Medicare-to-Medicaid Crossover Invoice

IMPORTANT:

1. You **must** write *CROSSOVER* at the top of every crossover claim.
2. HCA-28 form is *only* to be used for **Inpatient** claims or claims **prior to June 1, 2016**.
3. Do **not** use this form for **HMO copay** or **third party liability** claim submissions.
4. Use one invoice for each claim.

Please check one: ☐ Medicare only ☐ Medicare supplemental claims ☐ Medicare replacement	
SoonerCare Provider ID:	
Member ID:	Member Name First: Last:
Patient Control Number:	
Medicare HIC Number:	
From DOS:	To DOS:
Total Billed: $	
Date Paid:	
Coinsurance: $	Medicare Remark Code:
Deductible: $	Medicare Remark Code:
Blood Deductible: $	
Total Allowed: $	Medicare Remark Code:
Medicare Remark Code :	
Amount Paid: $	Medicare Remark Code:

Mail claims for payment to:
DXC Technology
P.O. Box 18110
Oklahoma City, OK 73154

Provider Signature ______________________ Date ____________

Oklahoma HealthCare Authority

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Field Descriptions for Medicare-Medicaid Crossover Invoice

Form Locator	HCA-28 Form
SoonerCare Provider ID	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider. *Required*
Member ID	Enter the member's 9-digit SoonerCare identification number. *Required*
Patient Control Number	Patient's Account Number; enter your internal patient tracking number. The tracking number should be the same as the submitted claim. *Optional*
Medicare HIC Number	Enter the Patient's Medicare HIC Number; the Medicare HIC Number should be the same number as submitted on the claim. *Required*
Dates of Service	Enter the From and To Dates of Service as MM/DD/YYYY. *Required*
Total Billed	Enter the Amount Billed from the Medicare Explanation of Benefits (EOB). *Required*
Date Paid	Enter the Date Paid as MM/DD/YYYY from the Medicare Explanation of Benefits (EOB). *Required*
Coinsurance	Enter the Coinsurance Amount from the Medicare Explanation of Benefits (EOB). *Required, if applicable*
Coinsurance Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable*
Deductible	Enter Deductible Amount from the Medicare Explanation of Benefits (EOB). *Required, if applicable*
Deductible Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable*
Blood Deductible	Enter the Blood Deductible from the Medicare Explanation of Benefits (EOB). *Required, if applicable*
Total Allowed	Enter the Amount Allowed from the Medicare Explanation of Benefits (EOB). *Required, if applicable*
Total Allowed Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable*
Amount Paid	Enter the Amount Paid from the Medicare Explanation of Benefits (EOB). *Required, if applicable*
Amount Paid Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable*
Provider Signature	Signature of Physician or Supplier; the name of the authorized person, someone designated by the agency or organization. *Required*
Date	Enter date the claim was signed as MM/DD/YYYY. *Required*