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CMS-1500 Medicare Attachment Summary

Please use this form in lieu of attaching the Medicare Explanation of Benefits (EOB) when billing Vermont Medicaid for **Medicare Deductible and/or Coinsurance**.

All the fields on this form must be completed in order to process your claim in a timely manner. If any of the fields are not completed, the claim and attachments will be returned to you for completion. Do not modify this form; enter information in the designated field.

Please note: This attachment MUST NOT be used when submitting claims electronically. The Medicare Attachment Summary Form is only to be used for beneficiaries who are enrolled in both Medicare and Vermont Medicaid. It is not to be used for reporting actions by any other insurers. This form should not be attached if an item or service is non-reimbursable by Medicare. If the service or item is denied by Medicare, a completed claim along with the Medicare EOB should be submitted within twelve months of the date of service.

Indicate Medicare Part C Carrier: ____
(If applicable, please add co-pay to the co-insurance amount and enter the sum in the Co-Insurance Amount Field)

Billing Provider Name: ________________________________
(must match the provider name, as it appears, in form loc. 33 on your CMS1500 claim form)

Beneficiary (Patient) Name: _____________________
(must match the beneficiary (patient) name, as it appears, in form loc. 2 on your CMS1500 claim form)

1. Other Insurance (Check One)	a. Yes	b. No
	☐	☐
	c. Amount	
2. Medicare Paid Date		
3. Total Medicare Paid Amount		

4a. Detail # (Do not edit)	b. Medicare Deductible	c. Medicare Co-insurance	d. Medicare Paid Amount	e. Medicare ICN
1				
2				
3				
4				
5				
6				

Please verify that the claim detail number information on this attachment corresponds to the claim detail number on the CMS 1500. Inaccurate information will result in claims processing errors.

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Instructions for Completing the CMS-1500 Medicare Attachment

Please complete and attach the Medicare Attachment, instead of attaching a copy of the Medicare EOB, to the CMS-1500. This attachment form will assist providers in submitting claims successfully for Medicare deductible and/or co-insurance. There are 6 lines provided on this form that correlate to the 6 claim lines on the CMS-1500. When submitting claims on the CMS-1500 for Medicare deductible and/or co-insurance this Medicare attachment must be completed and submitted with the CMS 1500 claim form.

Please DO NOT staple or paper clip this form to the claims.

Billing provider and Recipient information section must be completed as indicated on the claim.

Other insurance – Check yes or no. If you are checking yes also enter the payment in the amount field. If there is no payment, please attach the other insurance EOB.

Medicare Paid Date – Enter Medicare PAID date from the Medicare EOB. If you have more than one EOB for the same claim, enter the oldest Medicare Paid Date.

Total Medicare Paid Amount – Enter the SUM of the Medicare paid amounts from the Medicare EOB for the details that apply to the crossover claim.

Medicare Deductible – Enter the DEDUCTIBLE amount for each applicable detail.

Medicare Co-insurance – Enter the CO-INSURANCE amount for each applicable detail.

Medicare Paid Amount – Enter the Medicare Paid Amount for each applicable detail.

Medicare ICN – please enter the ICN for the applicable detail from Medicare EOB.

For Mental Health Claims – please add the co-insurance amount and the PR-122 line amount together and enter the sum in the Co-insurance field.

For Medicare Part C – please add co-pay to the co-insurance amount and enter the sum in the Co-insurance field.