STATE OF FLORIDA

MEDICARE PART C - MEDICAID
UB-04 CROSSOVER INVOICE

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

Blood Deductible Amount	$	
Allowed Amount	$	
Co-Pay Amount	$	
Co-Insurance Amount	$	
Deductible Amount	$	
Medicare Paid Amount	$	

Medicare Paid Date	

Statement Covers Period (from box 6 of UB-04)	
From	
To	

Medicaid Recipient #	

Last Name		First Name	

Medicaid Provider ID #	

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

Provider Name and Address

Mail with accompanying UB-04 to:

UB-04 Crossover Claims
P.O. Box 7064
Tallahassee, FL 32314-7064

AHCA Form 5000-3528 6/12
Incorporated by reference in 59G-5.020, F.A.C.