

# Crossover Outpatient Facility Claim Type 31

## TMHP Standardized Medicare Advantage Plan (MAP) Remittance Advice Notice Template Instructions

Providers that bill outpatient crossover claims on the UB-04 CMS-1450 paper claim form may submit the Crossover Outpatient Facility Claim Type 31 template with a copy of a completed claim form. The MAP explanation of benefits (EOB) is required when submitting the Crossover Outpatient Facility Claim Type 31 template. All fields (excluding Medicaid information fields) on the form must be completed using the MAP EOB.

**Important:** All details from the MAP EOB must be included in the template even if a deductible or coinsurance is not due.

The TMHP Standardized MAP Remittance Advice Notice template must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Outpatient Facility Claim Type 31 template:

#	Field Description	Guidelines
0	MAP (Medicare Part C)	Check the box to indicate that the client has a MAP, Part C Medicare.  <b>Note:</b> The Crossover Outpatient Facility Claim Type 31 TMHP Standardized MAP Remittance Advice Notice Template must only be used for MAP claims. Medicare Part A or Medicare Part B only claims must not be submitted with a template.
1	Medicare Paid Date	Enter the Medicare Paid Date listed on the MAP EOB.
2	Provider Name	Enter the billing provider's name.
3	NPI/API	Enter the National Provider Identifier (NPI)/Atypical Provider Identifier (API) for the billing providers.
4	TPI	Enter the Texas Provider Identifier (TPI) for the billing provider.
5	Medicare ID	Enter the Medicare Provider ID of the billing provider number listed on the MAP EOB.
6	Street Address, City, State, ZIP Code	Enter the billing provider's street address, city, state, and ZIP Code in the appropriate fields.
7	Bill Type	Enter the Medicare Bill Type listed on the MAP EOB. <b>Note:</b> The Medicare Bill Type may not match the type of bill (TOB) listed on the claim form.
8	From DOS	Enter the first date of service (DOS) for all procedures in a MM/DD/YYYY format.
9	Through DOS	Enter the last DOS for all procedures in a MM/DD/YYYY format.
10	Client Last Name	Enter the patient's last name listed on the MAP EOB.
11	Client First Name	Enter the patient's first name listed on the MAP EOB.
12	Medicare Number	Enter the patient's Medicare number (Medicare Identification number). <b>Note:</b> Do not use the MAP ID number or any number other than the Medicare number.
13	Medicare ICN	Enter the Medicare Internal Control Number (ICN) listed on the MAP EOB.
14	Total Charges	Enter the Medicare total charges (billed amount) listed on the MAP EOB.
15	Covered Charges	Enter the covered charges listed on the MAP EOB.
16	Non Covered Charges/Reason Code	Enter the noncovered charges listed on the MAP EOB followed by the reason code.
17	Deductible	Enter the Medicare deductible amount listed on the MAP EOB.
18	Blood Deductible	Enter the blood deductible listed on the MAP EOB, if applicable.
19	Coinsurance	Enter the Medicare coinsurance amount listed on the MAP EOB.
20	Medicare Paid Amount	Enter the Medicare paid amount listed on the MAP EOB.
21	Detail(s) Information	
21a	Rev Cd	

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21b	CPT	Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed on the MAP EOB. <b>Note:</b> The procedure code listed on the TMHP Standardized MAP Remittance Advice Notice template may not match the procedure code listed on the claim form attached.
21c	Mods	Enter the modifier (when applicable) listed on the Medicare or MAP EOB for each detail.
21d	From DOS	Enter the first date of service (DOS) for each procedure in a MM/DD/YYYY format.
21e	Units	Enter the number of units (quantity billed) from the MAP EOB.
21f	Charges	Enter the Medicare charges (billed amount) listed on the MAP EOB for each detail.
21g	Allow	Enter the Medicare allowed amount listed on the MAP EOB for each detail.
21h	Ded	Enter the Medicare deductible amount listed on the MAP EOB for each detail.
21i	Coins	Enter the Medicare coinsurance amount listed on the MAP EOB for each detail.
21j	Blood Ded	Enter the Medicare blood deductible amount listed on the MAP EOB for each detail.
21k	Paid	Enter the Medicare paid amount listed on the MAP EOB for each detail.
21l	Reason Code	Enter Medicare's reason code listed on the MAP EOB for each detail.
22	Totals Information	
22a	Total Charges	Enter the Medicare total charges (billed amount) listed on the MAP EOB. <b>Note:</b> 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.
22b	Total Allow	Enter the Medicare total allowed amount listed on the MAP EOB.
22c	Total Ded	Enter the Medicare total deductible amount listed on the MAP EOB.
22d	Total Coins	Enter the Medicare total coinsurance amount listed on the MAP EOB.
22e	Total Blood Ded	Enter the Medicare total blood deductible amount listed on the MAP EOB.
22f	Total Paid	Enter the Medicare total paid amount listed on the MAP EOB.
22g	Total Pages	If the crossover claim contains more than 10 detail line items, use multiple pages to identify up to 28 detail line items for the claim as necessary. Add the number of the page in the first blank line and the total page count in the second blank line (e.g., "1 of 3", "2 of 3", "3 of 3". This field is only required if multiple pages are necessary to capture all billed detail line items. If multiple pages are necessary, Boxes 1-6 must be completed on each page submitted.

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<input type="checkbox"/> MAP (Part C Medicare) <b>Note:</b> The Crossover Outpatient Facility Claim Type 31 TMHP Standardized MAP Remittance Advice Notice Template must only be used for MAP claims. Medicare Part A or Medicare Part B only claims must not be submitted with a template.)										
1 Medicare Paid Date:										
2 Provider Name:			3 NPI/API:			4 TPI:			5 Medicare ID:	
6 Street Address:										
City:				State:				ZIP Code:		
7 Bill Type:		8 From DOS:			9 Through DOS:					
10 Client Last Name:					11 Client First Name:					
12 Medicare Number:					13 Medicare ICN:					
14 Total Charges:		15 Covered Charges:			16 Non Covered Charges/Reason Code:					
17 Deductible:		18 Blood Deductible:			19 Coinsurance:			20 Paid Amount Medicare:		
21 Detail(s) Information										
a. Rev Cd	b. CPT/Mods	d. From DOS	e. Units	f. Charges	g. Allow	h. Ded	i. Coins	j. Blood Ded	k. Paid	l. Reason Code
22 Totals Information				a. Charges	b. Allow	c. Ded	d. Coins	e. Blood Ded	f. Paid	g. Total Pages ____ of ____

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