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

The Professional Medicare Crossover Invoice should be used to submit services to Iowa Medicaid that were originally billed to Medicare on a CMS1500 claim form that did not electronically crossover from Medicare. The table below follows the Medicare Crossover Invoice (Professional) 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 the address, city, 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	RENDERING PHYS NPI	OPTIONAL	Enter the NPI associated with the rendering provider.
12	REFERRING PHYS NPI	OPTIONAL	Enter the NPI associated with the referring provider.
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. • If more than one claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on *each page* of the claim in field 14.
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	PRIM 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.
SERVICE INFORMATION TRANSFERRED FROM MEDICARE EXPLANATION OF BENEFITS			
19	FROM	**REQUIRED**	Enter the from date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format
20	TO	**REQUIRED**	Enter the to date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format
21	POS	**REQUIRED**	Enter the two-digit place of service code from the Medicare Explanation of Benefits. The place of service code must be converted to one of the following codes if the code from the Medicare Explanation of Benefits is not on the list below: 11 Office 12 Home 19 Off Campus-Outpatient Hospital 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility
22	QTY	**REQUIRED**	Enter the number of times this procedure was performed or number of supply items dispensed from the Medicare Explanation of Benefits

23	PROC CODE & MODS	**REQUIRED**	Enter the appropriate five-digit procedure code and any necessary modifier (up to two modifiers allowed) for each of the dates of service from the Medicare Explanation of Benefits. DO NOT list services for which Medicare did not cover.
24	NDC	*SITUATIONAL*	**REQUIRED** if the procedure code is a J-code. Enter the eleven-digit NDC (without dashes or spaces) associated with the procedure code.
25	BILLED AMT	**REQUIRED**	Enter the billed amount for each procedure code from the Medicare Explanation of Benefits.
26	ALLOWED AMT	**REQUIRED**	Enter the amount allowed by Medicare for each procedure code from the Medicare Explanation of Benefits.
27	COPAY	*SITUATIONAL*	**REQUIRED** if there is a copay amount indicated on the Medicare Explanation of Benefits. Enter the copay amount for each procedure code from the Medicare Explanation of Benefits.
28	COINSURANCE	*SITUATIONAL*	**REQUIRED** if there is a coinsurance amount indicated on the Medicare Explanation of Benefits. Enter the coinsurance amount for each procedure code from the Medicare Explanation of Benefits.
29	DEDUCTIBLE	*SITUATIONAL*	**REQUIRED** if there is a deductible amount indicated on the Medicare Explanation of Benefits. Enter the deductible amount for each procedure code from the Medicare Explanation of Benefits.
30	PSYCH REDUCTION	*SITUATIONAL*	**REQUIRED** if there is a psychiatric reduction amount (PR-122) indicated on the Medicare Explanation of Benefits. Enter the psychiatric reduction amount (PR-122) for each procedure code from the Medicare Explanation of Benefits.
31	MEDICARE PD	*SITUATIONAL*	**REQUIRED** if there is a Medicare payment indicated on the Medicare Explanation of Benefits. Enter the amount paid by Medicare for each procedure code from the Medicare Explanation of Benefits.
32	TOTAL BILLED AMT	**REQUIRED**	Enter the total of the line item billed amounts (boxes 25) on the LAST page of the claim. If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Billed Amount. The pages prior to the last page should have “continued” or “page 1 of _” in Box 32.
SIGNATURE OF PHYSICIAN OR SUPPLIER			
33	SIGNATURE	**REQUIRED**	The provider or an authorized representative must sign the claim.
34	DATE	**REQUIRED**	The provider or authorized representative must indicate the original filing date.