Wyoming Department of Health

K0108/E1399 Crossover Claim Form

Client Name: _____ Provider Name: _____

Client Medicaid ID: _____ Provider NPI: _____

Claim Date(s) of Service: _____ Medicaid RA No.:_____

List below each item billed to Medicare and indicate whether paid or denied, and if denied, denial reason:

	Circle One	Item Description	Billed Amount	Medicare Paid/Denied	Denial Reason
Example:	K0108 / E1399	Foot Rest	$75.83	Denied	PR-204
1.	K0108 / E1399				
2.	K0108 / E1399				
3.	K0108 / E1399				
4.	K0108 / E1399				
5.	K0108 / E1399				
6.	K0108 / E1399				
7.	K0108 / E1399				
8.	K0108 / E1399				
9.	K0108 / E1399				
10.	K0108 / E1399				
11.	K0108 / E1399				
12.	K0108 / E1399				
13.	K0108 / E1399				
14.	K0108 / E1399				

Contact Name: _____ Phone No.: _(_____)_____