MEDICARE CROSSOVER INVOICE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

MCR

HFS USE ONLY

CLAIM TYPE

☐ PRACTITIONER 23 ☐ DENTAL 24 ☐ LAB/X-RAY 25 ☐ MED EQUIP/SUP/PHARM 26 ☐ TRANSPORTATION 28

USE CAPITAL LETTERS ONLY

RECIPIENT & INSURED INFORMATION

1. RECIPIENT'S NAME (FIRST, MIDDLE, LAST)	2. RECIPIENT'S BIRTHDATE	3. RECIPIENT'S SEX	4. WAS CONDITION RELATED TO
		MALE ☐ FEMALE ☐	A. RECIPIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT AUTO ☐ OTHER ☐

5. RECIPIENT'S MEDICAID NUMBER	6. MEDICARE HIC NUMBER	7. RECIPIENT'S RELATION TO INSURED
		SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. RECIPIENT'S OR AUTHORIZED PERSON'S SIGNATURE	9. OTHER HEALTH INSURANCE INFORMATION
SIGNED (INSURED OR AUTHORIZED) DATE	IS THERE ANOTHER HEALTH BENEFIT PLAN NO ☐ YES ☐ POLICY/GROUP NUMBER INSURED'S NAME INSURANCE PLAN/PROGRAM NAME

SERVICE INFORMATION TRANSFERRED FROM MEDICARE EXPLANATION OF BENEFITS (EOB)

	10A FROM MM/DD/YY	10A TO MM/DD/YY	10B POS	10C TOS	10D DAYS OR UNITS	10E PROCEDURE CODE	10F AMOUNT ALLOWED	10G DEDUCTIBLE	10H COINSURANCE	10I PROVIDER PAID
1										
2										
3										
4										
5										

11. FOR NDC USE ONLY	12. FOR MODIFIER USE ONLY
SERVICE SECTION 1	SERVICE SECTION 1
SERVICE SECTION 2	SERVICE SECTION 2
SERVICE SECTION 3	SERVICE SECTION 3
SERVICE SECTION 4	SERVICE SECTION 4
SERVICE SECTION 5	SERVICE SECTION 5

13A. ORIGIN OF SERVICE	13B. MODIFIER	14A. DESTINATION OF SERVICE	14B. MODIFIER

15A. ORIGIN OF SERVICE	15B. MODIFIER	16A. DESTINATION OF SERVICE	16B. MODIFIER

17. ICN #	18. DIAGNOSIS OR NATURE OF INJURY OR ILLNESS	18A. PRIMARY DIAGNOSIS CODE	18B. SECONDARY DIAGNOSIS CODE	19. MEDICARE PAYMENT DATE

PHYSICIAN OR SUPPLIER INFORMATION

20. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED	21. ACCEPT ASSIGNMENT	22. PHYSICIAN/SUPPLIER NAME, ADDRESS, CITY, STATE, ZIP CODE
	YES ☐ NO ☐ 23. HFS PROVIDER NUMBER 24. PAYEE CODE	

25. NAME OF REFERRING PHYSICIAN OR FACILITY	26. IDENTIFICATION NUMBER OF REFERRING PHYSICIAN	27. MEDICARE PROVIDER ID NUMBER	28. TAXONOMY CODE

29A. TPL CODE	29B. TPL STATUS	29C. TPL AMOUNT	29D. TPL DATE	30A. TPL CODE	30B. TPL STATUS	30C. TPL AMOUNT	30D. TPL DATE

SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE SIDE AND IS PART OF THIS BILL.)

31. PROVIDER SIGNATURE (DO NOT USE RUBBER STAMP)

32. DATE

Completion mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment. Form Approved by the Forms Management Center.

MEDICAID PAYMENTS (Provider Certification)

My signature on the reverse side of this bill certifies that:

All entries on this claim are true, accurate and complete. The services claimed herein have been provided in compliance with the laws and regulations regarding health care services, including but not limited to: the Criminal Penalties for Acts Involving Federal Health Care Programs (42 USC sec. 1320a-7b); State of Illinois Vendor Fraud and Kickback statute (305 ILCS sec. 5/8A-3); and Limitation on Certain Physician Referrals (42 USC sec. 1395nn), Health Care Worker Self-Referral Act (225 ILCS sec. 47/1).

I agree that payment received according to the State's Medical Assistance Program pricing limits will be accepted as payment in full and I will not accept additional payment from any person or persons.

I agree to keep and make available such records as are necessary to disclose fully the nature and extent of services provided and to furnish such information regarding any payments claimed as State and Federal officials may request.

I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action.

Services were provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap in accordance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.

PLACE OF SERVICE CODES - See Provider Handbook