



# Medicare-to-Medicaid Crossover Invoice

**IMPORTANT:**

1. You **must** write *CROSSOVER* at the top of every crossover claim.
2. HCA-28 form is *only* to be used for **Inpatient** claims or claims **prior to June 1, 2016**.
3. Do **not** use this form for **HMO copay** or **third party liability** claim submissions.
4. Use one invoice for each claim.

Please check one:	
<input type="checkbox"/> Medicare only	<input type="checkbox"/> Medicare supplemental claims
<input type="checkbox"/> Medicare replacement	
SoonerCare Provider ID:	
Member ID:	Member Name First: Last:
Patient Control Number:	
Medicare HIC Number:	
From DOS:	To DOS:
Total Billed: \$	
Date Paid:	
Coinsurance: \$	Medicare Remark Code:
Deductible: \$	Medicare Remark Code:
Blood Deductible: \$	
Total Allowed: \$	Medicare Remark Code:
Medicare Remark Code:	
Amount Paid: \$	Medicare Remark Code:

**Mail claims for payment to:**  
 Hewlett Packard Enterprise  
 P.O. Box 18110  
 Oklahoma City, OK 73154

\_\_\_\_\_  
 Provider Signature

\_\_\_\_\_  
 Date

# Medicare-to-Medicaid Crossover Invoice

## Field Descriptions for Medicare-Medicaid Crossover Invoice

Form Locator	HCA-28 Form
SoonerCare Provider ID	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider. <i>Required</i>
Member ID	Enter the member's 9-digit SoonerCare identification number. <i>Required</i>
Patient Control Number	Patient's Account Number; enter your internal patient tracking number. The tracking number should be the same as the submitted claim. <i>Optional</i>
Medicare HIC Number	Enter the Patient's Medicare HIC Number; the Medicare HIC Number should be the same number as submitted on the claim. <i>Required</i>
Dates of Service	Enter the From and To Dates of Service as MM/DD/YYYY. <i>Required</i>
Total Billed	Enter the Amount Billed from the Medicare Explanation of Benefits (EOB). <i>Required</i>
Date Paid	Enter the Date Paid as MM/DD/YYYY from the Medicare Explanation of Benefits (EOB). <i>Required</i>
Coinsurance	Enter the Coinsurance Amount from the Medicare Explanation of Benefits (EOB). <i>Required, if applicable</i>
Coinsurance Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable</i>
Deductible	Enter Deductible Amount from the Medicare Explanation of Benefits (EOB). <i>Required, if applicable</i>
Deductible Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable</i>
Blood Deductible	Enter the Blood Deductible from the Medicare Explanation of Benefits (EOB). <i>Required, if applicable</i>
Total Allowed	Enter the Amount Allowed from the Medicare Explanation of Benefits (EOB). <i>Required, if applicable</i>
Total Allowed Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable</i>
Amount Paid	Enter the Amount Paid from the Medicare Explanation of Benefits (EOB). <i>Required, if applicable</i>
Amount Paid Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable</i>
Provider Signature	Signature of Physician or Supplier; the name of the authorized person, someone designated by the agency or organization. <i>Required</i>
Date	Enter date the claim was signed as MM/DD/YYYY. <i>Required</i>