DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

SUPPLEMENTAL ATTACHMENT FOR RENAL DIALYSIS PROVIDERS

Please use this form in lieu of attaching the Medicare Explanation of Benefits (EOMB) Statement when billing Medical Assistance (MA) for Medicare Deductible and/or Coinsurance. Please note that this form must be used when entering Attachment Type 05 (Medicare EOMB Attached*) in Block 19 of the CMS-1500 Claim Form. ***This attachment must not be used when submitting claims electronically.***

Provider Name: _____ **Provider Number:** _____

Recipient Name: _____ **Recipient Number:** _____

Claim Line	Medicare Deductible	Medicare Coinsurance	Medicare Allowed Amount	Medicare Paid Amount	Date of Medicare EOMB
#1					/ /
#2					/ /
#3					/ /
#4					/ /
#5					/ /
#6					/ /

INSTRUCTIONS FOR COMPLETING THE SUPPLEMENTAL ATTACHMENT FOR RENAL DIALYSIS PROVIDERS

Please complete the Supplemental Attachment for Renal Dialysis Providers instead of attaching a copy of the Medicare EOMB to the CMS-1500. Medical Assistance recognizes that Renal Dialysis Providers receive an EOMB from Medicare that does not provide a claim line-by-claim line breakdown. This form will assist Renal Dialysis Providers in submitting claims successfully for Medicare deductible and/or coinsurance. There are six lines provided on this form that correlate to the six claim lines of the CMS-1500. When submitting claims on the CMS-1500 for Medicare deductible and/or coinsurance, the Supplemental Attachment for Renal Dialysis providers **must** be completed and paper clipped to the CMS-1500 Claim Form.

- **Claim Line** - Leave this field blank. The line numbers denoted in this column correlate the claim lines on the CMS-1500 Claim Form. *Please Note: For Medical Assistance billing purposes, you must indicate the Medicare deductible and/or coinsurance applicable to each claim line.*
- **Medicare Deductible** - This field must be completed when Medicare applies any portion of the payment toward the recipient's Medicare deductible. Using your Medicare EOMB, please indicate the amount Medicare applied to the recipient's yearly Medicare Part B deductible.
- **Medicare Coinsurance** - Complete this field, when applicable. Please enter the amount of coinsurance applicable to each claim line.
- **Medicare Allowed Amoun**t - This field must be completed. Please enter the Medicare Allowed/Approved Amount applicable to each claim line.
- **Medicare Paid Amount** - This field is not required. If completed, it must contain the amount Medicare paid for the applicable claim line.
- **Date of Medicare EOMB** - Please enter the date of the Medicare EOMB in this field.