Medicare to Medicaid Crossover Invoice

HCA-28B

1 Please check one:
☐ Medicare only ☐ Medicare supplement claims ☐ Medicare replacement

2 SoonerCare Provider ID		3 Member ID	
4 Member Last Name		4a Member First Name	
5 Patient Control Number		6 Medicare HIC Number	

7 Detail(s) Information

Dtl #	a. From DOS	b. To DOS	c. Procedure Code	d. Charges	e. Allow Amt	f. Ded	g. CoIns	h. Blood Ded	i. Paid	j. Paid Date	k. Medicare Reason Code
1											
2											
3											
4											
5											
6											

8 Totals Information		a. Charges	b. Allow	c. Ded	d. Coins	e. Blood Ded	f. Paid		g. Total Pages

9 Provider Signature _____ 10 Date _____

Mail claims for payment to:

DXC
PO Box 18110
Oklahoma City, OK 73154

Important: By submitting this form to OHCA, the provider attests that the information included in the form matches the EOB. If the information on this crossover claim type form does not exactly match the information on the EOB, the claim may be denied or returned.

Medicare to Medicaid Crossover Invoice

DO NOT USE THIS FORM FOR HMO COPAY OR THIRD PARTY LIABILITY CLAIM SUBMISSIONS

Instructions:

1 You **must** write ***CROSSOVER*** at the top of every crossover claim.
2 Use one invoice for each EOB claim.
3 Mail the completed form to:

DXC
PO Box 18110
Oklahoma City, OK 73154

	Field Description	Guidelines
1	Check One	Depending upon the form to be submitted, check the appropriate box.
2	SoonerCare Provider ID	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider. *Required*
3	Member ID	Enter the member's 9-digit SoonerCare identification number. Must be nine digits. *Required.*
4	Member Last Name:	Enter the member's last name.
4a	Member First Name	Enter the member's first name.
5	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*
6	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*
7	**Detail Lines**	
7a	From DOS	Enter in the From date of service in "MM/DD/YYYY" format. *Required.*
7b	To DOS	Enter in the To date of service in "MM/DD/YYYY" format. *Required.*
7c	CPT	Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed.
7d	Charges	Enter the Medicare charges (billed amount) listed on the MAP EOB for each detail. *Required.*
7e	Allow Amt	Enter the Medicare Allowed amount listed on the EOB for each detail. *Required, if applicable.*

7f	Ded	Enter the Medicare deductible amount listed on the EOB for each detail
7g	Coins	Enter the Medicare Coinsurance amount listed on the MAP EOB for each detail. *Required, if applicable.*
7h	Blood Ded	Enter the Blood Deductible listed on the EOB, if applicable. *Required, if applicable.*
7i	Paid	Enter the Medicare Paid amount listed on the EOB for each detail. *Required, if applicable.*
7j	Date Paid	Enter in the Date Paid in a "MM/DD/YYYY" format. *Required.*
7k	Medicare Reason Code	Enter Medicare's reason code listed on the MAP EOB for each detail. *Required, if applicable.*
8	**Totals Information**	Enter the Medicare total charges (billed amount) listed on the EOB. ***Note:*** *A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate "Continue" in this block.*
8a	Charges	Enter the total Charges amount listed on the EOB.
8b	Allow	Enter the Medicare total Allowed amount listed on the EOB.
8c	Ded	Enter the Medicare total Deductible amount listed on the EOB.
8d	Coins	Enter the Medicare total Coinsurance amount listed on the EOB.
8 e	Blood Ded	Enter the Medicare total Blood Deductible amount listed on the EOB.
8f	Paid	Enter the Medicare total Paid amount listed on the EOB.
8g	Total Pages	Enter the total number of pages that are submitted, for more than one page. If the crossover claim contains more than 7 detail line items, use multiple pages to identify up to the detail line items for the claim (as necessary).
9	Provider Signature	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization. *Required*
10	Date	Enter date the claim was signed as MM/DD/YYYY. *Required.*