

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.

This attachment MUST NOT be used when submitting claims electronically.

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	
		<input type="checkbox"/>	<input type="checkbox"/>	
		c. Amount		
2. Medicare Paid Date				
3. Total Medicare Paid Amount				
4a. Detail #	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.