Wyoming Department of Health

K0108/E1399 Crossover Claim Form

Provider Name _____ **NPI/Provider Number** _____

Member Name _____ **Member ID** _____

Claim Date(s) of Service _____ **Medicaid RA Number** _____

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

Line	Select One	Item Description	Billed Amount	Medicaid Paid/Denied	Denial Reason
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 Person _____ **Contact Number** _____