

Provider Web Portal Quick Guide – Submitting a Claim with Other Insurance or Medicare Crossover Information

This Quick Guide covers when and how to enter other insurance information (Third-Party Liability) or Medicare crossover information.

Other insurance information should be entered on claims with Third-Party Liability (TPL)/commercial insurance. For claims billed to Medicare, provide the Medicare crossover information (see description below).

Medicare crossover information should be entered on any claim that was billed to Medicare first. The term "Crossover claim" may refer to a claim that is directly from Medicare (and has since "crossed over" to Health First Colorado [Colorado's Medicaid Program] for processing) **or** a provider-initiated claim (submitted via the Provider Web Portal, batch or paper)." A crossover claim does not necessarily have to come directly from Medicare. Medicare Health Maintenance Organization (HMO) Co-pays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Co-pay amount into the Co-insurance Amount field under the Medicare Crossover Details section of the claim.

From the list below, identify the example below which most closely matches your claim, then proceed to the appropriate page for instructions. The sample screens shown in this guide may vary depending on claim information.

2
2
9
10
13
18

Entering Other Insurance Information on a Claim

Professional Claim with TPL

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields, then check the "Include Other Insurance" box under the Claim Information section. Click "Continue." If you are submitting a claim with Medicare crossover information, see the instructions starting on page 13 of this guide.

Submit Professional Claim	Step 1
* Indicates a required field.	
Provider Information	
Billing Provider ID	S ID Type ✓ Name _
Taxonomy	×
Referring Provider ID	ID Type V Name _
Taxonomy	×
Supervising Provider ID	ID Type V Name _
Taxonomy	×
Service Facility Location	S ID Type Same _ Same
Taxonomy	V
Member Information	
*Member ID	
Last Name	_ First Name _
Birth Date	-
Address	
City	
State	✓ Zip Code₀
Claim Information	
Date Type	Date of Current®
Accident Related Reason	
*Patient Number	
*Transport Certification	○Yes ○No
Enter a Previous Claim ICN if	filing a claim with dates of service older than 120 days. The previous claim must have been filed
within the defined timely filing) period.
Previous claim ICN	
Note	
*Does the pro	vider have a signature on file? OYes ONo
Include Other 🔽	Total Charged Amount \$0.00
Insurance	
	Continue Cancel

2. On the Submit Professional Claim: Step 2 page under the Other Insurance Details section, click [+] to add new other insurance information.

Submit Profe	ssional Claim: Step 2			1
* Indicates a r	required field.			
	Claim	Type Professional		
Provider Info	ormation			
Billing	Provider ID 1234567891	ID Type NPI	Name Medical Pro	wider
	Taxonomy Clinic/Center - P	rimary Care		
Patient and C	laim Information			
	Member ID Z123456 Member Jane Smith Birth Date mm/dd/ccyy	Total Charged A	Gender Female Amount \$0.00	
				Evened All J. Collance A
Diagnosis Co	des			Expand All Collapse Al
Please note the	number to edit the row. Click th at the 1st diagnosis entered is o Diagnosis Type	ne Remove link to remove th onsidered to be the principal	e entire row. (primary) Diagnosis Code. Diagnosis Code	Action
1				
1 *Diag	nosis Type ICD-10-CM V	*Diagnosis Code®		
Ad	d Reset			
100				
Other Insura	nce Details	helen		
Enter the carni	er and policy noicer information	below.		
Select a carrier Carrier.	r from the Existing Carrier field.	If the carrier is not found, se	lect the Other Carrier radio bu	tton and enter an Other
			R	efresh Other Insurance
#	Ca	arrier	Pol	icy ID Action
E Click to add	a new other insurance.			
Bac	k to Step 1		Conti	nue Cancel

1. Enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select <u>Other Carrier</u> and type the Carrier Name.

Carrier.	Camin		Refresh Othe	er Insurance
Click to collapse.	Currier		roncy ib	Action
Select an existing Carrier of	r specify an Other Carrier			
Existing Carrier Other Carrier	KAISER 000461-KAISER DEDMANENTE	1		
*Policy Holder Last Name *Policy ID	002682-KAISER PERMANENTE 003682-KAISER- EXTENDED CHOICE PLAN	*First Name	MI]
Insurance Type *Responsibility	003712-KAISER HMO CALIF. 003877-KAISER 004124-	Relationship	T	
	SPRINGS	to Insured		
Add Cancel				

3. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates (as applicable). Leave the Insurance Type field blank.

Other Insurance Details		
nter the carrier and policy holder information below. Gelect a carrier from the Existing Carrier field. If the carrier is not foun Carrier.	d, select the Other Carrier radio button	and enter an Other
	Refres	sh Other Insurance
# Carrier	Policy I	D Action
] Click to collapse.		
Existing Carrier 000461-KAISER PERMANER Other Carrier		
*Policy Holder Last SMITH *Fi	rst Name JOHN	MIJ
*Policy ID ABCDEF123456789		
*Effective From 01/01/2018 T	ective Too	
Insurance Type *Responsibility	ations	Ĩ
	Leave the Insurance Type	
		J

4. Select the payer responsibility from the drop-down list.

Note: Health First Colorado is the payor of last resort.

1 Hills			Refresh Other 1	Insuran
	Carrier		Policy ID	Acti
Click to collapse.				
elect an existing Ca	rrier or specify an Other Carrier			
Existing C	arriere 000461-KAISER PERMANEI			
• Other	Carrier _			
*Policy Holder Las	t SMITH	*First Name JOHN	MI J	
Name	e			
*Policy II	ABCDEF123456789			
*Effective From	01/01/2018	Effective Too		
T			-	
Insurance Type	2 *D_+L_	nt Deletionelie		
Responsibility	/ Pate	to Insured	•	
	P-Primary			
Clair Filing Indicato	r S-Secondary	T		
	T-Tiertiary			
Add Cance	A-Payer Responsibility Four			
-	B-Payer Responsibility Five			
Back to Step 1	C-Payer Responsibility Six		Continue Cancel	
DOCK TO STEP .	D-Payer Responsibility Seven		continue cancer	
	E-Paver Responsibility Fight			

5. Select the relationship of the covered individual to the responsible individual from the drop-down list.

Other Insurance Details					-			
Enter the carrier and policy holder information below.								
Select a carrier from the Ex Carrier.	isting Carrier field. If the car	rrier is not found, select the	e Other Carrier radio butto	on and enter an Ot	ther			
			Ref	resh Other Insur	ance			
#	Carrier		Policy	/ ID A	ction			
Click to collapse.								
_Select an existing Carr	ier or specify an Other Ca	rrier						
Existing Car	riere 000461-KAISER PERI	MANEI						
O Other Ca	arrier _							
*Policy Holder Last	SMITH	*First Name	JOHN	MI J				
Name								
*Policy ID	ABCDEF123456789							
*Effective Frome	01/01/2018 📰	Effective Too	*					
				-				
*Decreance Type	D Drimon 🖉	*Dationt Delationship		1				
Responsibility	P-Primary •	to Insured	•					
			01-Spouse					
*Claim Filing Indicator		T	18-Self					
	1		20-Employee					
Add Cancel]		21-Unknown					
			39-Organ Donor					
Back to Step 1			53-Life Partner	Cancel				
			G8-Other Relationship		a to Ton			

6. Select the Claim Filing Indicator from the drop-down list, then click the "Add" button.

Other Insurance Details			
Enter the carrier and policy	holder information below.		
Select a carrier from the Ex Carrier	isting Carrier field. If the carrier is not found, selec	t the Other Carrier radio button	and enter an Other
	11-Other Non-Federal Programs	Refre	sh Other Insurance
#	12-Preferred Provider Organization (PPO)	Policy	ID Action
Click to collapse.	13-Point of Service (POS) 14-Exclusive Provider Organization (EPO)		
Select an existing Carri Existing Car Other Ca Other Ca *Policy Holder Last Name *Policy ID	15-Indemnity Insurance 17-Dental Maintenance Organization AM-Automobile Medical BL-Blue Cross/Blue Shield CH-Champus CI-Commercial Insurance Co. DS-Disability FI-Federal Employees Program	ЛНОГ	MI J
*Effective Fromo	HM-Health Maintenance Organization LM-Liability Medical OF-Other Federal Program TV-Title V		T
*Responsibility	VA-Veterans Affairs Plan WC-Worker's Compensation Health Claim ZZ-Mutually Defined	01-Spouse V	
*Claim Filing Indicator		T	
Add Cancel			
Back to Step 1		Continue	Cancel

7. Review the next screen to ensure the other insurance information has been saved. If you are finished adding other insurance information, click "Continue." If you need to add more other insurance information, click + and repeat the applicable steps.

Other Insurance Details								
Enter the carrier and policy holder information below.								
Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.								
	Refresh Other Insurance							
#	Carrier		Policy ID	Action				
1	000461-KAISER PERMANENTE		ABCDEF123456789	Remove				
• (E Click to add a new other insurance.							
	Back to Step 1 Continue Cancel							

8. Proceed to the Submit Professional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added.

Whether the TPL was paid or denied, you must enter a paid date.

TPL Denied

If th deni **``0.00**″

If the TPL was denied, enter "0.00" in the Paid Amount field and "1" in the Paid Units field.

Once complete, click "Submit."

S	abmit Profe	ssional Clair	n: Step 3				2
-	Indicates a n	required field.					
			Claim Type Pro	fessional			
Pr	ovider Info	rmation					
	Billing	Provider ID	1234567891 ID	Type NPI Name	Medical Provi	der	
		Taxonomy	Clinic/Center - Primary Car	e			
Pa	itient and C	laim Inform	ation				
		Member 10 Member	Jane Smith	Gender Female			
		Birth Date	mm/dd/ccyy	Total Charged Amount \$0.00			
					E	xpand All	Collapse All
Di	agnosis Co	des					Ľ
0	ther Insura	nce Details					
#			Carrie	er		Policy	/ ID
1	000749-H	IUMANA HEAL	TH CARE		5	325234	
Se	ervice Detai	ils number to ed	it the row. Click the Remov	a link to remove the entire row.			
Sv	c From		ne the row. Click the Remov	e link to remove the entire row.	Charge	11-11-	
- #	Date	To Date	Place of Service	Procedure Code	Amount	Units	Action
1							
1	*From Dates		To Date	*Place of Service		✓ EMG	~
	Procedure		Modifiers		*Diagnosis		~~
	Codee				Pointers		
	Amount		Tonits	Type Service	Plan	0	
	CUTA				Service		
	Number						
F	Rendering Provider ID		S ID Type				
	Taxonomy					~	
F	Referring Provider ID] 🔍 ID Type 🔤 🗸				
	Taxonomy					~	
	NDCs for Sv	rc. # 1					0
	Other Insur	ance for Ser	vice Detail				-
<	lick the row	number to ea	lit the row. Click the Remove	e link to remove the entire row.			
	#		Co. 10	Paid Amount	Fil Date P	aid Units	Action
C	Click to	mapse.					
	Other	Carrier		~			
1							
	*Paid A	mount	*Paid I	Dateo 📰 *Paio	d Units		K
				1	_		\sim
		-			Add	Cancel	
1							
	Ad	d Reset	If the	TPL was denied,			
			enter	the denial date in			
			the	Paid Date field			
				ago 0 of 21			
			Po				

Institutional Claim with TPL

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields.

Check the "Include Other Insurance" box under the Claim Information section, then click "Continue."

Submit Institutional Claim	n: Step 1		2
Claim Information			
*Covered Dates 🛛	04/23/2018 - * 04/2	5/2018	
*Admission Date/Houre	04/23/2018 📰 -	(hh:mm) Discharge Hour	(hh:mm)
*Admission Type 🛛	3-Elective	*Admission Source	2-Clinic or Physician's Office
*Admitting Diagnosis Type	ICD-10-CM V	*Admitting Diagnosis 🛛	F03-UNSPECIFIED DEMENTIA
*Patient Status e	01-Discharged to Home or	*Facility Type Code	86-Residential Facility
*Patient Number	test1234		
Previous Claim ICN			
Note			
Include Other Insurance		т	otal Charged Amount \$0.00
			Continue Cancel

2. On the Submit Institutional Claim: Step 2 page under the Other Insurance Details section, enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select <u>Other Carrier</u> and type the Carrier Name.

Su	bmit Institutional Claim: Step 2				?			
Oth	er Insurance Details							
Ente	er the carrier and policy holder information below.				_			
Sele Carr	Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.							
			Re	fresh Other I	nsurance			
#	Carrier	Policy ID	Paid Amount	Paid Date	Action			
•	Click to collapse.							
	elect an existing Carrier or specify an Other Carrie Existing Carrier • Other Carrier _	r						

3. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates.

Other Insurance Details											
Enter the carrier and policy holder information below.											
Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.											
			Re	fresh Other Ir	nsurance						
# Ca	arrier	Policy ID	Paid Amount	Paid Date	Action						
Click to collapse.				·							
Select an existing Carrier or specify an Other Carrier • Existing Carrier • • Other Carrier _ • Other Carrier											
*Policy Holder Last MI MI											
*Policy ID	*Policy ID										
*Effective From		Effective To ₀									

4. Proceed to the Submit Institutional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added. Once complete, click "Submit."

Sub	Submit Institutional Claim: Step 3									
Serv	Service Details									
Sele	Select the row number to edit the row. Click the Remove link to remove the entire row.									
Svc #	Svc #Revenue CodeHCPCS/Proc CodeFrom DateTo DateUnitsCharge AmountAct									
1										
1	*Revenue	НСРС	S/Proc Cod	le						
	Codee			θ						
	Modifiers									
	From Date e	To Date e	*Units		*Unit Type	Unit 🗸				
*C	harge Amount				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Add Reset									
Atta	ichments						-			
Click	the Remove link to remove the	ie entire row.								
#	Transmission Method	File	Cont	rol #	Attach	ment Type	Action			
• C	lick to add attachment.									
	Back to Step 1 Back t	to Step 2			Su	bmit Cancel				

Entering Medicare Crossover Information on a Claim

Professional Claim with Medicare (Crossover)

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields under the Provider Information, Member Information and Claim Information sections. Do <u>not</u> check the "Include Other Insurance" box under the Claim Information section. Click "Continue."

Submit Professional Claim: S	tep 1		
Provider Information			
Billing Provider ID	Q		Name
Taxonomy			
Referring Provider ID	2	то туре	name _
Taxonomy			
Supervising Provider ID	9	ID Type 🛛 🗸	Name _
Taxonomy			
Service Facility Location ID	3	ID Type 🔍 🗸	Name _
Taxonomy			
1ember Information			
*Member ID			
Last Name		First Name	î
Birth Date			~
Address		7	
		=	
City		=	
State		V Zip Codee	
laim Information			
Data Tura [Data of Comments	
	¥	Date of currente	
*Datiant Number	¥	_	
Patient Number	8489 70.000		
*Transport Certification)Yes ()No		
Enter a Previous Claim ICN if fi within the defined timely filing	ing a claim with dates o period.	of service older than 120 days. T	The previous claim must have been filed
Previous Claim ICN	and a state of the		
Note]
*Does the prov	ider have a signature	on file? OYes ONo	4
Include Other			Total Charged Amount \$0.00
			total charged fundant fores
Insurance	Do not c	heck the	
Insurance	Do <u>not</u> c "Includ	heck the e Other	Continue

2. On the Submit Professional Claim: Step 2 page, complete all applicable fields under the Diagnosis Codes section, then click "Add." Repeat until all diagnosis codes have been added, then click "Continue."

Submit Professional Claim: Step 2									
Diagnosis Codes 🗧									
Select the Please not	Select the row number to edit the row. Click the Remove link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.								
#	Diagnosis Type	Diagnosis Code	Action						
<u>1</u>									
1 *	1 *Diagnosis Type ICD-10-CM ∨ *Diagnosis Code θ								
	Add Reset								
Ľ	Back to Step 1	Continue							

3. On the Submit Professional Claim: Step 3 page under the Medicare Crossover Details section, enter the associated Medicare crossover information for each service line. Click "Add" to repeat the process until all service detail lines have been added. Once complete, click "Submit."

Submit Profes	sional Claim: Ste	p 3				
Service Detail	5					
Select the row I	number to edit the i	row. Click the Rem	ove link to remo	ve the entire row.		
Svc From # Date	To Date	Place of Service	Pro	cedure Code	Charge Amount	Units Acti
1						
1 *From Dateo	T T	Date 9	*Place o Service	f		✓ EMG ✓
*Procedure Code e	Mo	difiers 9			*Diagnosis Pointers	
*Charge Amount		*Units	Unit Type	Jnit V EPSDT Service	Family Plan	
CLIA Number					Jervice	t a
Rendering Provider ID	Q 1	D Туре	2			
Taxonomy						~
Referring Provider ID	Q 1	D Type				
Laxonomy						X
Medicare Cro	ossover Details					
Allov	ved Medicare 0.0	0		Co-insurance Amo	ount 0.00	
Deduc	Amount	-	Develsie	tais Consistent Arres	A	
Deduc		0	Psychia	tric Services Amo	0.00	
Medic	Amount 0.0	0	*Mec	licare Payment Da	nee	
NUCS IOL SY						
-						
Add	Reset					
Attachments						
Click the Remo	ve link to remove t	he entire row.				
# Transn	nission Method	Fil	e	Control #	Attachm	ent Type Acti
 Click to add 	attachment.		0			
Back	to Step 1 Back	to Step 2 M	edicare HMO	Copays should	be Subr	nit Cancel
			treated like o	original Medica	re	
			Coinsurance.	Enter the total	of	
		Me	edicare Coins	urance + Medie	care	
			Copay amo	unt in the "Co-		
			insurance	Amount" field.		

Institutional Inpatient Claim with Medicare (Crossover)

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields under the Provider Information and Member Information sections.

Submit Institutional Claim: 9	Step 1			?
Provider Information				4
If Surgical Procedure Code(s) an	re to be submitted with th	ne claim, an Operating Pr	ovider ID is required.	
Billing Provider ID	9	ID Type 📃 💙	Name _	~
Taxonomy				~
Institutional Provider ID	٩. I	ID Туре 🔍 🗸	Name _	
Taxonomy				~
Attending Provider ID	3	ID Type 🔍 🗸	Name _	
Taxonomy				~
Operating Provider ID	3	ID Type 🔍 🗸	Name _	
Taxonomy				~
Other Operating Provider DID	9	ID Type 🔍 🗸	Name _	
Taxonomy				~
Member Information				
*Member ID		1		
Last Name _		First N	ame _	
Address		1		
		1		
City				
State	~	Zip Co	odee	

2. Proceed to the Claim Information section and complete all applicable fields. Select the appropriate Facility Type Code from the drop-down list. Do <u>not</u> check the "Include Other Insurance" box under the Claim Information section.

	11-Hospital Inpatient (Part A)
	18-Hospital Swing Bed
	21-SNE Innation
	28-SNF Swing Bed
Claim Information	41-Religious Nonmedical Health Care Institutions - Inpatie
	65-Intermediate Care - Level I
*Covered Datese	e 66-Intermediate Care - Level II
***	1 86-Residential Facility
*Admission Date/Houre	(hh:mm) Distor Residential racincy
*Admission Typee	*Admission Sourcee
*Admitting Diagnosis ICD-10-CM 🗸	*Admitting Diagnosise
Туре	
Patient Statuse	*Facility Type Code
*** ··· · · · ·	
Patient Number	
Enter a Previous Claim ICN if filing a claim w	with dates of service older than 120 days. The previous claim must have been filed
within the defined timely filing period.	
Previous Claim ICN	
Note	
Include Other Incurance	Total Charged Amount \$0.00
	Total charged Amount \$0.00
	Do not check the
	Do <u>not</u> check the
	"Include Other
	Insurance Dox.

3. Proceed to the Medicare Crossover Details section and complete all applicable fields, then click Continue."

Medicare Crossover Detail	5		
Deductible Amount	0.00	Co-insurance Amo	unt 0.00
Blood Deductible Amount	0.00		
Medicare Payment	0.00	*Medicare Payment Dat	tee 📰
		treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-	
		insurance Amount" field.	



Institutional Outpatient Claim with Medicare (example for Part B-only)

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields. Do <u>not</u> check the "Include Other Insurance" box under the Claim Information section. Once complete, click "Continue."

When b only (fo an outp facili	illing Medicare Par r inpatient services patient claim), choo ty type 12 from the drop-down list.	t B- on ose	12-Outpatient 13-Hospital Outpatient 14-Hospital Other Part B 22-SNF Inpatient Part B 23-SNF Outpatient 32-Home Health 34-Home Health (Part B Only) 43-Religious Nonmedical Health Care Institutions - Outpatient 71-Clinical Rural Health 72-Clinic ESRD 73-Federally Qualified Health Centers 74-Clinic OPT
Submit Institutional Claim: St	tep 1		75-Clinic CORF 76-Community Mental Health Centers
			77-Clinic - FQHC 78-Licensed Freestanding Emergency Medical Facility 79-Clinic - Other
Claim Information			81-Nonhospital based hospice
Admission Type 0 3-6 Admitting Diagnosis IC Type Patient Status 0 *Patient Number tes	Elective D-10-CM V st1234	Admission S Admitting Dia	e Source e 1 gnosis e pe Code 13-Hospital Outpatient
Previous Claim ICN			
Note			
Include Other Insurance			Total Charged Amount \$0.00
	Do <u>not</u> "Inclu Insura	check the ude Other ance" box.	Continue

2. On the Submit Institutional Claim: Step 2 page, complete all applicable fields, then click "Add." Repeat the process as needed for each detail line. Once complete, click "Continue."

Submit Institutional Claim: Step 2	?
Diagnosis Codes	-
Select the row number to edit the row. Click the Remove link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.	
# Diagnosis Type Diagnosis Code	Action
1	
1 *Diagnosis Type ICD-10-CM V *Diagnosis Code θ	
Add Reset	
Eutomal Cause of Taium Diagageis Codes	
Select the row number to edit the row. Click the Remove link to remove the entire row.	-
# Diagnosis Type External Cause of Injury Diagnosis Code	Action
1	
1 *Diagnosis Type ICD-10-CM v *External Cause of	
Injury Diagnosis Code e	
Add Reset	
Patient Reason for Visit Diagnosis Codes	-
Select the row number to edit the row. Click the Remove link to remove the entire row.	
# Diagnosis Type Patient Reason for Visit Diagnosis Code 1 1	Action
-	
for Visit Diagnosis Code θ	
Add	
Click the Remove link to remove the entire row.	
# Condition Code	Action
1	
1 *Condition Code $_{\Theta}$	
Add Reset	
Occurrence Codes	
Select the row number to edit the row. Click the Remove link to remove the entire row.	_
For an Occurrence Code enter the same From and To Date. For an Occurrence Span enter the From and To dates of the s	pan.
# Occurrence code From Date To Date	Action
$\begin{array}{c c} & \bullet \\ & \bullet \\ & \bullet \end{array} $	
Add Reset	
Value Codec	
Select the row number to edit the row. Click the Remove link to remove the entire row.	
# Value Code Amount	Action
1	
1 *Value Code • *Amount	
Add Reset	
Surgical Procedures	-
Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this pan	el.
Dept to Ober 1	

3. On the Submit Institutional Claim: Step 3 page, complete all applicable fields under the Service Details section. Enter the associated Medicare Crossover Details for each service line. Click "Add" to repeat the process until all service detail lines have been added. Click "Submit" once completed.

Sub	mit Institutional Clai	n: Step 3							?
Ser	vice Details								
Sele	ct the row number to e	lit the row.	Click the Remove link	to rem	ove the enti	re row.			
Svc #	Revenue Code		HCPCS/Proc Code	e	From Date	To Date	Units	Charge Amount	Action
1									
1	*Revenue Code ₀			НСРС	S/Proc Coo	ie			
	Modifiers								
	From Date e		To Date e		*Units		*Unit	t Unit 🗸	
*C	harge Amount						туре	-	
Me	edicare Crossover Det	ails							
Ble	Deductible Amou ood Deductible Amou Medicare Payme Amou	nt 0.00 nt 0.00 nt 0.00 nt		*Me	Co-insurai dicare Payi	nce Amount ment Date	t 0.00		
	Add Reset								
			Medicare treated Coinsura Medicare Copay insura	ike o like o ance. I Coinsi amoi ance /	Copays s riginal Mo Enter the urance + unt in the Amount" 1	hould be edicare total of Medicare "Co- field.			

Need More Help?

Please visit the <u>Quick Guides and Webinars</u> web page to find all the Provider Web Portal Quick Guides.