



Medicare Crossover for Other Blue Plan Members (UB-04)

Tips from Blue Cross and Blue Shield of Florida

Completing a claim correctly when a member from another Blue Cross and/or Blue Shield Plan has primary coverage with Medicare will decrease your chance of receiving claim denials. The following instructions apply to items on the UB-04 form or its electronic counterpart that require specific Medicare Supplement information:

Form Locator 50 – Payer

- Enter “Medicare” as the primary payer on line A.
- Enter the appropriate Blue Plan name as the secondary payer on line B.
 - Not entering the member’s actual Blue Plan as the correct secondary payer will result in claim issues. A claim crossed over in error to Blue Cross and Blue Shield of Florida (BCBSF) cannot be processed and you may not receive a remittance notice. Therefore, be sure to enter the correct Blue Plan when you submit the claim to Medicare. If your system is set-up to automatically populate BCBSF, please change it to the correct Blue Plan.
 - If you do not know the member’s Blue Plan, call BlueCard Eligibility at **(800) 676-BLUE (2583)**, speak the alpha prefix and you will be routed to the member’s Blue Plan.

Form Locator 53 – ASG BEN

- A “Y “ indicating benefits were assigned must be entered in order for you to receive payment from the Blue Plan.
- This indicator authorizes payment of mandated Medigap benefits to you if required Medicare Supplement information is included on the claim.
- The member or representative’s signature must be on file as a separate Medigap authorization.
- The Medigap assignment on file must specify the insurer. It may state that the authorization applies to all occasions of service until it is revoked.

Form Locator 54 – Prior Payments

- Enter the amount you have received toward payment of this bill from Medicare on line A.

Form Locator 58 – Insured’s Name

- Enter the last name, first name and middle initial of the insured. The name must be entered exactly as it is on the ID card.

Form Locator 59 – P. Rel

- Enter the appropriate code indicating the relationship of the patient to the insured (e.g., code 18 = self).

Form Locator 60 – Insured’s Unique ID

- Enter the patient’s Medicare HIC number as shown on the ID card on line A.
- Enter the patient’s complete Blue Plan ID number, including three-digit alpha prefix on line B. Member IDs for other Blue plans include the alpha prefix in the first three positions and can contain any combination of numbers and letters up to 17 characters.

Form Locator 61 – Group Name

- Enter the name of the group or plan through which the insurance is provided to the member.

Form Locator 62 – Insurance Group No.

- Enter the group number as identified on the ID card.

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, “Processed as primary, forwarded to additional payer(s).” 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 primary payment date for processing of the secondary claim.

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

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.