

**Iowa Medicaid Enterprise  
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 you have any questions about this information, please contact Provider Services at 1-(800)-338-7909 (Local in the Des Moines area at (515)-256-4609)

<b>Field no.</b>	<b>Field Name</b>	<b>Requirements</b>	<b>Instructions</b>
<b>Medicare information</b>			
1	Medicare's ICN	<b>Situational</b>	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	<b>REQUIRED</b>	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.
<b>Member's Information</b>			
3	Member's Name	<b>REQUIRED</b>	Enter the last name, first name and middle initial of the member.
4	Member's Medicaid ID#	<b>REQUIRED</b>	Enter the member's <b>Medicaid ID number</b> found on the <i>Iowa Medicaid Eligibility Card</i> . The ID number consists of seven digits followed by a letter, i.e. 1234567A
5	Patient Account Number	optional	Enter the account number assigned to the patient by the provider of service. This field is limited to 10 characters.
<b>Provider's Information</b>			
6	Provider's Name, Address, City, State	<b>REQUIRED</b>	Enter the name, address, city, and state of the billing provider.

7	Zip	<b>REQUIRED</b>	Enter the zip code associated with the billing provider's address.
8	NPI	<b>REQUIRED</b>	Enter the NPI associated with the billing provider.
9	Taxonomy code	<b>REQUIRED</b>	Enter the taxonomy code associated with the billing provider.
<b>Other Health Insurance Information</b>			
10	Is There Another Insurance/TPL	<b>Situational</b>	<b>REQUIRED IF</b> the member has insurance other than Medicare and Medicaid (example: Commercial Insurance)  Check if the member has other insurance.  If no, leave blank.
11	Did The Other Insurance/TPL Deny Coverage	<b>Situational</b>	<b>REQUIRED IF</b> 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.
12	Other Insurance/TPL Amount Paid	<b>Situational</b>	<b>REQUIRED IF</b> 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, contractual write-offs, Medicare payments or previous Medicaid payments are not to be listed in this field.
<b>Diagnosis or Nature of Injury or Illness</b>			
13	Prim. Diag. Code	<b>REQUIRED</b>	Indicate the applicable primary ICD-9-CM diagnosis code.
14	Other Diag. Code	<b>Situational</b>	<b>REQUIRED IF</b> there is an additional diagnosis code. Enter the ICD-9-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
15	Other Diag. Code	<b>Situational</b>	<b>REQUIRED IF</b> there is an additional diagnosis code. Enter the ICD-9-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
16	Other Diag.	<b>Situational</b>	<b>REQUIRED IF</b> there is an additional diagnosis code.

	Code		Enter the ICD-9-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
17	Other Diag. Code	<b>Situational</b>	<b>REQUIRED IF</b> there is an additional diagnosis code. Enter the ICD-9-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
18	Other Diag. Code	<b>Situational</b>	<b>REQUIRED IF</b> there is an additional diagnosis code. Enter the ICD-9-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
<b>Service Information Transferred From Medicare Explanation of Benefits (EOB)</b>			
19	Type of Bill	<b>REQUIRED</b>	<p>Enter a three-digit number consisting of one digit from each of the following categories in this sequence:</p> <p>First digit      Type of facility  Second digit    Bill classification  Third digit      Frequency</p> <p><u>Type of Facility</u></p> <ol style="list-style-type: none"> <li>1 Hospital or psychiatric medical institution for children (PMIC)</li> <li>2 Skilled nursing facility</li> <li>3 Home health agency</li> <li>7 Rehabilitation agency</li> <li>8 Hospice</li> </ol> <p><b>Bill Classification</b></p> <ol style="list-style-type: none"> <li>1 Inpatient hospital, inpatient SNF or hospice (nonhospital based)</li> <li>2 Hospice (hospital based)</li> <li>3 Outpatient hospital, outpatient SNF or hospice (hospital based)</li> <li>4 Hospital referenced laboratory services, home health agency, rehabilitation agency</li> </ol> <p><b>Frequency</b></p> <ol style="list-style-type: none"> <li>1 Admit through discharge claim</li> <li>2 Interim – first claim</li> <li>3 Interim – continuing claim</li> </ol>

			4 Interim – last claim
20	Date(s) of Service From To	<b>REQUIRED</b>	Enter the month, day, and year under both the From and To categories for the period from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format.
21	Covered Days	<b>Situational</b>	<b>REQUIRED FOR NURSING FACILITIES</b> Enter the number of covered days. Do not use the day of discharge in your calculations.
22	Total Covered Charges	<b>REQUIRED</b>	Enter the total covered charges from the Medicare Explanation of Benefits.
23	Total Non-Covered Charges	<b>Situational</b>	<b>REQUIRED IF</b> 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.
24	Deductible	<b>Situational</b>	<b>REQUIRED IF</b> there is a deductible amount indicated on the Medicare Explanation of Benefits. Enter the total deductible amount from the Medicare Explanation of Benefits.
25	Blood Deductible	<b>Situational</b>	<b>REQUIRED IF</b> 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.
26	Coinsurance	<b>Situational</b>	<b>REQUIRED IF</b> there is a coinsurance amount indicated on the Medicare Explanation of Benefits. Enter the total coinsurance amount from the Medicare Explanation of Benefits.
27	Copay	<b>Situational</b>	<b>REQUIRED IF</b> there is a copay amount indicated on the Medicare Explanation of Benefits. Enter the total copay amount from the Medicare Explanation of Benefits.
28	Provider Paid	<b>Situational</b>	<b>REQUIRED IF</b> 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.
<b>Signature of Physician or Supplier</b>			

29	Provider Signature	<b>REQUIRED</b>	The provider or an authorized representative must sign the claim.
30	Signature Date	<b>REQUIRED</b>	The provider or authorized representative must indicate the original filing date.