

UB 04 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. 1 on your UB04 claim form)

Beneficiary (Patient) Name: _____
(must match the beneficiary (patient) name, as it appears, in form loc. 8b on your UB04 claim form)

The amounts below must represent a sum of all the details on the claim that contain deductible or co-insurance or Medicare payment.

1. Medicare Paid Date		
2. Deductible Amount		
3. Co-insurance Amount		
4. Medicare Paid Amount		
5. Medicare ICN		
6. Other Insurance (non-Medicare)—check one	a. Yes	b. No
	<input type="checkbox"/>	<input type="checkbox"/>
	c.Amount	