



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



### Medicare Secondary Payer Explanation Form

**ALL fields are REQUIRED.**

Select the region in which the services were provided:

South Carolina

North Carolina

Virginia

West Virginia

#### Provider Information

Provider Name:

National Provider Identifier (NPI):

#### Patient and Claim Information

Patient Name:

Medicare Beneficiary Identifier (MBI/HIC):

#### Primary Insurer Company Information

Name:

Address:

  

City:

State:

ZIP Code:

#### Does Capitation Apply?

Yes

No

Date of Service *	Procedure Code (CMS-1500 Claim Form)	Charges (Item 24f CMS-1500 Claim Form)	Primary Insurer Allowed Amount (From the EOB)	Primary Insurer Paid Amount* (From the EOB)	Patient Responsibility (Co-pay, Deductible)

\* Please see disclaimer below.

In situations where the primary insurer's explanation of benefits (EOB) is very general in the reason the service was denied or partially paid (remark/reason codes are very vague), please give further explanation below:

Explanation:

  
  
  

**Disclaimer:** This form is intended to clarify information submitted on the primary insurer's original EOB that may be very generalized or needs further clarification for Medicare to process the secondary claim. **This form must be submitted in addition to the primary insurer's original EOB.** The following information must be on the original EOB and cannot be accepted from this form alone: patient's identification (patient's name and/or HIC number), date of service, primary insurer paid amount and the remark codes/reason for denial or partial payment.

Please mail this form along with the CMS-1500 claim form to  
Palmetto GBA - JM MAC  
Mail Code: AG-600  
P.O. Box 100190  
Columbia, SC 29202-3190

CL-JM-B-4004



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