MEDICARE ADVANTAGE INSTITUTIONAL CROSSOVER COVER SHEET UB-92

Review instructions in their entirety before completing this form.

Inaccurate/Incomplete Cover Sheets will not be processed and will be returned for correction.

1. Medicaid Assigned Carrier Code

H					0

2. Medicare Paid Date (MM-DD-YYYY)

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3. Provider Number

4. Recipient Identification Number (13 digits)

5. Total Deductible Amount

6. Blood Deductible Amount

7. Medicare Per Diem Rate

8. Total Medicare Payment Amount

9. Co-Pay Amount

<u>Instructions</u> – please review in their entirety before completing this form.

This form is to be completed for all Institutional Crossover Claims provided by a Medicare Advantage Carrier. This form is to be attached to the top of each UB-92 and must be completed in its entirety before submission of the claim. **Inaccurate/Incomplete Cover Sheets will be 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 ends 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. **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.
6. **Blood Deductible Amount** – enter the amount of blood deductible if identified on the Explanation of Benefits
7. **Medicare Per Diem Rate** – enter the Per Diem Rate as identified on the Explanation of Benefits, if applicable
8. **Total Medicare Payment Amount** – enter the amount paid by Medicare as identified on the Explanation of Benefits
9. **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.