                     1    115.13       92.10   PR   2       23.03
0821  11/26   90999                     1    115.13       92.10   PR   2       23.03
0821  11/28   90999                     1    115.13       92.10   PR   2       23.03
0821  11/30   90999                     1    115.13       92.10   PR   2       23.03
==========================================================================================
```

Claim 1 of 2

Figure 6c. Medicare *Remittance Advice* Example. Split Bill Claim 1 of 2.

Note: Supplies and Epoetin are not subject to Medicare's line item billing requirement.

```
==========================================================================================
                Medicare National Standard Intermediary Remittance Advice

A1 Dialysis                          FPE:      11/30/07     Medicare Contractor
100 First Street                     PAID:     12/15/07     5555 55th Street
Anytown, CA 95823-5555               CLM#:     166          City CA 90000-9000
0123456789                           TOB:      721          555-555-5555
==========================================================================================
PATIENT: DOE, JANE                                                  PCN: 123456789
    HIC: 123456789X                     SVC FROM:  11/02/2007       MRN: 000193638
PAT STAT:    CLAIM STAT: 1                  THRU:  11/30/2007       ICN: 12345678901234
==========================================================================================
CHARGES:                            PAYMENT DATA:     =DRG                  0.290 =REIM RATE
    4875.00 =REPORTED                 0.00 =DRG AMOUNT                       0.00 =MSP PRIM PAYER
       0.00 =NCVD/DENIED              0.00 =DRG/OPER/CAP                     0.00 =PROF
COMPONENT
       0.00 =CLAIM ADJS               0.00 =LINE ADJ AMT                     0.00 =ESRD AMOUNT
    4875.00 =COVERED                  0.00 =OUTLIER (C)                      0.00 =PROC CD
AMOUNT
DAYS/VISITS:                          0.00 =CAP OUTLIER                   3900.67 =ALLOW/REIM
          0 =COST REPT                0.00 =CASH DEDUCT                      0.00 =G/R AMOUNT
          0 =COVD/UTIL                0.00 =BLOOD DEDUCT                     0.00 =INTEREST
          0 =NON-COVERED            975.23 =COINSURANCE                      0.00 =CONTRACT ADJ
          0 =COVD VISITS              0.00 =PAT REFUND                       0.00 =PER DIEM AMT
          0 =NCOV VISITS              0.00 =MSP LIAB MET                  3900.67 =NET REIM AMT
==========================================================================================
REV   DATE   HCPCS   APC/HIPPS  MODS   QTY CHARGES ALLOW/REIM  GC   RSN   AMOUNT   REMARK CODES

0270  11/02  A4657                    21    10.50       8.40  PR   2       2.10
0635  11/02  Q4081                    13  3045.12    2436.10  PR   2     609.02
0636  11/05  J1580                    1       .95        .76  PR   2       0.19
0636  11/12  J1580                    1       .95        .76  PR   2       0.19
0636  11/19  J1580                    1       .95        .76  PR   2       0.19
0636  11/26  J1580                    1       .95        .76  PR   2       0.19
0636  11/05  J2916                    10    49.50      39.60  PR   2       9.90
0636  11/12  J2916                    10    49.50      39.60  PR   2       9.90
0636  11/19  J2916                    10    49.50      39.60  PR   2       9.90
0636  11/26  J2916                    10    49.50      39.60  PR   2       9.90
0636  11/02  90740                    1    113.91      91.13  PR   2      22.78
0771  11/02  G0010                    1      7.88       6.30  PR   2       1.58
0821  11/02  90999             G4     1    115.13      92.10  PR   2      23.03
0821  11/05  90999                    1    115.13      92.10  PR   2      23.03
0821  11/07  90999                    1    115.13      92.10  PR   2      23.03

0821  11/09  90999                    1    115.13      92.10  PR   2      23.03
0821  11/12  90999                    1    115.13      92.10  PR   2      23.03
0821  11/14  90999                    1    115.13      92.10  PR   2      23.03
0821  11/16  90999                    1    115.13      92.10  PR   2      23.03
0821  11/19  90999                    1    115.13      92.10  PR   2      23.03
0821  11/21  90999                    1    115.13      92.10  PR   2      23.03
0821  11/23  90999                    1    115.13      92.10  PR   2      23.03
0821  11/26  90999                    1    115.13      92.10  PR   2      23.03
0821  11/28  90999                    1    115.13      92.10  PR   2      23.03
0821  11/30  90999                    1    115.13      92.10  PR   2      23.03
==========================================================================================
```

Claim 2 of 2

Figure 6d. Medicare *Remittance Advice* Example. Split Bill Claim 2 of 2.

Note: Supplies and Epoetin are not subject to Medicare's line item billing requirement.