



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

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Medicare Crossover for Other Blue Plan Members (CMS-1500)

Tips from Blue Cross and Blue Shield of Florida

Completing a claim correctly when a member has primary coverage with Medicare and secondary coverage (Medicare Supplement) from another Blue Plan will decrease your chance of receiving claim denials. The following instructions apply to items on the CMS-1500 form or its electronic counterpart that require specific Medicare Supplement information:

Item 9

- Enter the last name, first name and middle initial of the member if it is different from that shown in Item 2. Otherwise, you may enter the word "SAME". If no Medigap benefits are assigned, leave blank.

Item 9a

- Enter the Medicare Supplement member's policy and/or group number preceded by MEDIGAP, MG, or MGAP.
- Item 9d must be completed if you enter a policy and/or group number in 9a.

Item 9b

- Enter the birth date (MM/DD/YYYY) and gender of the member.

Item 9c

- Leave this field blank if the Blue Plan secondary payer's name is entered in 9d.
- Enter the correct Blue Plan name as the secondary carrier in 9c. For example, if the member has a Medicare Supplement with Blue Cross and Blue Shield (BCBS) of Michigan, then BCBS of Michigan should be indicated as the secondary carrier, not Blue Cross and Blue Shield of Florida (BCBSF). Use an abbreviated street address, two letter postal code, and zip code copied from the member's Medicare Supplement ID card. For example: 1234 Anywhere St, MD 12345.

Item 9d

- Enter the correct Blue Plan name as the secondary carrier. **Note:** All information must be complete and accurate in items 9, 9a, 9b, 9c and 9d of the CMS-1500 form in order for the Medicare carrier to be able to forward claim information. If prior arrangements have been made with the private insurer, the carrier will forward the Medicare information electronically. Otherwise, the carrier will forward a hard copy of the claim to the private insurer.

Item 11d

- If you submit a claim with a Medicare Remittance Notice attached, always mark “YES” in 11d.
- If you mark “NO” in 11d, the claim will pass through the system but attachments will not be reviewed.
- If your billing system is hard-coded to mark “NO” automatically in 11d, please manually override your system to mark “YES” when submitting a claim with the Medicare Remittance Notice attached.

Item 13

- The signature in this item authorizes payment of mandated Medigap benefits to a participating physician or supplier if required Medicare Supplement information is included in items 9 through 9d.
- The member or member’s representative must sign this item or the signature must be on file as a separate Medigap authorization.
- The Medigap assignment on file in the participating physician or supplier’s office must specify the insurer. It may state that the authorization applies to all occasions of service until it is revoked.

Filing the Claim

File the claim to your Medicare carrier for primary payment. Claim information will not be crossed over to the member’s supplement plan (the secondary payer) until after Medicare has processed the claim and released it from the Medicare payment hold. Medicare secondary claims will normally be electronically forwarded by GHI (the CMS vendor) directly to the member’s supplement Blue Plan for processing of the secondary benefits. Check the Medicare Remittance Notice to identify whether the claim was crossed over directly to the member’s Medicare supplement Blue Plan. If it did, you do not need to take further action. The paper remittance notice will state “Claim information forwarded to: (Name of secondary payer).” The 835 (electronic remittance) record can also carry the secondary forwarding information.

You will receive payment or processing information from the member’s supplement plan after they receive the Medicare payment. Please allow 45 days from the Medicare payment date for the secondary claim (Medicare Supplement coverage) to process.

If the claim did not crossover electronically to the secondary payer (Medicare supplement plan), then file the claim to BCBSF with the Medicare Remittance Notice attached. Send the claim to: BCBSF, P.O. Box 1798, Jacksonville, Florida 32231-0014. Do not send secondary claims directly to the member’s Blue Plan secondary payer.

Note: If more than one claim appears on the Medicare Remittance Notice, please indicate the specific claim you are filing.

Inquiries

Direct inquiries on secondary claims to BCBSF unless the member’s Blue Plan has requested specific information from you on a particular claim. Inquiries received on secondary claims by BCBSF will be coordinated with the member’s Blue Plan for resolution.

Example: A provider received the primary Medicare payment. The Medicare Remittance Notice stated, “Claims information was forwarded to: (Name of secondary payer).” It has been 45 days since Medicare’s payment and no communication has been received from the member’s supplement plan. This should be sent to BCBSF as an inquiry so the member’s Blue Plan can be contacted and a resolution made on the status of the secondary claim. BCBSF will communicate the resolution back to the provider.