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

Page updated: August 2020

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.

The examples in this section do not necessarily represent current Medicare or Medi-Cal policy.

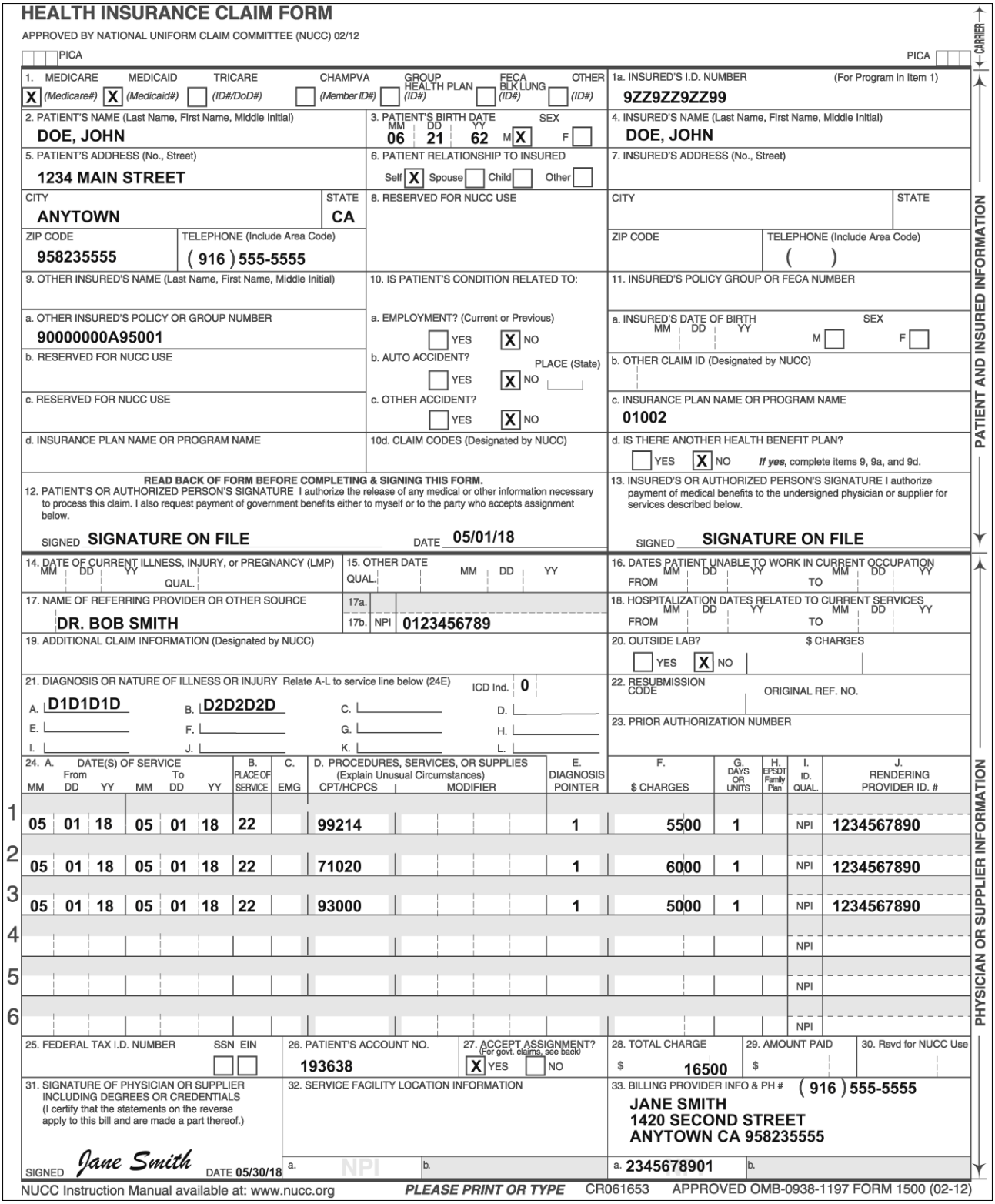
Note: A crossover claim reflects what was billed to Medicare, but only Medi-Cal-required fields are used for claims processing.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9ZZ9ZZ9ZZ99

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 [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. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 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 [ ] NO [X]

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a, and 9d.

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 05/01/18

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

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

17a.

17b. NPI 0123456789

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. 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 05 01 18	05 01 18	22		99214		1	5500	1		NPI	1234567890
2 05 01 18	05 01 18	22		71020		1	6000	1		NPI	1234567890
3 05 01 18	05 01 18	22		93000		1	5000	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) YES [X] NO [ ]

28. TOTAL CHARGE $ 16500

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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 05/30/18

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 **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

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
1420 SECOND STREET
ANYTOWN, CA 95823-5555

05/30/18

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME **MEDICARE ID**/EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	 TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANC	PAYMENT	INTERES
JOHN DOE	05 01 18	05 01 18	22	99214	55.00	40.00		0.00	8.00	32.00	
9ZZ9ZZ9ZZ99	05 01 18	05 01 18	22	71020	60.00	50.00		0.00	10.00	40.00	
90000000A95001	05 01 18	05 01 18	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.

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

3a PAT. CNTL # 123456789
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100115

8 PATIENT NAME b DOE, JANE
9 PATIENT ADDRESS

10 BIRTHDATE 08241980 | 11 SEX F | 12 ADMISSION DATE 100115 | 13 HR 15 | 14 TYPE 3 | 15 SRC | 16 DHR 12 | 17 STAT 01
18–28 CONDITION CODES | 29 ACDT STATE | 30

31 OCCURRENCE CODE 50 DATE 111515
32–34 OCCURRENCE | 35–36 OCCURRENCE SPAN | 37

38 | 39 VALUE CODES: a A1 10000 | 40 VALUE CODES: A2 12719 | 41 VALUE CODES

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
300	DESCRIPTION	36415	100115	1	2410		
301	DESCRIPTION	80053	100115	1	18575		
301	DESCRIPTION	83880	100115	1	21600		
301	DESCRIPTION	84484	100115	1	10210		
305	DESCRIPTION	85025	100115	1	8055		
305	DESCRIPTION	85379	100115	1	10550		
324	DESCRIPTION	71020	100115	1	18300		
450	DESCRIPTION	9928325	100115	1	131500		
730	DESCRIPTION	93005	100115	1	13000		
921	DESCRIPTION	93970	100115	1	98700		
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
A MEDICARE	01101			23017	332900
B O/P MEDI-CAL					22719

56 NPI 0123456789
57 OTHER PRV ID

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

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX 0 | 67 D1D1D1D

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE | b. OTHER PROCEDURE | c. OTHER PROCEDURE | d. OTHER PROCEDURE | e. OTHER PROCEDURE | 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 | 81CC a b c d

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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
140 Second Street
Anytown, CA 95823-5555
0123456789

FPE:02/01/16
PAID:11/15/15
CLM#:166

Medicare Contractor
1234 B Street
Anytown, CA 98765-5555
TOB: 131 555-555-5555

PATIENT: DOE, JANE
MEDICARE ID: 9ZZ9ZZ9ZZ99
PAT STAT: CLAIM STAT: 19

SVC FROM: 10/01/2015
THRU: 10/01/2015

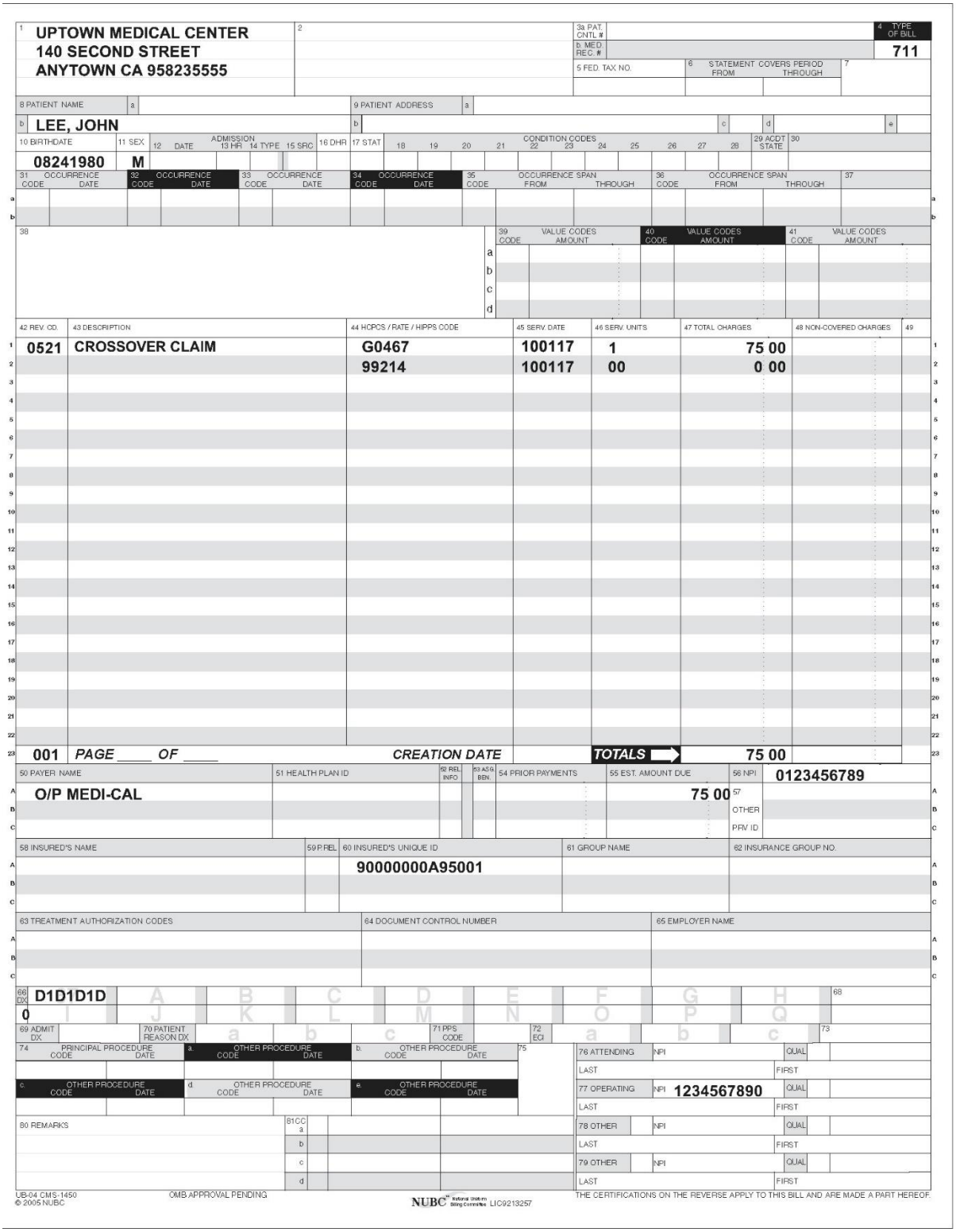
PCN: 123456789
MRN: 000193638
ICN: 12345678901234

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	10/01	36415			1	24.10	3.00	CO	42	21.10	
0301	10/01	80053			1	185.75	14.77	CO	42	170.98	
0301	10/01	83880			1	216.00	47.43	CO	42	168.57	
0301	10/01	84484			1	102.10	13.75	CO	42	88.35	
0305	10/01	85025			1	80.55	10.86	CO	42	69.69	
0305	10/01	85379			1	105.50	14.22	CO	42	91.28	
0324	10/01	71020	00260		1	183.00	25.07	CO	45	137.42	
								PR	2	20.51	
0450	10/01	99283	00611	25	1	1315.00	4.07	CO	45	1173.36	
								PR	1	100.00	
								PR	2	37.57	
0730	10/01	93005	00099		1	130.00	18.05	CO	45	107.44	
								PR	2	4.51	
0921	10/01	93970	00267		1	987.00	78.95	CO	45	843.45	
								PR	2	64.60	

Figure 2b: Medicare *Remittance Advice* Example.



1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555							4 TYPE OF BILL: 711	
8 PATIENT NAME	LEE, JOHN			9 PATIENT ADDRESS					
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE	30
08241980	M								
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49		
0521	CROSSOVER CLAIM	G0467	100117	1	75 00				
		99214	100117	00	0 00				
001	PAGE ____ OF ____	CREATION DATE		TOTALS	75 00				
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789		
O/P MEDI-CAL					75 00	57 OTHER PRV ID			
58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.					
		90000000A95001							
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME							
66 DX: D1D1D1D 0									
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73					
74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING	NPI	QUAL			
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST	FIRST				
				77 OPERATING	NPI 1234567890	QUAL			
				LAST	FIRST				
80 REMARKS	81CC			78 OTHER	NPI	QUAL			
				LAST	FIRST				
				79 OTHER	NPI	QUAL			
				LAST	FIRST				

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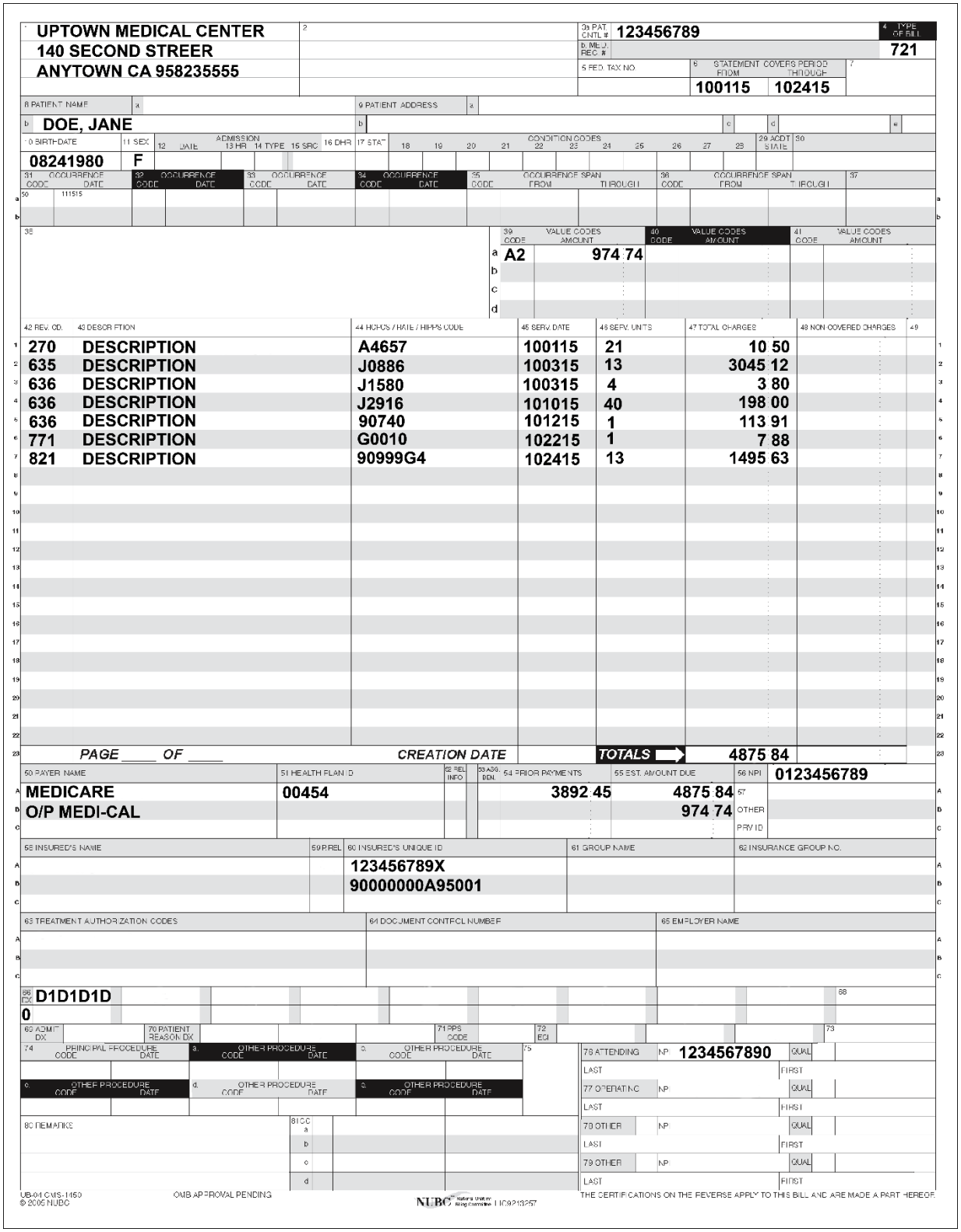
Figure 3: Billing Medi-Cal for Rural Health Clinics/Federally Qualified Health Centers.



UPTOWN MEDICAL CENTER
140 SECOND STREER
ANYTOWN CA 958235555

3b PAT. CNTL # 123456789
4 TYPE OF BILL 721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102415

8 PATIENT NAME: DOE, JANE
9 PATIENT ADDRESS
10 BIRTHDATE: 08241980
11 SEX: F
50: 111515

39 VALUE CODES a A2 974 74

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES
270	DESCRIPTION	A4657	100115	21	10 50	
635	DESCRIPTION	J0886	100315	13	3045 12	
636	DESCRIPTION	J1580	100315	4	3 80	
636	DESCRIPTION	J2916	101015	40	198 00	
636	DESCRIPTION	90740	101215	1	113 91	
771	DESCRIPTION	G0010	102215	1	7 88	
821	DESCRIPTION	90999G4	102415	13	1495 63	
				TOTALS	4875 84	

PAGE ____ OF ____ CREATION DATE

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789
A MEDICARE	00454	3892 45	4875 84	57	
B O/P MEDI-CAL			974 74	OTHER PRV ID	

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: D1D1D1D
0

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

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OMB APPROVAL PENDING
NUBC National Uniform Billing Committee
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.

Medicare National Standard Intermediary Remittance Advice

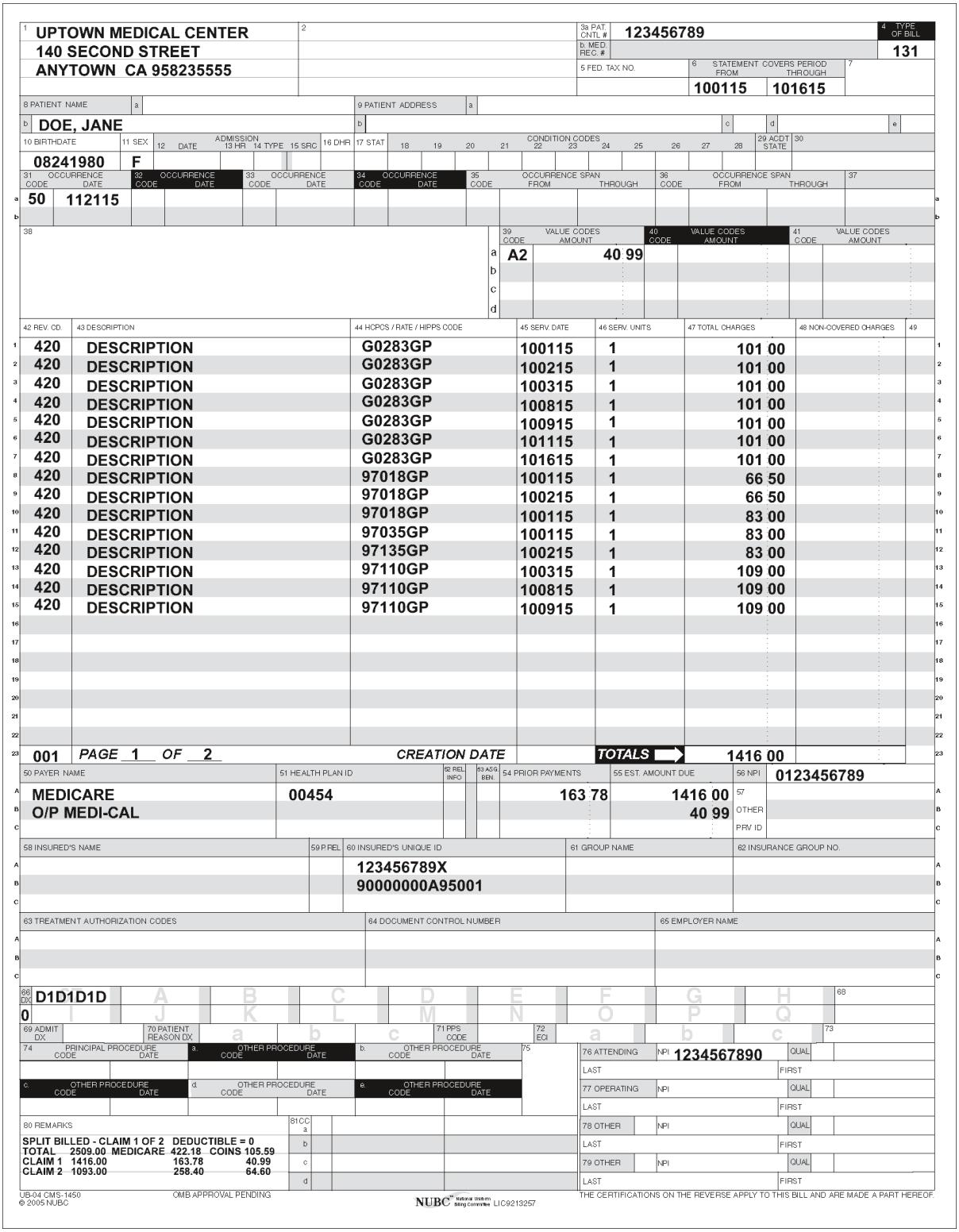
Uptown Medical Center	FPE:	10/30/16	Medicare Contractor
140 Second Street	PAID:	11/15/16	1234 B Street
Anytown, CA 95823-5555	CLM#:	166	Anytown, CA 98765-5555
0123456789	TOB:	721	555-555-5555

PATIENT: DOE, JANE — PCN: 123456789
MEDICARE ID: 9ZZ9ZZ9ZZ99 — SVC FROM: 10/01/2016 — MRN: 000193638
PAT STAT: CLAIM STAT: 1 — THRU: 10/24/2016 — 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	10/01	A4657			21	10.50	8.40	PR	2	2.10	
0636	10/03	J1580			4	3.80	3.04	PR	2	0.76	
0636	10/10	J2916			40	198.00	158.40	PR	2	39.60	
0636	10/12	90740			1	113.91	91.13	PR	2	22.78	
0771	10/22	G0010			1	7.88	6.30	PR	2	1.58	
0821	10/24	90999		G4	13	1496.63	1189.08	CO	97	6.50	
									45	2.15	
								PR	2	75.47	

Figure 4b: Medicare *Remittance Advice* Example.



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

3a PAT. CNTL # 123456789
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 101615

8 PATIENT NAME b DOE, JANE
9 PATIENT ADDRESS
10 BIRTHDATE 08241980
11 SEX F
31 OCCURRENCE CODE 50 DATE 112115
38

39 VALUE CODES a A2 40 99

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
420	DESCRIPTION	G0283GP	100115	1	101 00	
420	DESCRIPTION	G0283GP	100215	1	101 00	
420	DESCRIPTION	G0283GP	100315	1	101 00	
420	DESCRIPTION	G0283GP	100815	1	101 00	
420	DESCRIPTION	G0283GP	100915	1	101 00	
420	DESCRIPTION	G0283GP	101115	1	101 00	
420	DESCRIPTION	G0283GP	101615	1	101 00	
420	DESCRIPTION	97018GP	100115	1	66 50	
420	DESCRIPTION	97018GP	100215	1	66 50	
420	DESCRIPTION	97018GP	100115	1	83 00	
420	DESCRIPTION	97035GP	100115	1	83 00	
420	DESCRIPTION	97135GP	100215	1	83 00	
420	DESCRIPTION	97110GP	100315	1	109 00	
420	DESCRIPTION	97110GP	100815	1	109 00	
420	DESCRIPTION	97110GP	100915	1	109 00	
001	PAGE 1 OF 2	CREATION DATE		TOTALS	1416 00	

50 PAYER NAME: MEDICARE / O/P MEDI-CAL
51 HEALTH PLAN ID: 00454
54 PRIOR PAYMENTS: 163 78 / 40 99
55 EST. AMOUNT DUE: 1416 00
56 NPI 0123456789
57 OTHER PRV ID

58 INSURED'S NAME
60 INSURED'S UNIQUE ID: 123456789X / 90000000A95001
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX D1D1D1D / 0
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
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

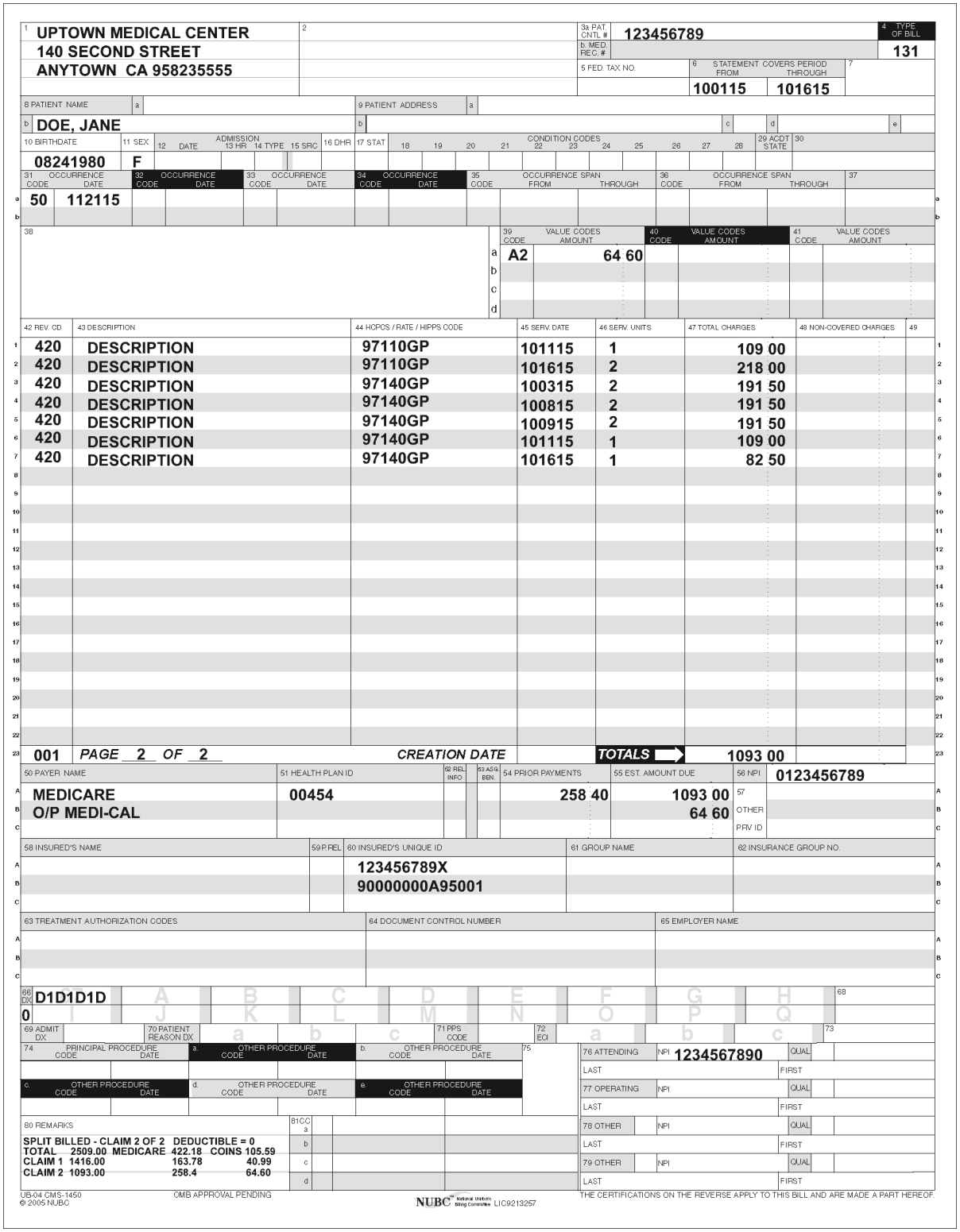
76 ATTENDING NPI 1234567890 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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

81 CC 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

3a PAT. CNTL # 123456789
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 101615

8 PATIENT NAME: b DOE, JANE
10 BIRTHDATE 08241980 | 11 SEX F

31 OCCURRENCE CODE 50 DATE 112115

39 VALUE CODES AMOUNT: a A2 64 60

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
420	DESCRIPTION	97110GP	101115	1	109 00	
420	DESCRIPTION	97110GP	101615	2	218 00	
420	DESCRIPTION	97140GP	100315	2	191 50	
420	DESCRIPTION	97140GP	100815	2	191 50	
420	DESCRIPTION	97140GP	100915	2	191 50	
420	DESCRIPTION	97140GP	101115	1	109 00	
420	DESCRIPTION	97140GP	101615	1	82 50	
001	PAGE 2 OF 2	CREATION DATE		TOTALS	1093 00	

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE	00454	258 40	1093 00	0123456789
O/P MEDI-CAL			64 60	

58 INSURED'S NAME	60 INSURED'S UNIQUE ID
	123456789X
	90000000A95001

66 DX: D1D1D1D0

76 ATTENDING NPI 1234567890

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 1093.00 258.4 64.60

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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: 10/30/16	Medicare Contractor
140 Second Street	PAID: 11/21/16	1234 B Street
Anytown, CA 95823-5555	CLM#: 23	Anytown, CA 98765-5555
0123456789	TOB: 131	555-555-5555

PATIENT: DOE, JANE — PCN: 123456789
MEDICARE ID: 9ZZ9ZZ9ZZ99 — SVC FROM: 10/01/2016 — MRN: 000193638
PAT STAT: — CLAIM STAT: 1 — THRU: 10/16/2016 — ICN: 12345678901234

CHARGES:	PAYMENT DATA: =DRG	0.290	=REIM RATE
2509.00	=REPORTED	0.00	=DRG AMOUNT	0.00	=MSP PRIM PAYER
133.00	=NCVD/DENIED	0.00	=DRG/OPER/CAP	0.00	=PROF
COMPONENT					
0.00	=CLAIM ADJS	0.00	=LINE ADJ AMT	0.00	=ESRD AMOUNT
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	10/01	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/02	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/03	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/08	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/09	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/11	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/16	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/01	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	10/02	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	10/01	97018		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	10/03	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/08	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/09	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/11	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/16	97110		GP	2	218.00	49.73	CO	42	155.84	
								PR	2	12.43	
0420	10/03	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/08	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/09	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/11	97140		GP	1	109.00	22.98	CO	42	80.28	
								PR	2	5.74	
0420	10/16	97140		GP	1	82.50	22.98	CO	42	52.78	
								PR	2	5.74	

Claim 1 of 2

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

Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center
140 Second Street
Anytown, CA 95823-5555
00454

FPE: 10/30/16
PAID: 11/21/16
CLM#: 23
TOB: 131

Medicare Contractor
1234 B Street
Anytown, CA 98765-5555
555-555-5555

PATIENT: DOE, JANE
MEDICARE ID: 9ZZ9ZZ9ZZ99
PAT STAT: CLAIM STAT: 1

SVC FROM: 10/01/2016
THRU: 10/16/2016

PCN: 123456789
MRN: 000193638
ICN: 12345678901234

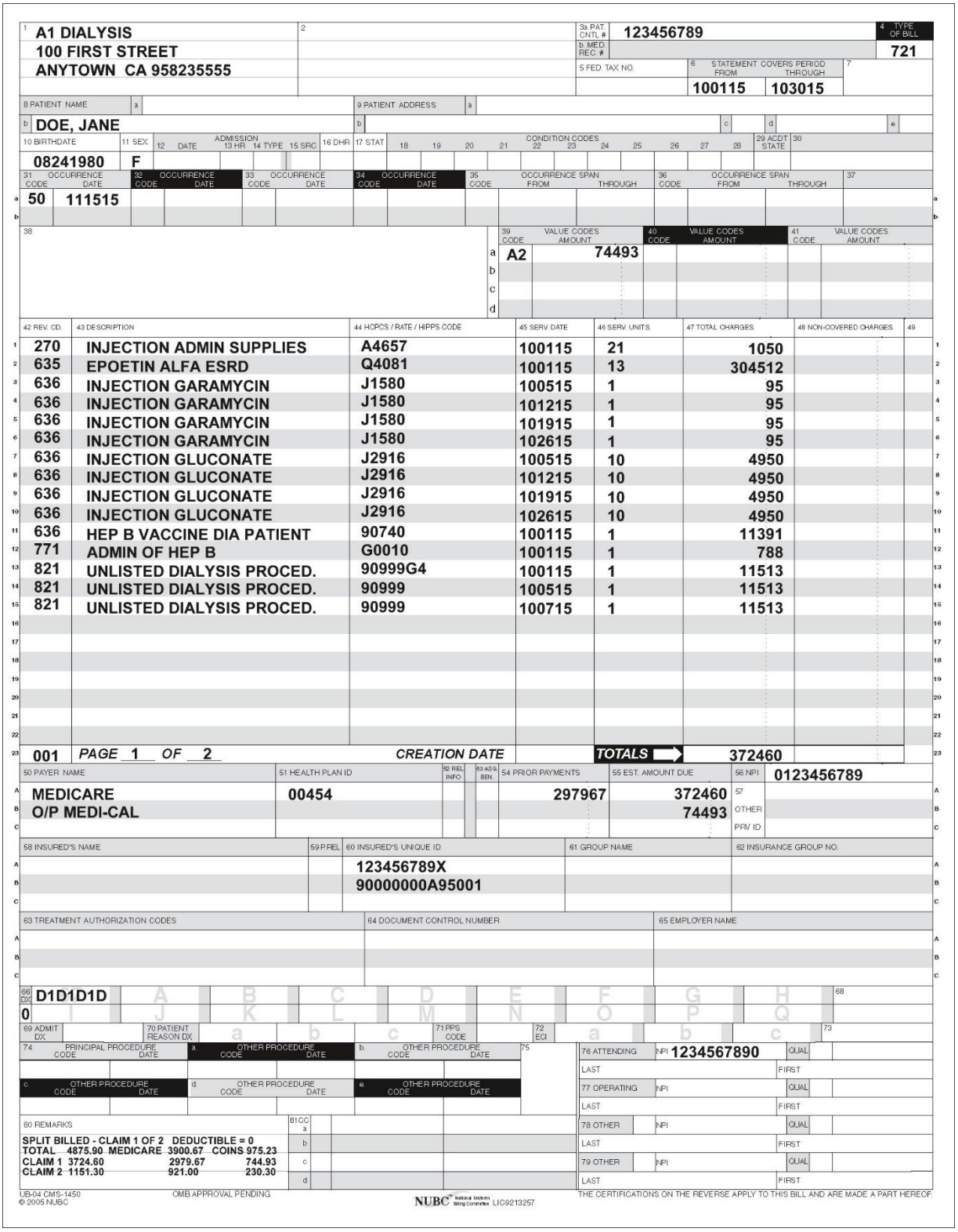
CHARGES:	PAYMENT DATA: =DRG	0.290	=REIM RATE
2509.00 =REPORTED	0.00 =DRG AMOUNT	0.00	=MSP PRIM PAYER
133.00 =NCVD/DENIED	0.00 =DRG/OPER/CAP	0.00	=PROF
COMPONENT			
0.00 =CLAIM ADJS	0.00 =LINE ADJ AMT	0.00	=ESRD AMOUNT
2374.00 =COVERED	0.00 =OUTLIER (C)	0.00	=PROC CD
AMOUNT			
DAYS/VISITS:	0.00 =CAP OUTLIER	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	10/01	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/02	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/03	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/08	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/09	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/11	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/16	G0238		GP	1	101.00	9.70	CO	42	88.87	
								PR	2	2.43	
0420	10/01	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	10/02	97018		GP	1	66.50	0.00	CO	B15	66.50	
0420	10/01	97018		GP	1	83.00	10.65	CO	42	69.69	
								PR	2	2.66	
0420	10/03	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/08	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/09	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/11	97110		GP	1	109.00	24.86	CO	42	77.92	
								PR	2	6.22	
0420	10/16	97110		GP	2	218.00	49.73	CO	42	155.84	
								PR	2	12.43	
0420	10/03	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/08	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/09	97140		GP	2	191.50	45.95	CO	42	134.06	
								PR	2	11.49	
0420	10/11	97140		GP	1	109.00	22.98	CO	42	80.28	
								PR	2	5.74	
0420	10/16	97140		GP	1	82.50	22.98	CO	42	53.78	
								PR	2	5.74	

Claim 2 of 2

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



1	2	3a PAT. CNTL #	4 TYPE OF BILL
A1 DIALYSIS 100 FIRST STREET ANYTOWN CA 958235555		123456789 b. MED. REC. #	721
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH
		100115	103015

8 PATIENT NAME	9 PATIENT ADDRESS
b DOE, JANE	

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

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
a 50	111515													a
b														b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a A2	74493				
	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	INJECTION ADMIN SUPPLIES	A4657	100115	21	1050		1
2	635	EPOETIN ALFA ESRD	Q4081	100115	13	304512		2
3	636	INJECTION GARAMYCIN	J1580	100515	1	95		3
4	636	INJECTION GARAMYCIN	J1580	101215	1	95		4
5	636	INJECTION GARAMYCIN	J1580	101915	1	95		5
6	636	INJECTION GARAMYCIN	J1580	102615	1	95		6
7	636	INJECTION GLUCONATE	J2916	100515	10	4950		7
8	636	INJECTION GLUCONATE	J2916	101215	10	4950		8
9	636	INJECTION GLUCONATE	J2916	101915	10	4950		9
10	636	INJECTION GLUCONATE	J2916	102615	10	4950		10
11	636	HEP B VACCINE DIA PATIENT	90740	100115	1	11391		11
12	771	ADMIN OF HEP B	G0010	100115	1	788		12
13	821	UNLISTED DIALYSIS PROCED.	90999G4	100115	1	11513		13
14	821	UNLISTED DIALYSIS PROCED.	90999	100515	1	11513		14
15	821	UNLISTED DIALYSIS PROCED.	90999	100715	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	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789
A MEDICARE	00454			297967	372460	57 OTHER	
B O/P MEDI-CAL					74493	PRV ID	
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	A	B	C	D	E	F	G	H	68
D1D1D1D	I	J	K	L	M	N	O	P	Q	
0									

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

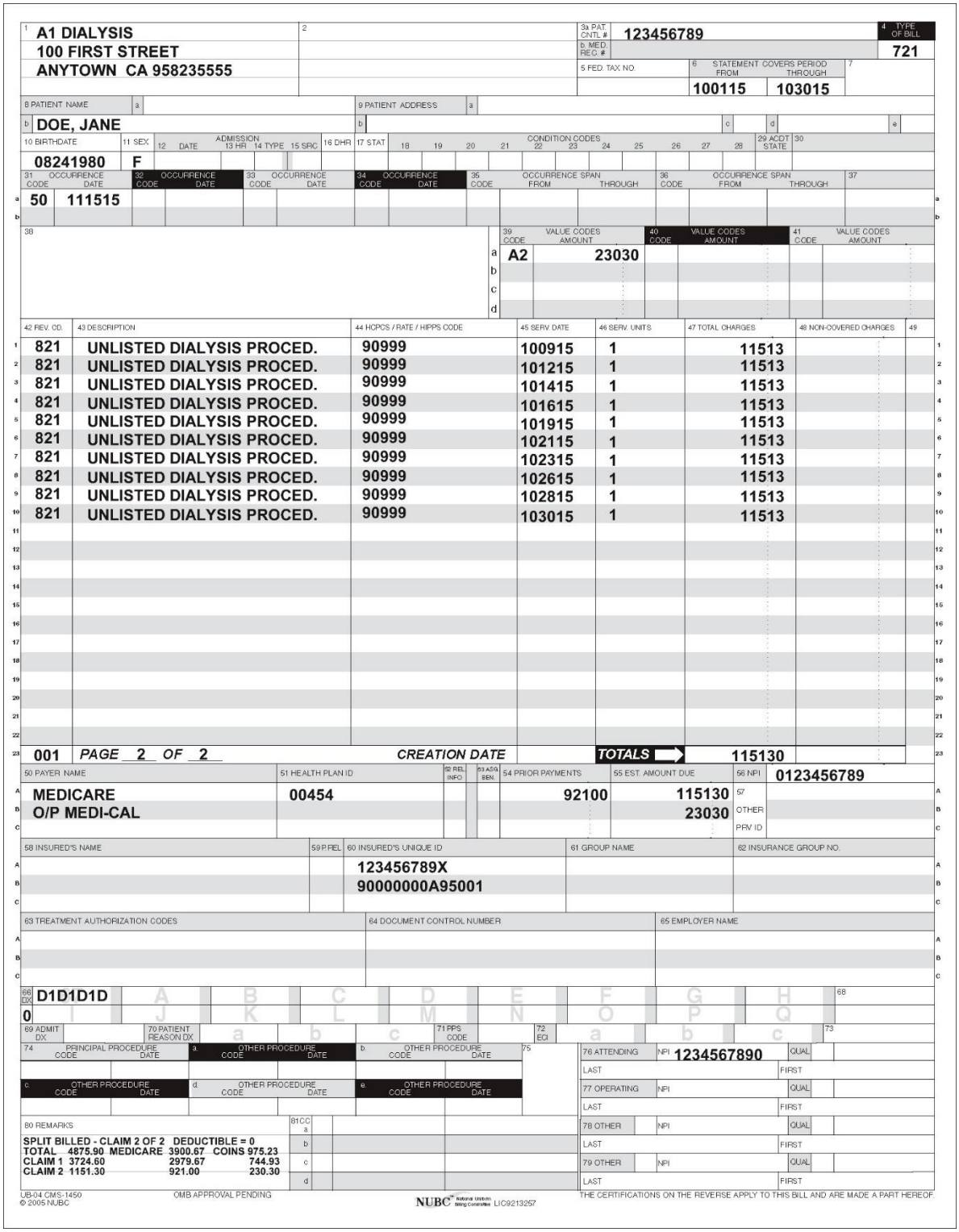
74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

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		
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	b		
	c		
	d		

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

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 100115 THROUGH 103015

7

8 PATIENT NAME
b DOE, JANE

9 PATIENT ADDRESS

10 BIRTHDATE 08241980

11 SEX F

12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC

16 DHR

17 STAT

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

29 ACDT STATE

30

31 OCCURRENCE CODE DATE: a 50 111515

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

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
821	UNLISTED DIALYSIS PROCED.	90999	100915	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	101215	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	101415	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	101615	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	101915	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	102115	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	102315	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	102615	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	102815	1	11513		
821	UNLISTED DIALYSIS PROCED.	90999	103015	1	11513		
001	PAGE 2 OF 2	CREATION DATE		TOTALS	115130		

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

51 HEALTH PLAN ID: 00454

52 REL INFO | 53 ASG BEN

54 PRIOR PAYMENTS: 92100; 23030

55 EST. AMOUNT DUE: 115130

56 NPI 0123456789

57 OTHER PRV ID

58 INSURED'S NAME

59 P REL

60 INSURED'S UNIQUE ID: 123456789X; 90000000A95001

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX: D1D1D1D
0

67 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 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
© 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 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:	10/30/15	Medicare Contractor
100 First Street	PAID:	11/15/15	5555 55th Street
Anytown, CA 95823-5555	CLM#:	166	City, CA 90000-9000
0123456789	TOB:	721	555-555-5555

PATIENT: DOE, JANE — PCN: 123456789
MEDICARE ID: 9ZZ9ZZ9ZZ99 — SVC FROM: 10/01/2015 — MRN: 000193638
PAT STAT: — CLAIM STAT: 1 — THRU: 10/30/2015 — 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	10/01	A4657			21	10.50	8.40	PR	2	2.10	
0635	10/01	Q4081			13	3045.12	2436.10	PR	2	609.02	
0636	10/05	J1580			1	.95	.76	PR	2	0.19	
0636	10/12	J1580			1	.95	.76	PR	2	0.19	
0636	10/19	J1580			1	.95	.76	PR	2	0.19	
0636	10/26	J1580			1	.95	.76	PR	2	0.19	
0636	10/05	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/12	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/19	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/26	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/01	90740			1	113.91	91.13	PR	2	22.78	
0771	10/01	G0010			1	7.88	6.30	PR	2	1.58	
0821	10/01	90999		G4	1	115.13	92.10	PR	2	23.03	
0821	10/05	90999			1	115.13	92.10	PR	2	23.03	
0821	10/07	90999			1	115.13	92.10	PR	2	23.03	
0821	10/09	90999			1	115.13	92.10	PR	2	23.03	
0821	10/12	90999			1	115.13	92.10	PR	2	23.03	
0821	10/14	90999			1	115.13	92.10	PR	2	23.03	
0821	10/16	90999			1	115.13	92.10	PR	2	23.03	
0821	10/19	90999			1	115.13	92.10	PR	2	23.03	
0821	10/21	90999			1	115.13	92.10	PR	2	23.03	
0821	10/23	90999			1	115.13	92.10	PR	2	23.03	
0821	10/26	90999			1	115.13	92.10	PR	2	23.03	
0821	10/28	90999			1	115.13	92.10	PR	2	23.03	
0821	10/30	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
100 First Street
Anytown, CA 95823-5555
0123456789

FPE: 10/30/15
PAID: 11/15/15
CLM#: 166
TOB: 721

Medicare Contractor
5555 55th Street
City, CA 90000-9000
555-555-5555

PATIENT: DOE, JANE
MEDICARE ID: 9ZZ9ZZ9ZZ99
PAT STAT: CLAIM STAT: 1

SVC FROM: 10/01/2015
THRU: 10/30/2015

PCN: 123456789
MRN: 000193638
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	10/01	A4657			21	10.50	8.40	PR	2	2.10	
0635	10/01	Q4081			13	3045.12	2436.10	PR	2	609.02	
0636	10/05	J1580			1	.95	.76	PR	2	0.19	
0636	10/12	J1580			1	.95	.76	PR	2	0.19	
0636	10/19	J1580			1	.95	.76	PR	2	0.19	
0636	10/26	J1580			1	.95	.76	PR	2	0.19	
0636	10/05	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/12	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/19	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/26	J2916			10	49.50	39.60	PR	2	9.90	
0636	10/01	90740			1	113.91	91.13	PR	2	22.78	
0771	10/01	G0010			1	7.88	6.30	PR	2	1.58	
0821	10/01	90999		G4	1	115.13	92.10	PR	2	23.03	
0821	10/05	90999			1	115.13	92.10	PR	2	23.03	
0821	10/07	90999			1	115.13	92.10	PR	2	23.03	
0821	10/09	90999			1	115.13	92.10	PR	2	23.03	
0821	10/12	90999			1	115.13	92.10	PR	2	23.03	
0821	10/14	90999			1	115.13	92.10	PR	2	23.03	
0821	10/16	90999			1	115.13	92.10	PR	2	23.03	
0821	10/19	90999			1	115.13	92.10	PR	2	23.03	
0821	10/21	90999			1	115.13	92.10	PR	2	23.03	
0821	10/23	90999			1	115.13	92.10	PR	2	23.03	
0821	10/26	90999			1	115.13	92.10	PR	2	23.03	
0821	10/28	90999			1	115.13	92.10	PR	2	23.03	
0821	10/30	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.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.