Iowa Medicaid Enterprise
Iowa Department of Human Services
Medicare Crossover Invoice (Institutional) Claim Form Instructions

The Institutional Medicare Crossover Invoice should be used to submit services to Iowa Medicaid that were originally billed to Medicare on a UB04 claim form that did not electronically crossover from Medicare. The table below follows the Medicare Crossover Invoice (Institutional) claim form instructions by field number, field name/description, whether or not that field is required, and a brief description of the information that needs to be entered in that field, and how it needs to be entered.

If handwritten please print legibly, and use only blue or black ink.

You must use the printable version if you have access to a computer. The printable version is available on the IME website at: http://www.ime.state.ia.us/Providers/ClaimsPage.html. If you need assistance please contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-256-4609.

FIELD NO.	FIELD NAME/DESCRIPTION	REQUIREMENTS	INSTRUCTIONS
MEDICARE INFORMATION			
1	MEDICARE'S ICN	*SITUATIONAL*	If available, enter the ICN number from the Medicare Explanation of Benefits. For Medicare HMO crossovers, please enter the HMO claim transaction number. If the ICN number is not available, leave blank.
2	MEDICARE PAYMENT DATE	**REQUIRED**	Enter the date from the Medicare Explanation of Benefits that Medicare paid for the service(s). Entries should be made in a MM/DD/YY format.
MEMBER INFORMATION			
3	MEMBER'S NAME	**REQUIRED**	Enter the last name, first name and middle initial of the member.
4	MEMBER'S MEDICAID ID #	**REQUIRED**	Enter the member's **Medicaid ID number** found on the *Iowa Medicaid Eligibility Card*. The ID number consists of seven digits followed by a letter, i.e. 1234567A
5	PATIENT ACCOUNT #	OPTIONAL	Enter the account number assigned to the patient by the provider of service. This field is limited to10 characters.
PROVIDER INFORMATION			
6	BILLING PROVIDER NPI	**REQUIRED**	Enter the NPI associated with the billing provider

7	BILLING PROVIDER NAME	**REQUIRED**	Enter the name of the billing provider.
8	BILLING PROVIDER ADDRESS	**REQUIRED**	Enter address, city, and state of the billing provider.
9	BILLING PROVIDER ZIP	**REQUIRED**	Enter the zip code associated with the billing provider's address.
10	TAXONOMY CODE	**REQUIRED**	Enter the taxonomy code associated with the billing provider.
11	ATTENDING PHYS NPI	OPTIONAL	Enter the NPI associated with the attending physician.
12	REFERRING PHYS NPI	OPTIONAL	Enter the NPI associated with the referring physician.
OTHER HEALTH INSURANCE INFORMATION			
13	DID THE OTHER INSURANCE/TPL DENY COVERAGE	*SITUATIONAL*	**REQUIRED** if the member has insurance other than Medicare and Medicaid that has denied payment. Check if the member's other insurance has denied payment. If no, leave blank.
14	OTHER INSURANCE/TPL AMOUNT PAID	*SITUATIONAL*	**REQUIRED** if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party. If none, leave blank. Recipient co-payments, Medicare payments or previous Medicaid payments are not to be listed in this field.
DIAGNOSIS OR NATURE OF INJURY OR ILLNESS			
15	ICD VER IND	**REQUIRED**	Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes. For ICD-9 enter "9" For ICD-10 enter "0"
16	DIAG CODE	**REQUIRED**	Indicate the applicable primary ICD-CM diagnosis code. (without a decimal point)
17	OTHER DIAG CODE	*SITUATIONAL*	**REQUIRED** if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.

18	OTHER DIAG CODE	*SITUATIONAL*	**REQUIRED** if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
19	OTHER DIAG CODE	*SITUATIONAL*	**REQUIRED** if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
20	OTHER DIAG CODE	*SITUATIONAL*	**REQUIRED** if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
21	PROC CODE	*SITUATIONAL*	**REQUIRED** for the principal surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
21A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM principal surgical procedure code entered in box 21, enter the date associated with the principal surgical procedure code.
22	OTHER PROC CODE	*SITUATIONAL*	**REQUIRED** for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
22A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM additional surgical procedure code entered in box 22, enter the date associated with the additional surgical procedure code.
23	OTHER PROC CODE	*SITUATIONAL*	**REQUIRED** for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
23A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM additional surgical procedure code entered in box 23, enter the date associated with the additional surgical procedure code.
24	OTHER PROC CODE	*SITUATIONAL*	**REQUIRED** for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
24A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM additional surgical procedure code entered in box 24, enter the date associated with the additional surgical procedure code.
25	OTHER PROC CODE	*SITUATIONAL*	**REQUIRED** for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
25A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM additional surgical procedure code entered in box 25, enter the date associated with the additional surgical procedure code.
26	OTHER PROC CODE	*SITUATIONAL*	**REQUIRED** for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.

26A	DATE	*SITUATIONAL*	**REQUIRED** if there is an ICD-CM additional surgical procedure code entered in box 26, enter the date associated with the additional surgical procedure code.
SERVICE INFORMATION TRANSFERRED FROM MEDICARE EXPLANATION OF BENEFITS			
27	COVERED DAYS	*SITUATIONAL*	**REQUIRED FOR NURSING FACILITIES** Enter the number of covered days. Do not use the day of discharge in your calculations.
28	TOB	**REQUIRED**	Enter a three-digit type of bill consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency <u>Type of Facility</u> 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice <u>Bill Classification</u> 1 Inpatient hospital, inpatient SNF or hospice (nonhospital based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient SNF or hospice (hospital based) 4 Hospital referenced laboratory services, home health agency, rehabilitation agency <u>Frequency</u> 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
29	FROM DATE	**REQUIRED**	Enter the from date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format.
30	TO DATE	**REQUIRED**	Enter the to date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format.
31	COVERED CHGS	**REQUIRED**	Enter the total covered charges from the Medicare Explanation of Benefits.
32	NON-COV CHGS	*SITUATIONAL*	**REQUIRED** if there are total non-covered charges indicated on the Medicare Explanation of Benefits. Enter the total non-covered charges from the Medicare Explanation of Benefits.

33	BLOOD DEDUCT	*SITUATIONAL*	**REQUIRED** if there is a blood deductible amount indicated on the Medicare Explanation of Benefits. Enter the total blood deductible amount from the Medicare Explanation of Benefits.
34	RESERVED	*LEAVE BLANK*	This field must be left **BLANK.**
35	DEDUCTIBLE	*SITUATIONAL*	**REQUIRED** if there is a deductible amount indicated on the Medicare Explanation of Benefits. Enter the total deductible amount from the Medicare Explanation of Benefits.
36	COINSURANCE	*SITUATIONAL*	**REQUIRED** if there is a coinsurance amount indicated on the Medicare Explanation of Benefits. Enter the total coinsurance amount from the Medicare Explanation of Benefits.
37	COPAY	*SITUATIONAL*	**REQUIRED** if there is a copay amount indicated on the Medicare Explanation of Benefits. Enter the total copay amount from the Medicare Explanation of Benefits.
38	MEDICARE PAID	*SITUATIONAL*	**REQUIRED** if there is a Medicare payment indicated on the Medicare Explanation of Benefits. Enter the total amount paid by Medicare from the Medicare Explanation of Benefits.

PART B (BUNDLING)

39	DEDUCTIBLE	*LEAVE BLANK*	This field must be left **BLANK**.
40	COINSURANCE	*LEAVE BLANK*	This field must be left **BLANK**.

SIGNATURE OF PHYSICIAN OR SUPPLIER

41	SIGNATURE	**REQUIRED**	The provider or an authorized representative must sign the claim.
42	DATE	**REQUIRED**	The provider or authorized representative must indicate the original filing date.