STATE OF FLORIDA

MEDICARE PART C - MEDICAID

CMS-1500 CROSSOVER INVOICE

Use a separate form for each Medicare Part C crossover claim.

Medicaid Recipient ID#		Last Name (first 2)		First Name (first 3)		Medicare Date Paid	

	From DOS	CPT/HCPC	Allowed	Deductible	Co-Pay	Co-insurance	Medicare Paid
1			$	$	$	$	$
2			$	$	$	$	$
3			$	$	$	$	$
4			$	$	$	$	$
5			$	$	$	$	$
6			$	$	$	$	$
7			$	$	$	$	$
8			$	$	$	$	$
9			$	$	$	$	$
10			$	$	$	$	$
11			$	$	$	$	$
12			$	$	$	$	$
13			$	$	$	$	$
14			$	$	$	$	$
15			$	$	$	$	$
16			$	$	$	$	$
17			$	$	$	$	$
18			$	$	$	$	$
19			$	$	$	$	$
20			$	$	$	$	$
21			$	$	$	$	$
22			$	$	$	$	$
23			$	$	$	$	$
24			$	$	$	$	$

*If more than 24 detail lines are needed, please submit additional invoice forms. page___of ___

Medicaid Provider #	

By signing below, I certify that the foregoing information is accurate and complete, and understand that falsifying essential information to receive payment from federal and state funds requested by this form may, upon conviction, be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the event of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the state agency may request. I further agree to accept as payment in full the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

Provider Signature _____ Date _____

Mail with accompanying CMS-1500 to:

CMS-1500 Crossover Claims

P.O. Box 7074

Tallahassee, FL 32314-7074

Provider Name and Address