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.

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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 and Co-Insurance Amounts** – enter the amount of Co-Pay/Co-Insurance identified on the Explanation of Benefits **IF** it is separately identified. If the Deductible and Co-pay/Co-Insurance amounts are not separated on the Explanation of Benefits, enter the Total Deductible in the appropriate field and the Co-pay/Co-Insurance amounts in the identified boxes. Please use the new form when entering copay or coinsurance amounts.
    - **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.
All line item data should be right justified and entered with only one number per box.

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 / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

Information for Claim Line 2

Line Medicare Allowed Amount

						.		
						.		

***Total Deductible Amount**

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						.		

***Total Co-Pay / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

Information for Claim Line 3

Line Medicare Allowed Amount

						.		
						.		

***Total Deductible Amount**

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						.		

***Total Co-Pay / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

Information for Claim Line 4

Line Medicare Allowed Amount

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						.		

***Total Deductible Amount**

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						.		

***Total Co-Pay / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

Information for Claim Line 5

Line Medicare Allowed Amount

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						.		

***Total Deductible Amount**

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						.		

***Total Co-Pay / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

Information for Claim Line 6

Line Medicare Allowed Amount

						.		
						.		

***Total Deductible Amount**

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						.		

***Total Co-Pay / Co-Insurance Amount**

						.		
						.		

Total Medicare Payment Amount

						.		
						.		

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

Revised 11/19/2024