pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

CMS-1500 MEDICARE ATTACHMENT

Please use this form in lieu of attaching the Medicare Explanation of Benefits (EOMB) when billing Medical Assistance (MA) for Medicare Deductible and/or Coinsurance. **Note: this form must be used when entering attachment type 05 (Medicare EOMB attached) in Block 19 of the CMS-1500 Claim form. Be advised that there are certain fields listed below as (REQUIRED) that must be completed in order to process your claim in a timely manner.**

This attachment *must not* be used when submitting claims electronically.

Billing Provider Name: _____(REQUIRED)

Billing Provider MAID Number: _____(REQUIRED)

Recipient Name: _____(REQUIRED)

Recipient MAID Number: _____(REQUIRED)

Date of Medicare EOMB: _____(REQUIRED)

Claim Line	Date of Service	Procedure Code	Reason Code	Medicare Deductible	Medicare Coinsurance/ Copayment	Medicare Allowed Amount	Medicare Paid (incl. Medicare Reduction(s)) Amount
#1							
#2							
#3							
#4							
#5							
#6							

Please verify that the claim line number information on the attachment corresponds to the claim detail number on the invoice. Inaccurate information will result in claims processing errors.

INSTRUCTIONS FOR COMPLETING THE CMS-1500 MEDICARE ATTACHMENT

Please complete and attach this Medicare Attachment, instead of attaching a copy of the Medicare EOMB, to the CMS-1500. Medical Assistance recognizes that Medicare Providers receive an EOMB from Medicare that does not always provide a claim line-by-claim line breakdown. This attachment form will assist Providers in submitting claims successfully for Medicare deductible and/or coinsurance. There are six lines provided on this form that correlate to the six claim lines of the CMS-1500. When submitting claims on the CMS-1500 for Medicare deductible and/or coinsurance, this Medicare Attachment must be completed and paper clipped to the CMS-1500 Claim Form. **Remember this is for PAPER claims only with attachment type 05.**

- **Billing Provider Name** - Place the name of the billing provider. (REQUIRED)
- **Billing Provider MAID Number** - Place the 13 digit Medicaid Identification number of the billing provider. (REQUIRED)
- **Recipient Name** - Place name as listed on ACCESS card. (REQUIRED)
- **Recipient MAID Number** - Place the 10 digit recipient MA identification number. (REQUIRED)
- **Date of Medicare EOMB** - Enter the date of the Medicare EOMB in this field. (REQUIRED)
- **Claim Line** - The line numbers denoted in this column correlate the claim lines of the CMS-1500 Claim Form. Please Note: For Medical Assistance billing purposes, you must indicate the Medicare deductible and/or coinsurance applicable to each claim line. (REQUIRED)
- **Reason Code(s)** - Include all of the adjustment reason codes that appear on the EOMB for the claim line except CO-45. (REQUIRED)
- **Medicare Deductible** - This field must be completed when Medicare applies any portion of the payment toward the Medicare deductible. Using your Medicare EOMB, please indicate the amount Medicare applied to the yearly Medicare Part B deductible. (MUST, IF APPLICABLE)
- **Medicare Coinsurance/Copayment** - Complete this field, when applicable. Please enter the amount of coinsurance and/or copayment applicable to each claim line. If Medicare assesses a coinsurance and a copayment on the same service, add the coinsurance amount and the copayment amount for the claim line and report the sum in Medicare Coinsurance/Copayment field. (MUST, IF APPLICABLE)
- **Medicare Allowed Amount** - This field must be completed. Please enter the Medicare Allowed/Approved Amount applicable to each claim line. (REQUIRED)
- **Medicare Paid** (incl. Medicare Reduction(s)) **Amount** - This field is required for FQHC and RHC providers and must contain the amount Medicare paid for the applicable claim line. **For all other providers**, report the amount Medicare Paid toward the service/item when billing for Medicare Deductible **and/or** Medicare Coinsurance/Copayment. **All providers must sum CARC 223 or 253 payment reduction(s) to the Net Medicare Paid Amount,** to reflect Medicare Payment reduction(s) in this field. Refer to the following MA Quick Tip link regarding Medicare Reductions for more information. http://www.dpw.state.pa.us/publications/forproviders/QuickTips/P_039243 (REQUIRED FOR FQHC AND RHC PROVIDERS/FOR ALL OTHER PROVIDERS MUST, IF APPLICABLE)