PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

Medicare Secondary Payer Explanation Form

***ALL** fields are **REQUIRED**.*

Provider Information

Provider Name:

National Provider Identifier (NPI):

Patient and Claim Information

Patient Name:

Medicare Number:

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 Medicare number), date of service, primary insurer paid amount and the remark codes/reason for denial or partial payment.

CL-RRB-B-4004

Revised 12/2019

Please mail this form along with the CMS-1500 claim form to:
Palmetto GBA
P.O. Box 10066
Augusta, GA 30903-0166