MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET INSTRUCTIONS

Preparation

This form is to be completed for all Professional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each CMS1500 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.**

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1. **Medicaid Assigned Carrier Code** – enter the six- (6) digit carrier code assigned to the Medicare Advantage provider. All codes begin with H. and end with a trailing 0.(zero).
2. **Medicare Paid Date** – enter the date of the Medicare Advantage Carrier Explanation of Benefits.
3. **Medicaid Provider Number** – enter the seven (7) digit provider number of the billing provider
4. **Recipient Identification Number** – enter the thirteen (13) digit Louisiana Medicaid recipient identification number. (The sixteen (16) digit Card Control Number is not acceptable.)
5. **Information for Line 1**
    - **Line Medicare Allowed Amount** –enter the amount Medicare allowed for the charges on the line.
    - **Total Deductible Amount** – enter the amount of Deductible identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, do not enter anything in this box.
    - **Total Co-Pay Amount** – enter the amount of Co-Pay identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay amounts are not separated on the Explanation of Benefits, enter the Deductible/Co-pay amount in this box.
    - **Total Medicare Payment Amount** – enter the total amount Medicare paid on this line charge.
6. **Information for Lines 2-6** – enter the requested amount for each claim line as outlined in Information for Line 1

MEDICARE ADVANTAGE PROFESSIONAL CROSSOVER COVER SHEET CMS 1500

Review instructions in their entirety before completing this form.

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Medicaid Assigned Carrier Code

H | | | | | 0

Medicare Paid Date (MM-DD-YYYY)

| | - | | - | | | | |

Provider Number

Recipient Identification Number (13 digits)

Information for Claim Line 1

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 2

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 3

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 4

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 5

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

Information for Claim Line 6

Line Medicare Allowed Amount

***Total Deductible Amount**

***Total Co-Pay Amount**

Total Medicare Payment Amount

* If EOB combines Total Deductible & Co-Pay Amounts, enter total in Co-Pay only (Leave Deductible Amount blank).