Medicare Claims Processing Manual

Chapter 21 - Medicare Summary Notices

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(Rev. 3210, 03-03-15)

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10 - General Medicare Summary Notices (MSN) Requirements

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006, Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

Effective July 1, 2002, the MSN is used by all A/B MACs (A), (B), (HHH), and DME MACs.

The MSN is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. The A/B MAC (A), (B), (HHH), or DME MAC mails a single MSN at the end of the month to each beneficiary for whom claim was processed during the month to inform the beneficiary of the disposition of all claims. All MACs shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with checks to the beneficiary will continue to be mailed out as processed. To ensure that all messages are uniform throughout the Medicare program, A/B MACs (A), (B), (HHH), and DME MACs may not use locally developed MSN messages until approved by the regional office (RO).

The MSNs are not sent to providers. Providers receive remittance advice records. (See Chapter 22 for instructions about the provider remittance record.)

The MSN contains the following sections or areas:

- Disclaimer;
- Title;
- Claims Information;
- Message; and
- Appeals.

Detailed requirements for completion of each section are included in §10.3. Generally, A/B MAC (A), (B), (HHH), or DME MAC requirements are the same. Where there are differences or where the specific specification applies to only the A/B MAC (B)/DME MAC or to only the A/B MAC (A)/(HHH), the difference is noted in the specific instruction.

Although every attempt has been made to make the MSN as simple as possible, the MSN is sufficiently complex that MACs must maintain continuing training efforts directed at beneficiaries and providers for understanding and interpretation of data on the MSN. Although providers are not mailed copies of MSNs, beneficiaries frequently show MSNs to providers to establish deductible status for provider billing.

10.1 - General Requirements for the MSN

(Rev. 1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. A/B MAC (A)/(HHH) MSN

The MSN is used to notify Medicare beneficiaries of action taken on A/B MAC (A)/(HHH) processed claims. MSNs are not used by A/B MACs (HHH) for RAPs, and RAP data are not included on the monthly MSN.

The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. The Balanced Budget Act of 1997 requires all Part A benefit notices to include the amount of Medicare payment for each service. A/B MACs (A) and (HHH), must furnish an MSN to all beneficiaries for whom claims are filed during the month unless the situation is specifically excluded by other manual instructions. MACs shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with a payment check to the beneficiary shall continue to be mailed out as processed. No-pay MSNs are defined as those MSNs which do not require payment to the beneficiary for the respective claim(s).

The MSN replaced the following documents:

- Form CMS-1533, Part A Medicare Benefit Notice, also known as the Part A Notice of Utilization (NOU) sent for inpatient services;

- Form CMS-1954, Benefit Denial Letter (BDL), sent for partially denied claims; and

- Form CMS-1955, BDL sent for totally denied claims.

Since CMS eliminated BDLs, Medicare beneficiaries receive the information previously conveyed on BDLs through narrative messages contained on the MSN. Providers no longer receive a separate written notification or copy of the BDL. Providers must utilize the coding information (e.g., ANSI Reason Codes) conveyed on the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

B. A/B MAC (B)/DME MAC MSN

The MSN is used to notify Medicare beneficiaries of action taken on their processed claims. The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights.

10.2 - Correction/Reissuance of Faulty MSNs
(Rev. 159, 04-30-04)

Occasionally programming errors will occur which cause inaccuracies on MSNs that do not materially affect benefits. An example of a potential programming error could be one data column writing in another data column. So long as the claims are correctly paid and the notice is intelligible, it is not necessary to identify the impacted MSNs or reissue them. The resources to identify and reissue all of the documents would not be justified.

In situations where MACs feel reissuance is absolutely necessary, they must work with their regional office to identify costs involved before proceeding. When such problems occur, MACs must take actions that will inform beneficiaries of the situation. These actions should fall within the framework of routine operations. Such actions include, but are not limited to, fielding calls from beneficiaries and alerting customer service representatives of the situation and posting an alert on MACs' Web sites. While not all of these solutions may be possible, MACs should take the most appropriate steps to best mitigate the potential confusion, but not incur special costs. Any communication regarding this type of situation should convey that it was a temporary programming error, which has been fixed, and is believed not to have affected the beneficiary's benefits.

A beneficiary may call the MAC to request a copy of the MSN with the correct information. In such cases, the MAC will provide one.

10.3 - A/B MAC (A), (B), (HHH), or DME MAC Instructions for Preparing the MSN

(Rev. 1, 10-01-03)
PM A-99-48

10.3.1 - Basic Concepts and Approaches

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Overview

The Medicare Summary Notice (MSN) is a printed notification, sent to Medicare beneficiaries enrolled in Original Medicare, that displays data for claims processed during a given reporting period. The MSN lists claim information in a summarized format. It also contains other helpful information for beneficiaries. Each MSN consists of the following four sections:

SECTION 1: SUMMARY (PAGE 1)
A one-page summary of the beneficiary's Medicare status and of the claims' data on the notice.

SECTION 2: MAKING THE MOST OF YOUR MEDICARE (PAGE 2)
One page with tips for beneficiaries on how to use their MSN, get help with Medicare issues, and learn more about Medicare services.

SECTION 3: CLAIMS (PAGE 3 - X)
A section, which may extend over multiple pages, listing the beneficiary claims submitted to Medicare over the period of the notice.

SECTION 4: DENIALS & APPEALS (LAST PAGE)
One page containing details on beneficiaries' appeals rights and, more generally, on how they can get help with denied claims.

Layout and content specifications for these sections begin at §10.3.4. Specifications address the position, formatting, content, and (if applicable) rules for dynamic content in individual subsections of each section.

B. Claim Types: The 'Extended Family' of MSNs

Medicare claims are processed and paid under a range of different systems. (In addition, different claim types may be processed and printed by separate MACs.) While the overall appearance and format of all MSNs is consistent, different claim types do require some variations in the notice, in both the type of content supplied and the specific language used.

This document identifies *eight* **primary claim types** in the "extended family" of MSNs:

GLOBAL NOTICE: This file version does not include specifications for Part A claims for inpatient mental health care in a psychiatric hospital. The instructions for these claims will be included in a subsequent version.

- **Part A Inpatient**
  Claims for inpatient hospital services and skilled-nursing facility services.

- **'B of A'**
  Claims for outpatient services provided by medical facilities; these claims are paid under the Part B program, but their claim data is presented in a format similar to Part A Inpatient claims.

- **Hospice**
  Claims for hospice care, which are paid for under Part A but require a claim format more similar to Part B claims.

- **Home Health**
  Claims for home-health services that are paid under Part A *or Part B*. These MSNs also require a claim format more similar to Part B claims.

- **Part B, unassigned**
  Claims for Part B medical services from providers that do not accept Medicare assignment; payment for unassigned claims may be made directly to beneficiaries, which affects the format of claims data on the MSN.

- **DME, assigned**
  Claims for durable medical equipment (DME) and related services from suppliers that accept Medicare assignment.

- **DME, unassigned**

Claims for DME from suppliers that do not accept Medicare assignment; payment for unassigned claims may be made directly to beneficiaries, which affects the format of claims data on the MSN.

COMBINED MSNs

In some instances, multiple claim types may be combined on a single MSN. This most commonly occurs with Part A Inpatient and 'B of A' claims, with Part B assigned and unassigned claims, and with DME assigned and unassigned claims. Instructions related to combined MSNs will be found below in any section or subsection that is affected.

PAY MSN*s*

From time to time, beneficiaries may receive an MSN that includes a check, refunding an overpayment made (most often) for Part B services, either assigned or unassigned. Instructions related to Pay MSNs will be found below in any section or subsection that is affected. Instructions for the check cover sheet are located near the rear of this chapter. Instructions for Pay MSN envelopes are located in the Envelopes section. In addition, there are examples of complete Pay MSNs in the Exhibits section.

EFFECT OF CLAIM TYPES

In the specifications below, layout and content instructions can be assumed to be global - that is, they apply to all MSNs, regardless of what types of claims appear on the notice.

However, there are particular sections and subsections of the MSN where the type of claims on the MSN determines not only what specific claim data is printed, but also affects the inclusion of other content and language across the notice.

If a given subsection is affected by the claim type(s) on the notice, specifications for that subsection will be split - into global specifications and specifications for each member of the extended family.

10.3.2 - Format Conventions for the MSN

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

This information describes the overall format conventions for the MSN.

MSNs are a combination of fixed and variable length sections, using a range of different typefaces and type styles, as well as a number of static graphic elements. For discussion of the display in specific areas of the notice, see the technical specifications beginning in section 10.3.3. MACs should establish page layout and page breaks as specified by these instructions and exhibits.

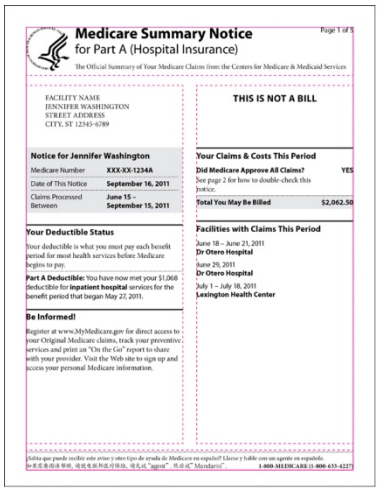
A. Printing Requirements

MSN MACs must follow these instructions:

- Generate all MSN forms by a laser printer.
- Ensure that the MSN is printed on 8.5 by 11 inch paper, exclusive of perforated marginal pin-feed tabs.
- Print duplex.
- Use black ink only on white paper.
- Use shading as required by the instructions and exhibits.
- Allow for coding necessary for mail sorting equipment (e.g., bar coding, aims marks).
- Ensure any MAC's notations placed on the MSN do not affect the design of the MSN.
- Refer to the specifications and exhibits for placement of information on the MSN.

B. Page Margins and Layout

Use 0.5-inch outer margins on the notice with exceptions when noted in the instructions. Alternate approved margins, 0.75-inch left and 0.25-inch right, may also be used when extra space is needed for bar code placement.


Medicare Summary Notice
for Part A (Hospital Insurance)
Page 1 of 5
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

FACILITY NAME
JENNIFER WASHINGTON
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	September 16, 2011
Claims Processed Between	June 15 – September 15, 2011

Your Claims & Costs This Period

Did Medicare Approve All Claims?	YES
See page 2 for how to double-check this notice.	
Total You May Be Billed	$2,062.50

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your $1,068 deductible for **inpatient hospital** services for the benefit period that began May 27, 2011.

Facilities with Claims This Period

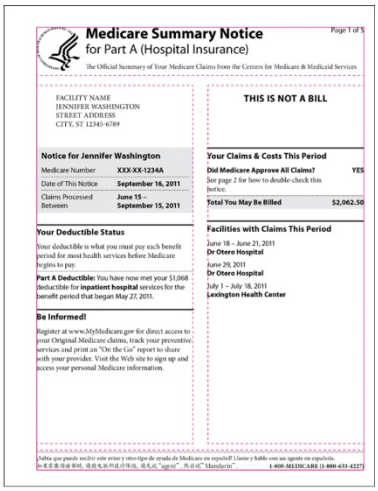
June 18 – June 21, 2011
Dr Otero Hospital
June 29, 2011
Dr Otero Hospital
July 1 – July 18, 2011
Lexington Health Center

Be Informed!

Register at www.MyMedicare.gov for direct access to your Original Medicare claims, track your preventive services and print an "On the Go" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要接听帮助，请致电联邦医疗保险，请见此"agent"，然后说"Mandarin"。
1-800-MEDICARE (1-800-633-4227)

figure 10.3.2.B1


Medicare Summary Notice
for Part A (Hospital Insurance)
Page 1 of 5
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

FACILITY NAME
JENNIFER WASHINGTON
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
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Claims Processed Between	June 15 – September 15, 2011

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June 29, 2011
Dr Otero Hospital
July 1 – July 18, 2011
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Be Informed!

Register at www.MyMedicare.gov for direct access to your Original Medicare claims, track your preventive services and print an "On the Go" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要接听帮助，请致电联邦医疗保险，请见此"agent"，然后说"Mandarin"。
1-800-MEDICARE (1-800-633-4227)

figure 10.3.2.B2

The MSN pages use two different column layouts, full page and two-column. Full-page layouts are 7.5 inches or 540 points wide with 0.5-inch margins on each side, as stated above. The Notice title, Foreign Language Footer, Section Title, and Claims section use this layout. This layout may be used on just a portion of a page, with the remainder of the page content split across two columns.

Two-column layouts have two separate 259 point columns with a 22 point gutter between, also with 0.5-inch margins on each side. The Summary section, Making the Most of Your Medicare section, Claims definitions, and Appeals section use this layout. In the specifications below, a given subsection may be described as being one-column

wide; this means that the subsection's content runs within one column in a two-column layout.

C. Type & Graphic Styles

The MSN uses two typefaces, Minion (serif) and CMS Myriad (sans serif) in Opentype format. Minion is a standard system font. The CMS Myriad font is customized for CMS use; the font file contains additional glyphs to be used in the MSN. (Font files may be requested from CMS, or may be included with Chapter 21 on an enclosed CD.)

Type & Graphics Glossary:

Alignment: The positioning of text within the page margins. Alignment can be flush left, flush right, justified, or centered. Flush left and flush right are sometimes referred to as left justified and right justified.

Baseline: The imaginary line on which the majority of the characters in a typeface rest.

Body Text: The paragraphs in a document that make up the bulk of its content. The body text should be set in an appropriate and easy-to-read face, typically at 10- or 12-point size.

Glyph: The word glyph is used differently in different contexts. In the context of modern computer operating systems, it is often defined as a shape in a font that is used to represent a character code on screen or paper. The most common example of a glyph is a letter, but the symbols and shapes in a font like ITC Zapf Dingbats are also glyphs.

Header: The short lines of emphasized text that introduce detail information in the body text that follows. Also the category of faces that are designed to work best in headline text.

Italic: A slanting or script-like version of a face. The upright faces are often referred to as Roman.

Leading (pronounced: ledding)**:** The amount of space added between lines of text to make the document legible. The term originally referred to the thin lead spacers that printers used to physically increase space between lines of metal type. Most applications automatically apply standard leading based on the point size of the font. Closer leading fits more text on the page, but decreases legibility. Looser leading spreads text out to fill a page and makes the document easier to read. Leading can also be negative, in which case the lines of text are so close that they overlap or touch.

Letterspacing: Adjusting the average distance between letters in a block of text to fit more or less text into the given space or to improve legibility. Kerning allows adjustments between individual letters; letterspacing is applied to a block of text as a whole. Letterspacing is sometimes referred to as tracking or track kerning.

Margin: The white spaces around text blocks. Margins typically need to be created on the edges of a page, since most printers can't print to the very edge. White space also makes a document look better and easier to read.

Point: A unit of measure in typography. There are approximately 72 points to the inch. A pica is 12 points.

Point Size: The common method of measuring type. The distance from the top of the highest ascender to the bottom of the lowest descender in points. In Europe, type is often measured by the cap-height in millimeters.

Rule: A solid or dashed graphic line in documents used to separate the elements of a page. Rules and other graphic devices should be used sparingly, and only for clarifying the function of other elements on the page.

Sans Serif: A type face that does not have serifs generally a low-contrast design. Sans serif faces lend a clean, simple appearance to documents.

Serif: Small decorative strokes that are added to the end of a letter's main strokes. Serifs improve readability by leading the eye along the line of type.

Style: One of the variations in appearance, such as italic and bold, that make up the faces in a type family.

CMS Myriad Regular
CMS Myriad Semibold
CMS Myriad Bold

Minion Pro Regular
Minion Pro Bold

figure 10.3.2.C

In most instances, Myriad is used for headers and for beneficiary-specific and dynamic information. Minion is typically used for instructional body text.

MSN MACs should:

- Use the exact type point sizes and leading in the specifications.
- Use uppercase and lowercase letters, as well as bold printing, throughout the form, except as specifically noted in the specifications.
- Not print text in italic type. In instances where italic is typically used, as in document titles, quotes are used instead (e.g., “Medicare & You” handbook).

See below for a list of the different type styles used in printing the MSN. The styles described below will be referenced throughout the detailed section and subsection specifications that follow. All elements can be assumed to be printed in 100% black, unless otherwise noted.

The naming convention of the different style groups are based on usage. Type Header is abbreviated to TH, Type Body to TB, Graphic style to GR, and Glyph to GL.

TYPE HEADER STYLES

Code	**Name**	**Font**	**Point Size**	**Leading**
TH 1.1	Notice Title	Myriad Bold	25 pt	25 pt
TH 1.2	Notice Subtitle	Myriad Regular	22 pt	25 pt
TH 1.3	Notice Subtitle Alternate	Myriad Regular	18 pt	25 pt
TH 1.4	*Notice Subtitle Alternate 2*	*Myriad Regular*	*17 pt*	*25 pt*
TH 2	Section Name	Myriad Bold	21 pt	22 pt
TH 3	Body Header	Myriad Bold	14 pt	16 pt
TH 4	Claim Date	Myriad Bold	16 pt	18 pt
TH 5.1	Claim Column Title	Myriad Semibold	*10 pt*	*10 pt*
TH 5.2	Claim Column Maximum	Myriad Bold	*10 pt*	*10 pt*

TYPE BODY STYLES

Code	**Name**	**Font**	**Point Size**	**Leading**
TB 1.1	Body Text	Minion Regular	12 pt	15 pt
TB 1.2	Body Highlight	Minion Bold	12 pt	15 pt
TB 1.3	*Alternate Address Text 1*	*Minion Bold*	*11 pt*	*12 pt*
TB 1.4	*Alternate Address Text 2*	*Minion Bold*	*10 pt*	*11 pt*
TB 2.1	Bene Data Text	Myriad Regular	12 pt	15 pt
TB 2.2	Bene Data Highlight	Myriad Bold	12 pt	15 pt
TB 3	Notice Title Tagline	Minion Regular	11 pt	25 pt

GRAPHIC STYLES AND SPACING

Code	**Name**	**Graphic Style**	**Space Before**	**Space After**
GR 1	Gray Fill	15% tint of black	N/A	N/A
GR 2.1	Black Rule	2 pt black line	0 points	6 points
GR 2.2	Black Rule only	2 pt black line	N/A	N/A
GR 3.1	Dotted Rule	1 pt dotted line	7 points	6 points
GR 3.2	Dotted Rule 2	1 pt dotted line	0 points	7 points
GR 3.3	Dotted Rule 3	1 pt dotted line	5 points	7 points
GR 4.1	Space after header	No rule	14 points	0 points
GR 4.2	Space after icon	No rule	10 points	0 points
GR 5	Space after text	No rule	7 points	0 points
GR 6	Space between paragraphs	No rule	12 points	0 points

GR 7	Appeals Form	White fill and 0.5 pt black line all around box	N/A	N/A
GR 8	*Space after Notice Title*	*No rule*	*17 points*	*0 points*

D. Glyphs & Static Print Elements

There are several locations on the MSN that require the insertion of graphic elements.

FLASH IMAGE

Code	**Name**	**Location**	**Size**	**Sample**
GL 1	HHS Seal	Page 1	72 pt x 72 pt	
GL 2	Foreign-Language Footer	Page 1	540 pt x 27 pt	See section 10.3.3.J
GL 3	Check logo	Pay MSN	540 pt x 27 pt	See section 10.3.9.C
GL 4	Notice Title, Part A	Pay MSN	540 pt x 27 pt	See section 10.3.9.D
GL 5	Notice Title, Part B	Pay MSN	540 pt x 27 pt	See section 10.3.9.D
GL 6	Notice Title, Part A and Part B	Pay MSN	540 pt x 27 pt	See section 10.3.9.D
GL 7	HHS Seal for envelope	Envelope	57.5 pt x 57.5 pt	
GL 8	Envelope Liner	Envelope		See section 10.3.10.D
GL 9	*RRB Logo*	*Page 1 of RRB Part B MSNs*	*70 pt x 70 pt*	

GLYPHS
Smaller icons used in headers can be found in CMS Myriad font file as glyphs.

Code	Name	Location	Size	Character Code	Sample
GL 9	Check This Notice	Page 2	15 pt x 15 pt		
GL 10	Report Fraud	Page 2	15 pt x 15 pt		
GL 11	Get Help	Page 2	15 pt x 15 pt		
GL 12	Benefit Period	Page 2	15 pt x 15 pt		
GL 13	Preventive Services	Page 2	15 pt x 15 pt		
GL 14	Messages from Medicare	Page 2	15 pt x 15 pt		
GL 15	Claims Continued Arrow	Claims	N/A		

E. Language & Style Conventions

The MSN generally follows CMS conventions for style and language use. One MSN-specific convention is noted below:

facility vs. provider vs. supplier

When describing the provider of the claimed services on an MSN, different terms are used for the different 'extended family' members: Part A Inpatient and 'B of A' use "facility," Part B (assigned and unassigned) use "provider," and DME notices (assigned and unassigned) use "supplier."

F. Organizing Principles for Specifications

The specifications that follow can be assumed to apply globally; when specifications vary by extended family member, the specifications will indicate which instructions apply globally and which relate to a particular member or members of the extended family.

The specifications are organized into chunks that relate to the individual subsections of the notice. Each unit of specifications will typically contain:

POSITION

- Instructions relating to the position of the subsection and its elements. The position coordinates are based on top and left edge of margin set as (0″, 0″). Adjust measurement according to margins used.

- Dimensions of content area and spacing between subsections.

- Specifications per section, listed by page position: top, left column, then right column.

FORMATTING

- All figures are style and layout examples. Any magenta guides are for layout reference only and are not to be printed. Refer to exhibits for accurate printed examples.

- Graphic example of subsection with type formats, graphic style and spacing used, and the content to which those formats are applied.

- Line by line code containing type, graphic, and spacing styles.

DYNAMIC RULES

- Description of any dynamically generated content within the section, and what rules should be applied to generate the content.

CONTENT

- Language and other specific content that should appear.

- General specifications are presented in Roman text. Type formats are indicated by bracketed codes (e.g., [TH 1.1]). Content that should be replicated on the MSN is presented in italic type; dynamic elements within the content are surrounded by curly brackets, {like this}.

In addition to figures for each subsection, exhibits are available for full MSNs for the base design family and worst-case scenarios. Reference will be made to corresponding files as needed.

10.3.3 - Specifications for Section 1: Summary (Page 1)

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Notice Title

This section names the notice, specifies the function of the notice and the Medicare program under which the notice's claims are paid, and identifies the Federal agencies responsible for generating the notice.

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 0″), and is full page or 540 points in width, 72 points in height.

The Department of Health & Human Services seal, a flash image, is 72 points by 72 points. Indent 9 points from the seal to start the three text elements.

MACs are not to change the format of the Notice Title subsection in order to use double window envelopes.

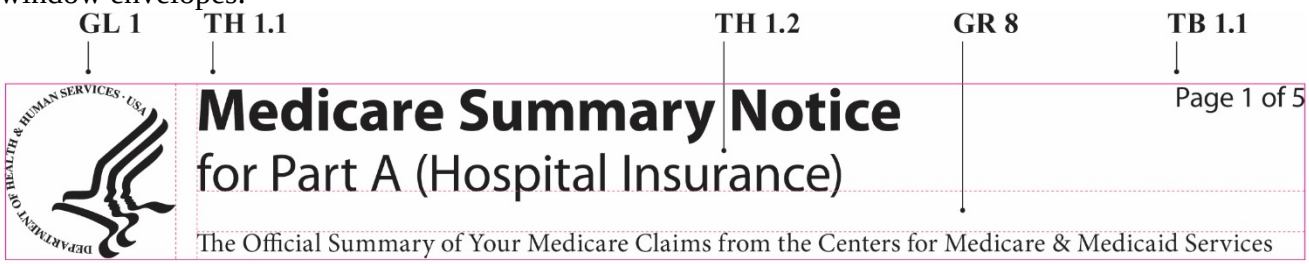

figure 10.3.3.A1

figure 10.3.3.A2

FORMATTING
[GL 1] DHHS Seal
[TH 1.1] notice title
[TH 1.2] notice subtitle, indicating to which Medicare program the notice relates
[TB 3] notice descriptive tagline
NOTE: Pagination specification on next subsection
NOTE: Use [TH 1.3] *or [TH1.4]* instead of [TH 1.2] for combined subtitle to fit in one line.
NOTE: *Use [TH 1.4] only if using [TH 1.3] for combined subtitle will not fit in one line.*

DYNAMIC RULES

The notice subtitle is dynamically generated based on which type(s) of claims are present on the MSN:

- Only claims paid by the Part A program;
- Part B, ‘B of A’, or DME claims - all of which are paid by the Part B program; or
- A combination of Part A Inpatient and ‘B of A’ claims that are paid by both Part A and Part B.

PART A INPATIENT, HOSPICE, AND HOME HEALTH (A) SPECIFICATIONS

CONTENT

Notices with only claims paid by the Part A program should have text content as follows:

> **Medicare Summary Notice**
> for Part A (Hospital Insurance)
> The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

PART B (ASSIGNED & UNASSIGNED), HOME HEALTH (B), 'B OF A', AND DME SPECIFICATIONS

CONTENT

Notices with only claims paid by the Part B program should have text content as follows:

> **Medicare Summary Notice**
> for Part B (Medical Insurance)
> The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

COMBINED PART A INPATIENT AND 'B OF A' SPECIFICATIONS

CONTENT

Notices that include both claims paid by the Part A program and also claims paid by the Part B programs - as on notices that have both inpatient hospital claims and outpatient 'B of A' claims - should have text content as follows:

> **Medicare Summary Notice**
> for Part A (Hospital Insurance) and Part B (Medical Insurance)
> The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

B. Pagination

The page number indicator, in the format Page 1 of #, must include the dynamically generated total page count for the notice in the second numeric position. Refer to specimen on section A for type style and placement relative to Notice title.

NOTE: This specification is for pagination on page 1 only. See section 10.3.4 for pagination included on page header for other pages.

POSITION

This subsection contains information of a fixed size. It does not vary in overall height but may vary in width depending on total page count.

The content area begins (0″, 6.75″), right aligned from right margin. It is 90 points in width, 11 points in height.

FORMATTING
[TB 2.1] all text, right aligned

C. Recipient Address

POSITION

This subsection contains information of a variable size.

The content area begins (0″, 1.35″) with 32 point indent from left margin. It is 1-column or 259 points in width with variable height, from 3 to 6 lines of text, not to exceed 82 points at 6 lines.

The name and address information is listed with 9-point clearance around the address when inserted into window envelope, to meet U.S. Postal Service regulations. For specifications on window size and position, see section 10.3.*10*.

The position may vary for envelope to align with the recipient address of the inserted MSN. Depending on the alignment, the address field of the printed MSN may be adjusted for ideal positioning.

FACILITY NAME
JENNIFER WASHINGTON
STREET ADDRESS
CITY, ST 12345-6789
LINE 5
LINE 6

TB 1.1

figure 10.3.3.C1

[The below figure is new.]

FACILITY NAME
JENNIFER WASHINGTON
STREET ADDRESS
CITY, ST 12345-6789
LINE 5
LINE 6

TB 1.3

figure 10.3.3.C2

FACILITY NAME
JENNIFER WASHINGTON
STREET ADDRESS
CITY, ST 12345-6789
LINE 5
LINE 6

← **TB 1.4**

figure 10.3.3.C3

FORMATTING
[TB 1.1] all text, all caps

NOTE: *MACs may also use a smaller font size [TB 1.3] or [TB 1.4] if needed.*

DYNAMIC RULES

All of the content in this subsection is dynamically generated.

At minimum, the beneficiary name and one- or two-line mailing address should be printed. The name should be printed with the given name first, followed by any middle initial(s), the family name, then any suffixes (e.g., Jr.)

If applicable, when the beneficiary's primary residence is a healthcare facility, a facility name may be appended above the beneficiary's name.

As necessary, a second name (the beneficiary's legal representative) may be added above the beneficiary's name, followed by "for". The name should be printed in bold with the given name first, followed by any middle initial(s), the family name, then any suffixes (e.g., Jr.)

In the case that a legal representative is indicated, the designated recipient's mailing address (if different from the beneficiary's address) should be used instead of the beneficiary's address.

The hierarchy of address should be as follows:

- *Legal representative*
- *Beneficiary's temporary address*
- *Beneficiary's permanent address*

CONTENT

{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{PERMANENT STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

Or

{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{TEMPORARY ADDRESS FACILITY NAME OR STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

Or

{LEGAL REPRESENTATIVE'S GIVEN NAME}{LEGAL REPRESENTATIVE'S MIDDLE INITIALS}{LEGAL REPRESENTATIVE'S FAMILY NAME}{LEGAL REPRESENTATIVE'S SUFFIX} FOR
{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{*LEGAL REPRESENTATIVE'S* STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

***NOTE**: Comma between City and State is optional, to follow current practice.*

D. Notice Details

This subsection provides a summary of whom the notice is for and what time period it covers.

POSITION

This subsection has a fixed size and position.

The subsection is printed on a gray highlight box. The gray area begins (0″, 2.75″). It is one-column or 259 points in width and 108 points in height.

Indent in 8 points all around to begin content area.

The three lines of body content are organized into static and dynamic text. Static text is in regular text, without changing content. Indent 133 points in from left margin to start dynamic text (e.g., beneficiary's Medicare number) in bold.

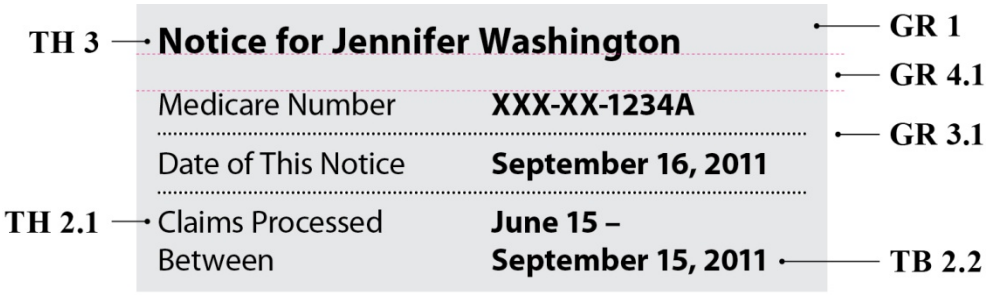

figure 10.3.3.D1

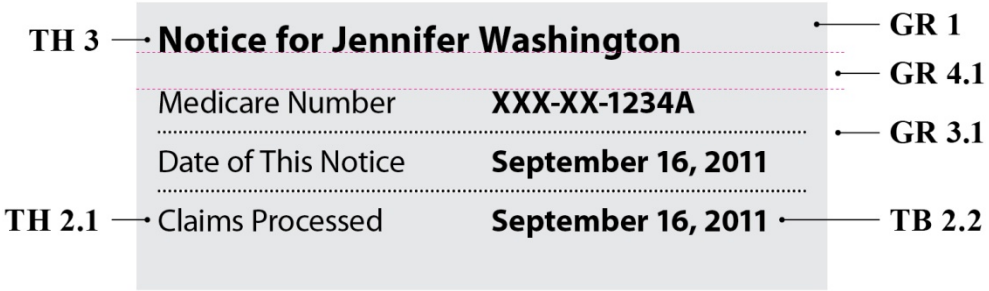

figure 10.3.3.D2

FORMATTING

[GR 1] gray background
[TH 3] notice details header
[GR 4.1] spacing after header
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content

DYNAMIC RULES

This subsection is comprised of four lines; each line has both static and dynamic content.

Notice for…

The first line has the static text “Notice for” followed by the beneficiary’s given and family names. Note that for space purposes the middle initial(s) and suffixes should not be included here.

Medicare Number

The second line has a static title and the beneficiary's Medicare number. The number should be masked for security purposes by replacing the first five digits of the number with capital Xs (e.g., XXX-XX).

When possible, the number should be broken by dashes in the format typical for Social Security numbers, with three digits followed by a dash, followed by two digits and a dash, and then a final four numbers (e.g., XXX-XX-1234).

When the beneficiary has a Medicare number that includes a letter or letters following the nine-digit numeric ID, the letter(s) should be listed immediately following the final four digits in all capital letters (e.g., XXX-XX-1234A).

Other formats for Medicare numbers may exist. In instances where the Medicare number differs from the formats described above, *MACs* should observe two principles: 1) the Medicare number should be printed with any standard spaces or dashes for easier comprehension, and 2) approximately the first third or three-quarters of the characters or digits should masked by Xs, corresponding when possible to space or hyphen breaks in the number format (e.g. XX-XXXX-1234AB).

Date of This Notice

The third line has a static title and the date that the notice was printed. The date is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

Claims Processed…

On a typical MSN, the fourth line has a static title, "Claims Processed Between" and dates that represent the start and end dates of the complete claim-processing period. The first date printed should correspond to the first day of the period that was reviewed for claims prior to the generation of the notice. The final date printed should reflect the final day that was reviewed for claims prior to the printing of the notice. This period typically spans an entire 90-day period prior to the printing of the notice. (Note that this is <u>not</u> the same as the processing dates of the first- and last-processed claims on the notice, which may cover a much shorter period.)

The dates are listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021) and are separated by an en-dash (not a hyphen); insert spaces to each side of the en-dash. If both the first and last date are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

NOTE: When printing a Pay MSN or other MSN with a single processing date, replace static text "Claims Processed Between" with the label "Claims Processed"; on an MSN of

this kind, only the single processing date should be listed, following the formatting conventions described above.

CONTENT

Notice for {Beneficiary Given Name}	**{Beneficiary Family Name}**
Medicare Number	**{XXX-XX-1234AB}**
Date of This Notice	{**Month DD, YYYY**}
Claims Processed	{**Month DD, YYYY**} -
Between	{**Month DD, YYYY**}

Or, if the notice is a Pay MSN or an MSN with a single processing date, use the following:

Notice for {Beneficiary Given Name}	**{Beneficiary Family Name}**
Medicare Number	**{XXX-XX-1234AB}**
Date of This Notice	{**Month DD, YYYY**}
Claims Processed	{**Month DD, YYYY**}

E. Deductible Status

This subsection contains information on the beneficiary's progress towards meeting his or her deductible(s).

GLOBAL SPECIFICATIONS

Position

The starting position of this subsection is fixed, although its length is variable. The content area begins (0″, 4.51″), 19 points from the baseline of the Notice Details subsection. It is one-column or 259 points in width, and its height is dependent on dynamic content.

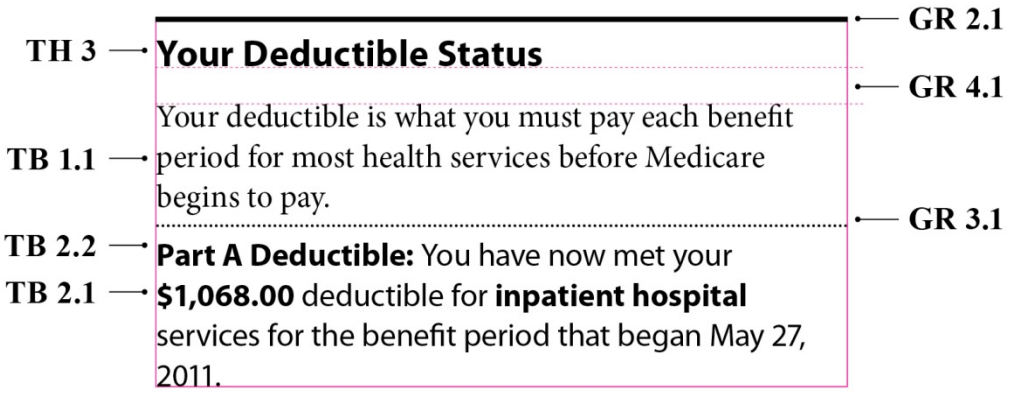

figure 10.3.3.E

FORMATTING

[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.1] generic descriptive body text
[GR 3.1] dotted rule
[TB 2.2] deductible header [TB 2.1] beneficiary-specific body text
[TB 2.2] dynamic elements within beneficiary-specific text

PART A INPATIENT, HOSPICE, AND HOME HEALTH (A) SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For Part A claims, content in the beneficiary-specific portion of this subsection is subject to the following variations:

At least one claim is for Part A Inpatient services that do carry a deductible and (e.g., inpatient hospital care) relate to a single benefit period, and

- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the benefit period; or
- The beneficiary has met his or her deductible in full for the benefit period.

or

- At least two claims are for Part A Inpatient services that do carry a deductible and relate to multiple benefit periods, and
- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for all benefit periods; or
- The beneficiary has met his or her deductible in full for all benefit periods; or
- The beneficiary has a mixture of met and unmet deductibles for the benefit periods related to claims on the notice.

or

- Claims are for Part A services, but not for any services with a Part A deductible (e.g., Skilled Nursing Facility, home-health, or hospice care).

See Exhibit 2.3 for example scenarios for Part A Inpatient and combined Part A Inpatient and ‘B of A’.

Single Benefit Periods

Only one active benefit period related to the claims listed on the statement should be printed. If there are any additional claims that pertain to another benefit period, suppress the status.

Variable and Dynamic Content

If the notice does contain at least one inpatient claim, one or some combination of the following statements should be printed:

> You have now met **${#,###.##}** of your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.
>
> or
>
> You have now met your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.

Or, if all the notice's claims do <u>not</u> carry a deductible - as for Skilled Nursing Facility, home-health, and hospice claims - the beneficiary-specific portion of this subsection should contain the following statement:

> You did not have inpatient hospital claims this claim period, so you did not have to pay towards the Part A deductible.

Or, if all the notice's claims are rejected, and there is no deductible information, the beneficiary-specific portion of this subsection should contain the following statement:

> You did not have *any payable* claims this claim period, so you did not have to pay towards the Part A deductible.

Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met **${#,###.##}** of your **${#,###.##}** deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated benefit period, as of the date the MSN was printed.

The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related benefit period. (In the second variation, where the beneficiary has met his or her deductible in full, only the total deductible amount needs to be indicated.)

Note that the amount should be rounded to the nearest whole dollar. Insert a comma between the thousands' digit and the hundreds' digit of any four-figure amount. If the beneficiary has not paid any amount toward his or her deductible, use **$0.*00*** for zero (e.g., You have now met **$0.*00*** of your **$1,068.*00*** deductible.).

The dynamic date should reflect the start date of the inpatient hospital benefit period associated with the claim.

CONTENT

Language for the Part A Inpatient deductible subsection is as follows:

> **Your Deductible Status**
>
> Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.
>
> **Part A Deductible:** You have now met **${#,###.##}** of your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.
>
> or, if the claim is without a deductible use:
>
> **Your Deductible Status**
>
> Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.
>
> **Part A Deductible:** You did not have inpatient hospital claims this claim period, so you did not have to pay towards the Part A deductible.

or, if the claim is without a deductible information due to rejected claims:

> ***Your Deductible Status***
>
> *Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.*
>
> ***Part A Deductible:*** *You did not have any payable claims this claim period, so you did not have to pay towards the Part A deductible.*

PART B (ASSIGNED AND UNASSIGNED) AND 'B OF A' SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For MSNs with claims paid by the Part B program - including Home Health (B), DME, and 'B of A' claims - the content in the beneficiary-specific portion of this subsection is subject to the following variations:

Claims relate to a single calendar year, and

- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the year; or
- The beneficiary has met his or her deductible in full for the year.

or

- Claims relate to multiple calendar years, and
- The beneficiary has paid nothing or has paid a portion of his or her deductible but has not yet met it in full for all calendar years; or
- The beneficiary has met his or her deductible in full for all calendar years; or
- The beneficiary has a mixture of met and unmet deductibles for the calendar years related to claims on the notice.

See Exhibit 2.2 for examples of different deductible scenarios for Part B MSNs.

Variable and Dynamic Content

There are two basic Part B deductible statements, with up to three dynamic fields:

> You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.
> *or*
>
> You have now met your **${###.##}** deductible for {YYYY}.

Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met {**$###.##**} of your {**$###.##**} deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated year, as of the date the MSN was printed. The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related year. (In the second variation, where the beneficiary has met his or her deductible in full, only the year needs to be indicated.)

The dynamic date should reflect the calendar year period associated with the claim(s).

Single vs. Multiple Years

If all claims on a notice relate to a single calendar year, the applicable statement above should be printed for that calendar year.

If claims relate to more than one calendar year, use the language above to describe the beneficiary's status for each year for which claims appear on the MSN, up to a maximum of three. If there are more than three benefit years referenced by the claims on the MSN, list the deductible status of the three most recent years.

CONTENT

Language for the Part B deductible subsection is as follows:

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** *deductible for {YYYY}.*

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: *You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.*

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY*}. You have now met your **${###.##}** deductible for {YYYY}.* You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For MSNs with claims paid by the Part B program - including Home Health (B), DME, and 'B of A' claims - the content in the beneficiary-specific portion of this subsection is subject to the following variations:

Claims relate to a single calendar year, and

- *The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the year; or*
- *The beneficiary has met his or her deductible in full for the year.*

or

- *Claims relate to multiple calendar years, and*
- *The beneficiary has paid nothing or has paid a portion of his or her deductible but has not yet met it in full for all calendar years; or*
- *The beneficiary has met his or her deductible in full for all calendar years; or*
- *The beneficiary has a mixture of met and unmet deductibles for the calendar years related to claims on the notice.*

or

- *The claim listed is denied for being a duplicate, and*
- *The beneficiary deductible status is not available to list because the claims data does not go to CWF.*

See Exhibit 2.2 for examples of different deductible scenarios for Part B MSNs.

Variable and Dynamic Content

There are two basic Part B deductible statements, with up to three dynamic fields:

*You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.*

or

*You have now met your **${###.##}** deductible for {YYYY}.*

Or

You did not have any payable claims this claim period, so you did not have to pay towards the Part B deductible.

*Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met {**$###.##**} of your {**$###.##**} deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated year, as of the date the MSN was printed. The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related year. (In the second variation, where the beneficiary has met his or her deductible in full, only the year needs to be indicated.)*

The dynamic date should reflect the calendar year period associated with the claim(s).

Single vs. Multiple Years

If all claims on a notice relate to a single calendar year, the applicable statement above should be printed for that calendar year.

If claims relate to more than one calendar year, use the language above to describe the beneficiary's status for each year for which claims appear on the MSN, up to a maximum of three. If there are more than three benefit years referenced by the claims on the MSN, list the deductible status of the three most recent years.

CONTENT
Language for the Part B deductible subsection is as follows:

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.
Part B Deductible: *You have now met your **${###.##}** deductible for {YYYY}.*

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.
Part B Deductible: *You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.*

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: *You have now met your* ***${###.##}*** *deductible for {YYYY}. You have now met* ***${###.##}*** *of your* ***${###.##}*** *deductible for {YYYY}.*

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: *You have now met your* ***${###.##}*** *deductible for {YYYY}. You have now met your* ***${###.##}*** *deductible for {YYYY}. You have now met* ***${###.##}*** *of your* ***${###.##}*** *deductible for {YYYY}.*

Or, if the claim is without a deductible use:

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.
Part A Deductible: *You did not have any payable claims this claim period, so you did not have to pay towards the Part B deductible.*

COMBINED PART A INPATIENT AND 'B OF A' SPECIFICATIONS

DYNAMIC RULES

When an MSN contains both Part A and Part B claims, then the deductible status for both types of claims must be listed. Follow the rules above for generating the beneficiary-specific content. Following the generic introduction, place the Part A deductible information, then the Part B deductible information.

CONTENT

Sample content for a combined deductible section:

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met **${#,###.##}** of your **${#,###.##}** deductible *for inpatient* hospital services for *the benefit* period that began on {**Month DD, YYYY**}.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY} and **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

F. Be Informed

This subsection contains changeable messaging from CMS.

POSITION

The position of this subsection is dynamic. The content area follows the Deductible Status subsection with 19 points from the baseline of the last line of the Deductible Status subsection. It is one-column wide with a variable length depending on the body text.

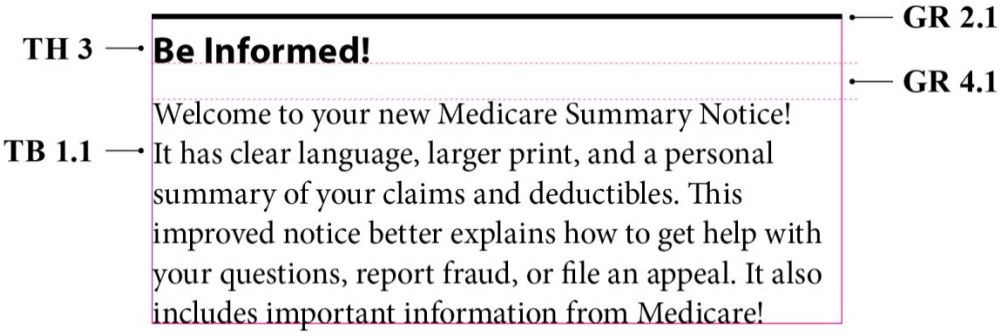

figure 10.3.3.F

FORMATTING
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.1] body text

DYNAMIC RULES

This subsection can accommodate one message from CMS of up to 300 characters (inclusive of spaces).

The current message for this subsection, also previously known as Be Informed, can be found *on the CMS website:* http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html?redirect=/MSN/02_MSNMessages.asp

CONTENT

Be Informed!
{CMS message of up to 300 characters]

G. Status Notification

This subsection contains high-priority messages to beneficiaries about the nature and status of the notice.

POSITION

This subsection contains text content of a variable size.
The content area begins (3.9″, 1.54″), is one-column or 259 points in width with variable height, and has from one to two lines of text.

[The below figures have been revised.]

figure 10.3.3.G1

figure 10.3.3.G2

figure 10.3.3.G3

figure 10.3.3.G4

FORMATTING

[TH 4] Big Header, all caps, center aligned
[TH 3] Small Header, center aligned

DYNAMIC RULES
The content of this section is variable depending on whether the notice is original or a duplicate copy of a previously generated notice or a Pay MSN.

If the notice is an original MSN, then the notification header indicates that the notice is not a bill.

If the notice is a duplicate, then the notification header indicates that the notice is a duplicate copy, and the subtitle indicates that the notice is not a bill. For an example of a duplicate MSN, see Exhibit 2.1.

If the notice is a Pay MSN, then the notification header indicates that the notice has a check enclosed, and the subtitle indicates that the notice is not a bill. For examples of Pay MSNs, see the Exhibits section.
CONTENT

THIS IS NOT A BILL

or

DUPLICATE COPY
This Is Not a Bill

or

CHECK ENCLOSED
This Is Not a Bill
or

CHECK SENT SEPARATELY
This Is Not a Bill

H. Claims & Costs

This subsection contains a summary of the approval status of the claims on the notice and the beneficiary's total liability for those claims. This subsection has two states: approved and denied. For examples of the Claims & Cost chart, reference any of Exhibits 1.1 through 1.9, showing the extended family of MSNs.

POSITION

The starting position of this subsection is fixed, although its length is variable.

The content area begins (3.9″, 2.75″). This subsection should top-align with the Notice Details subsection on the left column. It is one-column or 259 points in width and has a variable height dependent on dynamic content.

The "approved" version has five lines. The "denied" version has seven lines. Questions in bold have corresponding answers that are right aligned. Questions and static text field have a maximum of 27 characters, and the answer fields have a maximum of four characters. The total line, in a gray field, is to have a maximum of 12 characters for the total dollar amount.

figure 10.3.3.H1

FORMATTING - APPROVED
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.2] approval question [TB 2.2] “Yes”, all caps, right aligned
[GR 5] space after text
[TB 1.1] note text under approval
[GR 3.1] dotted rule
[GR 1] gray fill
[TB 2.2] total header [TB 2.2] Total amount, right aligned

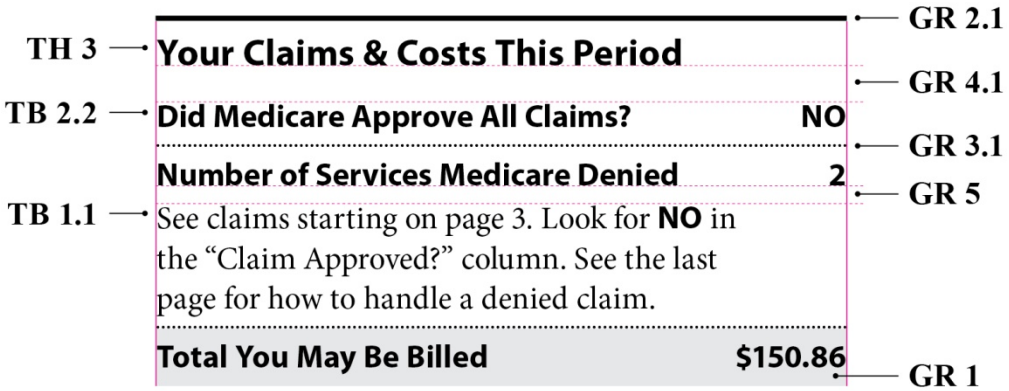

figure 10.3.3.H2

FORMATTING - DENIED
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.2] approval question [TB 2.2] “No”, bold, all caps, right aligned
[GR 3.1] dotted rule
[TB 2.2] number denied [TB 2.2] right aligned
[TB 1.1] note text under approval
[GR 3.1] dotted rule
[GR 1] gray fill
[TB 2.2] total header [TB 2.2] Total amount, right aligned

DYNAMIC RULES

This subsection contains up to three dynamically generated units of content:

Items approved or denied

The first content unit relates to whether all the claim items on the notice were approved. If yes, then the first two-line language option below should be printed, with a dynamically generated "YES" in all capital letters. If not, then the second, three-line language option should be included, with a dynamically generated "NO" in bold, all capital letters, plus a line totaling the number of denied claim items on the notice. (Note that this should correspond to a count of all the line items in the Claims section with NO in the "Service Approved?" column.)

Total MSN liability

The second content unit provides a dollar figure of the total amount of the beneficiary's liability for the claims on the notice. This should correspond to a sum of all the "Maximum You May Be Billed" claim totals on the notice.

Note that the amount should <u>not</u> be rounded - it should include any cents. Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or greater amount. If the beneficiary does not have any financial liability for the claims on the MSN, use **$0.00** for zero.

PART A INPATIENT SPECIFICATIONS

CONTENT

> **Your Claims & Costs This Period**
> **Did Medicare Approve All Claims?** {**YES}**
> See page 2 for how to double-check this notice
>
> or
>
> **Did Medicare Approve All Claims?** {**NO**}
> **Number of Claims Medicare Denied** {**# of claims denied**}
>
> See claims starting on page 3. Look for **NO** in the "Claim Approved?" column. See the last page for how to handle a denied claim.
>
> **Total You May Be Billed** **$**{**###,###.##**}

'B OF A',, HOSPICE, HOME HEALTH AND PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Services? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Services? {**NO**}
Number of Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

DME (ASSIGNED AND UNASSIGNED) Specifications

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Items and Services? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Items and Services? {**NO**}
Number of Items or Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Item/Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

COMBINED MSN: PART 1 INPATIENT, HOSPICE, HOME HEALTH OR 'B OF A', SPECIFICATIONS

CONTENT
Your Claims & Costs This Period
Did Medicare Approve All Claims and Services? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Claims and Services? {**NO**}
Number of Claims and Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

I. Facility/Provider/Supplier List
This subsection contains a dynamically generated summary of the providers/suppliers/facilities that submitted claims on the notice.

Up to six providers/suppliers/facilities may be listed here; each unique provider/supplier/facility should only be listed once, even if they submitted multiple claims. See Exhibit 2.4 for an example of a list that contains the maximum six providers/suppliers/facilities.

GLOBAL SPECIFICATIONS

POSITION

The position of this subsection is dynamic. The content area follows the Claims & Costs subsection on the right column with 19 points from the baseline. It is one-column or 259 points in width with a variable length, depending on the number of providers listed. The heading of the subsection is also dynamic, depending upon the member of the MSN family.

The facility/provider/supplier name has a maximum of 40 characters. The date and name of the provider/supplier/facility should be contained on one line each.

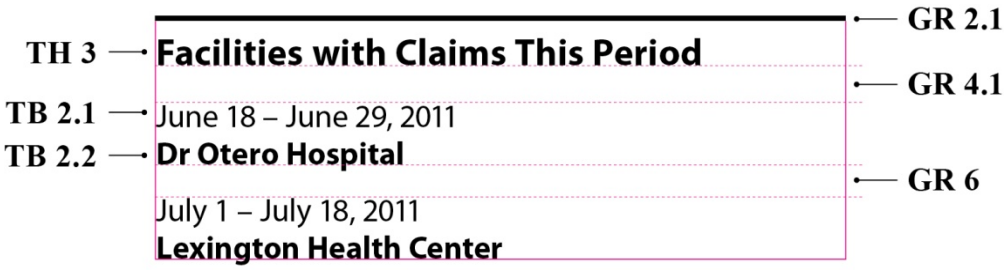

figure 10.3.3.I

FORMATTING
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.1] date
[TB 2.2] provider/facility/supplier name
[GR 6] space between paragraphs
[TB 2.1] date
[TB 2.2] provider/facility/supplier name
[GR 6] space between paragraphs
[TB 2.1] date
[TB 2.2] provider/facility/supplier name

(if more than 6 providers)

[GR 3.1] dotted rule
[TB 1.1] provider continuation note

DYNAMIC RULES

Providers should be listed in chronological order, by first date of service. The date is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a provider has multiple claims and/or multiple dates of service, list the first and last date of service for that provider, separated by an en-dash; insert spaces to either side of the en-dash. If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

In case of Part B, when there is more than one provider on a single claim, list the name of the first provider filing the claim.

In the event that the notice includes more than six unique providers, stop printing the list after the sixth chronological unique provider and insert the "You have more…" note listed in the Content specifications below.

PART A INPATIENT AND *'B OF A',* SPECIFICATIONS

CONTENT

Facilities with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}
or

{Month DD, YYYY} - {Month DD, YYYY}
{Facility Name}
[repeat, up to six unique facilities; if more than six exist, insert:]
You visited more facilities this period. Go to your complete list of claims, starting on page 3.

PART B (ASSIGNED AND UNASSIGNED), HOSPICE, AND HOME HEALTH (A) AND (B) SPECIFICATIONS

CONTENT

Providers with Claims This Period
{Month DD, YYYY}

or
{Month DD} - {Month DD, YYYY}

or

{Month DD, YYYY} - {Month DD, YYYY}
{Provider Name}

[repeat, up to six unique providers; if more than six exist, insert:]
You saw more providers this period. Go to your complete list of claims, starting on page 3.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

Suppliers with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}

or

{Month DD, YYYY} - {Month DD, YYYY}
{Supplier Name}
[repeat, up to six unique suppliers; if more than six exist, insert:]
You bought from more suppliers this period. Go to your complete list of claims, starting on page 3.

COMBINED MSN: PART A INPATIENT, HOSPICE OR HOME HEALTH SPECIFICATIONS

CONTENT

Facilities and Providers with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}
or

{Month DD, YYYY} - {Month DD, YYYY}
{Facility or Provider Name}
[repeat, up to five unique facilities; if more than five exist, insert:]
You visited more facilities this period. Go to your complete list of claims, starting on page 3.

J. Foreign Language Footer

This subsection contains a flash image with instructions for Spanish and Mandarin speakers.

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length. It begins (0″, 9.7″), and it is full-page or 540 points in width and 27 points in height.

NOTE: The image area will go beyond the 0.5 inch bottom margin of the page. This is an exception just for the first page, and all pages to follow should follow the standard margin.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en española.
如果需要国语帮助，请致电联邦医疗保险，请先说“agent”，然后说”Mandarin”. **1-800-MEDICARE (1-800-633-4227)**

figure 10.3.3.J

FORMATTING
[GL 2] foreign-language footer

DYNAMIC RULES
n/a
CONTENT
n/a

10.3.4 - Specifications for Header for Other Pages

(Rev. 2522, Issued: 08-21-12, Effective: 07-01-12 (Analysis and Design) 10-01-12 (Final Design Testing) 01-03-13(Final Implementation), Implementation: 07-01-12 (Analysis and Design) 10-01-12 (Final Design Testing) 01-03-13(Final Implementation)

This element repeats at the top of every page of the MSN, except for the first page. It contains the beneficiary’s name, a notification, and page numbering.

POSITION

This subsection is of a fixed size. It does not vary in overall width or length.

It begins (0″, 0″) and is full-page or 540 points in width.

The first content unit, the beneficiary's name, is flush left. The second content unit, containing the notification text and page numbering, is flush right.

figure 10.3.4

FORMATTING

[TB 2.2] beneficiary name
[TB 2.2] "This Is Not a Bill", all caps, right aligned
[TB 2.1] "|", then page number, right aligned

DYNAMIC RULES

This section contains two dynamic elements, the beneficiary's name and the page numbering.

The beneficiary's name should be printed with the given name first, followed by any middle initial(s), the family name, then any suffixes (e.g., Jr.)

The page number indicator, in the format {Page # of #}, must include the number of the page on which the element appears and, in the second numeric position, the total page count for the notice.

CONTENT

> **{Beneficiary's Given Name}{Beneficiary's Middle Initials}{Beneficiary's Family Name}{Beneficiary's Suffix}**
> **THIS IS NOT A BILL |** {Page # of #}

10.3.5 - Specifications for Section 2: Making the Most of Your Medicare (Page 2)

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Section Title

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 5″), 7 points from the baseline of the Headers for Other Pages subsection. It is full-page or 540 points in width and 24 points in height.

figure 10.3.5.A

FORMATTING

[GR 2.1] black rule
[TH 2] section name

DYNAMIC RULES
N/A - this section is static.

CONTENT
Making the Most of Your Medicare

B. How to Check This Notice

Global Specifications
POSITION

This subsection contains information of varying size per MSN type. It does not vary in overall width or length per type.

The content area begins (0″, 0.94″), 28 points from the baseline of the Section Title subsection. It is one-column or 259 points in width and varies in height depending on the MSN type. Content is static per type.

Indent 8 points from the top, left, and right, and 12 points at bottom to begin content area.

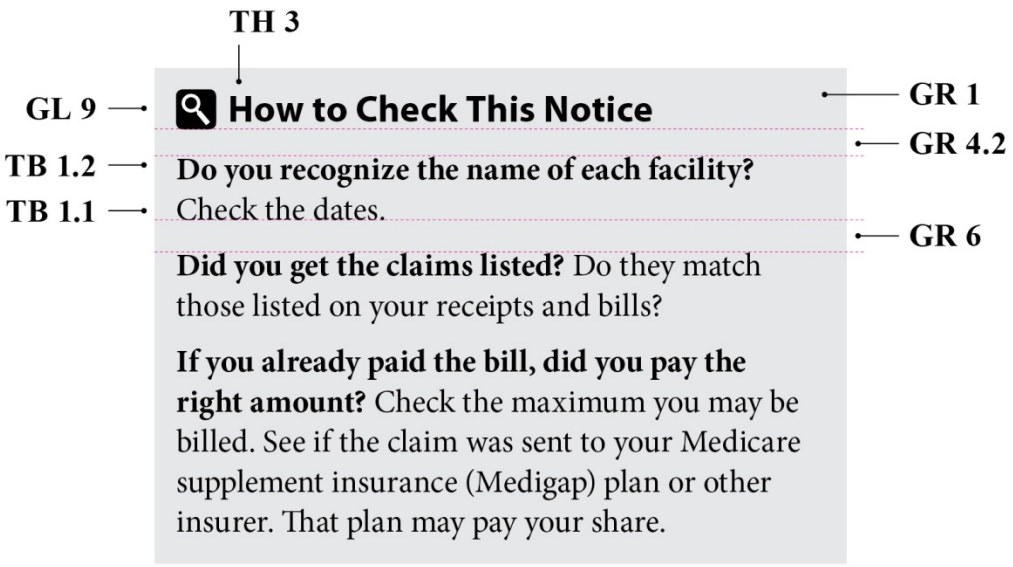

figure 10.3.5.B

FORMATTING

[GL 9] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph
[GR 6] space between paragraph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph
[GR 6] space between paragraph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph

DYNAMIC RULES

The body-text content varies depending on which member of the extended family the MSN belongs to - see the content specifications below.

PART A INPATIENT AND 'B OF A', SPECIFICATIONS

CONTENT

How to Check This Notice
Do you recognize the name of each facility? Check the dates.
Did you get the claims listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

HOSPICE AND HOME HEALTH SPECIFICATIONS

CONTENT

How to Check This Notice
Do you recognize the name of each doctor or provider? Check the dates. Did you have *a visit or service* that day?
Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Check This Notice
Do you recognize the name of each **doctor or provider?** Check the dates. Did you have an appointment that day?
Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Check this Notice
Do you recognize the name of each supplier? Check the dates. Did you make a purchase that day?
Did you get the items/services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

C. How to Report Fraud

Global Specifications

POSITION

This subsection is fixed in width and varies in length depending on content, however the position is dynamic.

The content area begins 19 points from the baseline of the How to Check This Notice subsection. It is one-column or 259 points in width.

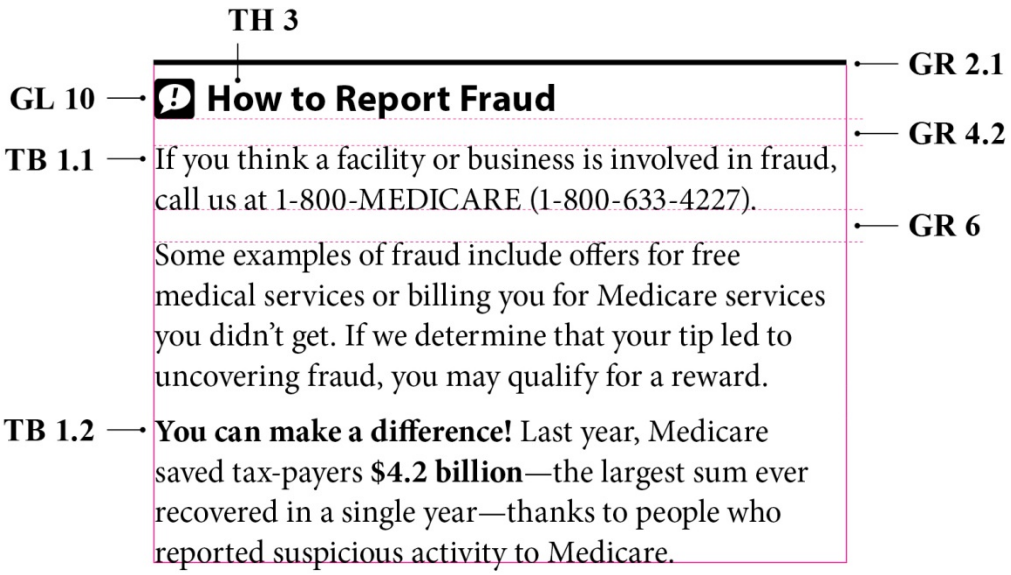

figure 10.3.5.C

FORMATTING

[GR 2.1] black rule
[GL 10] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence highlight [TB 1.1] body text

DYNAMIC RULES

Body-text content in the first paragraph varies depending on which member of the extended family the MSN belongs to - see the content specifications below.
The third and final paragraph of this section contains a fraud-specific message from CMS. The message must be a maximum 185 characters long (inclusive of spaces). The current fraud-specific message can be found *on the CMS website:*
http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html?redirect=/MSN/02_MSNMessages.asp

PART A INPATIENT AND 'B OF A', SPECIFICATIONS

CONTENT

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.
{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

PART B (ASSIGNED AND UNASSIGNED), HOSPICE, AND HOME HEALTH SPECIFICATIONS

CONTENT

How to Report Fraud
If you think a provider or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Report Fraud

If you think a supplier or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

D. How to Get Help with Your Questions

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

This subsection begins 19 points below the How to Report Fraud subsection. It is one-column or 259 points in width and 142 points in height.

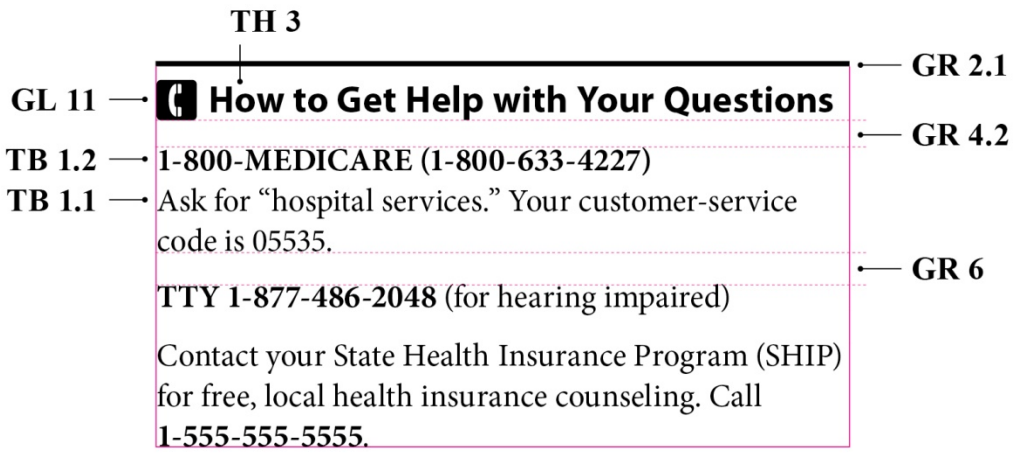

figure 10.3.5.D

FORMATTING

[GR 2.1] black rule
[GL 11] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.2] phone number
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] TTY phone number [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text [TB 1.2] SHIP phone number highlight

DYNAMIC RULES

This subsection contains three pieces of dynamic content: language in the first paragraph that's variable by extended-family member; a *MAC* ID number; and the SHIP phone number.

Body-text content in the first paragraph varies depending on which member of the extended family the MSN belongs to - see the content specifications below.

The first paragraph also contains the printing *MAC*'s ID number, in order to assist in tracking and routing beneficiary calls to the Medicare call center. This ID number is referred to on the notice as a "customer-service code."

The final paragraph should contain the primary phone number for the State Health Insurance Office, corresponding to the state listed in the notice mailing address in Section 1. The phone numbers for the SHIP offices can be found *on the CMS website:* http://www.medicare.gov/contacts/organization-search-criteria.aspx.

NOTE*: If the mailing address is that of the legal representative and the beneficiary's address indicates that the beneficiary lives outside of the 50 U.S. states and U.S. territories, then the final paragraph should be suppressed.*

PART A INPATIENT, HOSPICE, HOME HEALTH, AND 'B OF A', SPECIFICATIONS

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "hospital services" Your customer-service code is {5-DIGIT *A/B MAC (A)* ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE**}**.

Or, if the MSN mailing address is outside the 50 states:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "hospital services." Your customer-service code is {5-DIGIT *A/B MAC (A)* ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "doctors services." Your customer-service code is {5-DIGIT *A/B MAC (B)* ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE**}**.

Or, if the MSN mailing address is outside the 50 states:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "doctors services." Your customer-service code is {5-DIGIT *A/B MAC (B)* ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "medical supplies." Your customer-service code is {5-DIGIT *DME MAC* ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE**}**.

Or, if the beneficiary's pricing state is outside the 50 U.S. states and U.S. territories:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "medical supplies." Your customer-service code is {5-DIGIT *DME MAC* ID CODE}.
TTY 1-877-486-2048 (for hearing impaired)

E. Your Benefit Periods

This subsection is only for Part A Inpatient MSNs. It can also be included in combined Part A Inpatient and 'B of A' MSNs. It should be suppressed for Hospice, Home Health, Part B (assigned and unassigned), and DME (assigned and unassigned).

The Your Benefit Periods subsection may contain up to three dynamically generated content units, providing beneficiary-specific information related to inpatient hospital benefit days, inpatient lifetime reserve days*, inpatient mental health care in a psychiatric hospital limit,* and skilled nursing facility (SNF) benefit days.

Language variations exist to describe whether a beneficiary has used all their benefit days for a given type of claim period, or if benefit days remain.

See Exhibit 2.3 for examples of different scenarios regarding benefit periods.

POSITION

This subsection begins (3.9″, 0.94″). This should top align with the How to Check This Notice subsection on the left column. It is one-column or 259 points in width with a variable height, dependent on dynamic content.

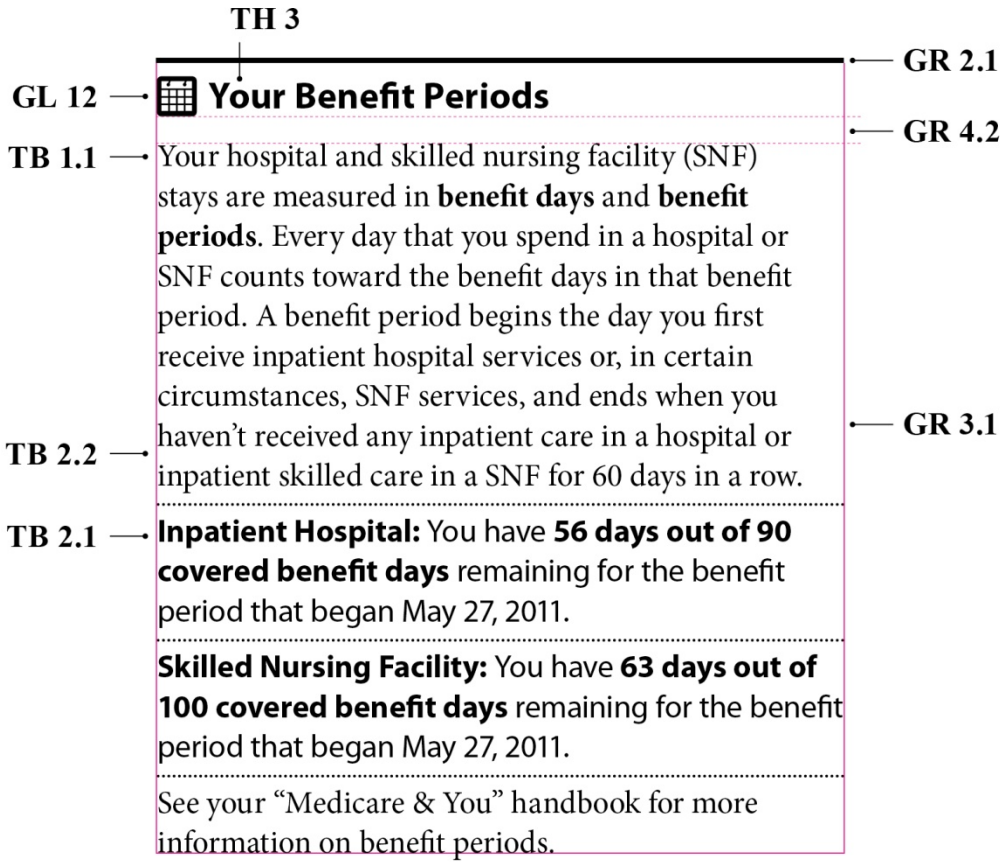

figure 10.3.5.E

FORMATTING

[GR 2.1] black rule
[GL 12] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph

[TB 1.1] body text of intro paragraph [TB 1.2] text in bold
[GR 3.1] dotted rule
[TB 2.2] headers for benefit period types [TB 1.1] beneficiary-specific dynamic data within benefit-period info
[GR 3.1] dotted rule
[TB 2.2] headers for benefit period types [TB 1.1] beneficiary-specific dynamic data within benefit-period info
[GR 3.1] dotted rule
[TB 1.2] final paragraph

INPATIENT HOSPITAL DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- *If a claim on the notice is for an inpatient hospital stay, and*
- *The benefit period associated with the claim was still active on the notice date of the MSN - because fewer than 60 days had passed between the last claimed date of stay in the benefit period and the notice date - then this subsection should list how many covered benefit days remain in the benefit period; or*
- *The benefit period associated with the claim is closed - because more than 60 days had passed since the last claimed date of stay and the notice date - then this subsection should indicate that the benefit period has ended.*
- *There is no benefit period associated with the claim because it was rejected, therefore no benefit days were used.*

The possible dynamic statements for inpatient hospital days are as follows:

You have **{#} out of 90 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

or

You have used all of your 90 covered benefit days for the benefit period that began {Month DD, YYYY}.

or

The benefit periods for all claims on this notice have ended.

or

You didn't have an active benefit period.

LIFETIME RESERVE DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- *If a claim on the notice is for an inpatient hospital stay and all inpatient hospital benefit days for the benefit period have been exhausted, and all or a portion of the claimed days have been paid using inpatient lifetime reserve days, and*

- *The beneficiary still has some number of inpatient lifetime reserve days available, then this subsection should list the remaining inpatient lifetime reserve days the beneficiary had on the date of the notice; or*

- *The beneficiary had exhausted all of their inpatient lifetime reserve days, then this subsection should indicate that all inpatient lifetime reserve days have been used.*

- *The beneficiary did not use any inpatient lifetime reserve days because the claim was rejected.*

The possible dynamic statements for inpatient lifetime reserve benefit days are as follows:

You have **{#} out of 60 lifetime reserve days** remaining.

or

You have used all of your 60 lifetime reserve days.

or

You *didn't* have *an active benefit period.*

***INPATIENT MENTAL HEALTH* DAYS**

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- *If a claim on the notice is for an inpatient mental health care in a psychiatric hospital stay, and*

- *The beneficiary still has some number of lifetime mental health care days available, then this subsection should list the remaining lifetime mental health care days the beneficiary had on the date of the notice; or*

- *The beneficiary had exhausted all of their lifetime mental health care days, then this subsection should indicate that all lifetime mental health care days have been used.*

- *The beneficiary did not use any mental health care days because the claim was rejected.*

The possible dynamic statements for inpatient lifetime reserve benefit days are as follows:

You have ***{#} out of*** **190** ***mental health care days*** *remaining.*

or

You have used all of your 190 *mental health care reserve days.*

or

You didn't have an active benefit period.

SKILLED NURSING FACILITY DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- If a claim on the notice is for a skilled nursing facility (SNF) stay, and

- The benefit period associated with the claim was still active on the notice date of the MSN - because fewer than 60 days had passed between the last claimed date of stay in the benefit period and the notice date - then this subsection should list how many covered benefit days remain in the benefit period; or

- The benefit period associated with the claim is closed - because more than 60 days had passed since the last claimed date of stay and the notice date - then this subsection should indicate that the SNF benefit period has ended.

- *There is no benefit period associated with the claim because it was rejected, therefore no benefit days were used.*

The possible dynamic statements for skilled nursing facility hospital days are as follows:

You have **{#} out of 100 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

or

You have used all of your 100 covered benefit days for the benefit period that began {Month DD, YYYY}.

or

The benefit periods for all claims on this notice have ended.

or

You didn't have an active benefit period.

DYNAMIC RULES

In an open inpatient hospital or skilled nursing facility benefit period, the number of remaining covered/reserve days should reflect the number of days that remained on the notice date. If the beneficiary had no remaining benefit days on that date, but the period was still open, then the second inpatient/SNF statement above should be used, indicating that all benefit days have been used for the period beginning on the stated date.

Only one active benefit period related to the claims listed on the statement should be printed. If there are any additional claims that pertain to another benefit period, suppress the status.

If claims on the notice use any combination of inpatient hospital days, inpatient lifetime reserve days, *inpatient mental health care days* or skilled nursing facility (SNF) days, then all of the applicable statements, as described above, should be included in this subsection.

If claims did not use lifetime reserve days *or inpatient mental health care days*, suppress this section and list skilled nursing facility benefit period immediately after inpatient hospital.

CONTENT

Static content, and sample dynamic content, is as follows:

Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have {**#**} **out of 90 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

Inpatient Lifetime Reserve: You have **{#} out of 60 lifetime reserve days** remaining.

Inpatient Mental Health: *You have* ***{#} out of 190 mental health care days*** *remaining.*

Skilled Nursing Facility: You have {**#**} **out of 100 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

See your "Medicare & You" handbook for more information on benefit periods.

F. Medicare Preventive Services

This subsection is only for Part B assigned and unassigned MSNs. It should be suppressed on all other types including Part A Inpatient, Hospice, *Home Health*, 'B of A', and DME. For Part A Inpatient claims, this subsection should be replaced by the Your Benefit Periods subsection, described above.

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

It begins (3.9″, 0.94″). This should top align with the How to Check This Notice subsection on the left column. It is one-column or 259 points in width and 139 points in height.

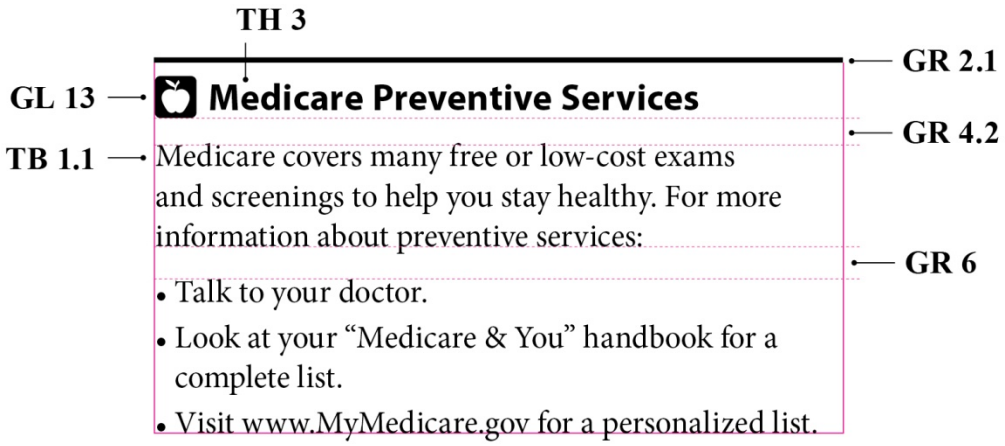

figure 10.3.5.F

FORMATTING

[GR 2.1] black rule
[GL 14] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.1] body text of intro paragraph
[GR 6] space between paragraph
[TB 1.1] body text of bulleted paragraph

DYNAMIC RULES

This section should be printed only on Part B assigned and unassigned notices. The content of the section is completely static.
CONTENT

Medicare Preventive Services
Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:

- Talk to your doctor.
- Look at your "Medicare & You" handbook for a complete list.
- Visit www.MyMedicare.gov for a personalized list.

G. Your Messages from Medicare

POSITION

The position of this subsection varies depending on the extended family member: On Part A Inpatient and combined MSNs, it follows the Your Benefit Periods subsection, positioned 19 points from the baseline. On Part B assigned and unassigned MSNs, it follows the Medicare Preventive Services subsection, with 19 points of space from the baseline. On Hospice, Home Health (A) and (B), 'B of A', and DME MSNs, it has a fixed start location at (3.9″, 0.94″), and is top aligned with the How to Check This Notice subsection.

In all cases, it is one-column or 259 points in width with variable height from the dynamic content, depending on the length of the CMS messages.

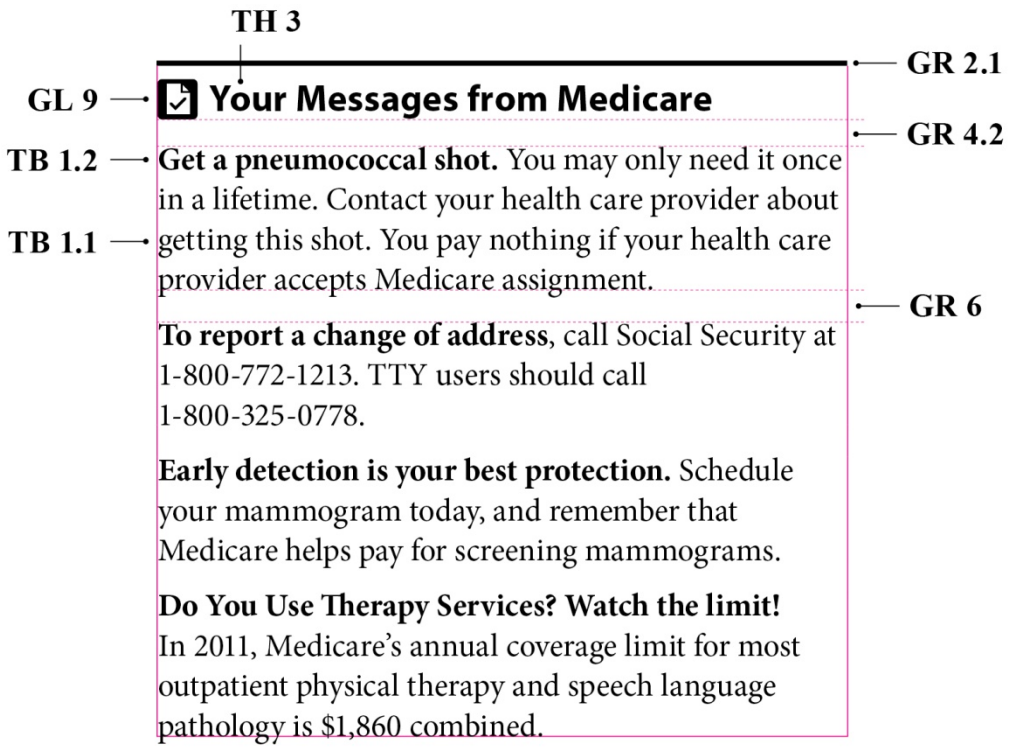

figure 10.3.5.G

FORMATTING

[GR 2.1] black rule
[GL 9] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.2] first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text

DYNAMIC RULES

This subsection can accommodate up to four messages from CMS. *First and second* messages must be no longer than 200 characters *(inclusive of* spaces*) and third and fourth messages must be no longer than 250 characters (inclusive of spaces).*

Current messages for this subsection, previously known as General Information Messages from Medicare, can be found *on the CMS website:* http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html.
The first sentence, or the phrase up to the punctuation, will be bolded depending on the message. Specific detail on where to bold will be provided by the CR of the variable messages.

10.3.6 - Specifications for Section 3: Claims

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Section Title

POSITION

This subsection contains information of a fixed size. It is fixed in width but may vary in overall length.

The content area begins (0″, 0.22″), 7 points from the baseline of the content described above under the Headers for Other Pages subsection. It is full-page or 540 points in width and variable in height.

figure 10.3.6.A

FORMATTING

[GR 2.1] black rule
[TH 2] section header

DYNAMIC RULES

The language in this section varies for different members of the extended family of MSNs. See the specific content specifications below for details.

When there is a combined MSN for Part A, order the claims as follows:

- *Part A Inpatient*
- *'B of A'*
- *Home Health*
- *Hospice*

When there is a combined MSN for Part B or DME, order the claims as follows:

- *Assigned*
- *Unassigned*

PART A INPATIENT SPECIFICATIONS

CONTENT

Your Inpatient Claims for Part A (Hospital Insurance)

HOSPICE SPECIFICATIONS

CONTENT

Your Hospice Claims for Part A (Hospital Insurance)

HOME HEALTH SPECIFICATIONS

CONTENT

Your Home Health Claims for Part A (Hospital Insurance)

PART B ASSIGNED AND DME ASSIGNED SPECIFICATIONS
CONTENT

Your Claims for Part B (Medical Insurance)

PART B UNASSIGNED AND DME UNASSIGNED SPECIFICATIONS

CONTENT

Your Unassigned Claims for Part B (Medical Insurance)

'B OF A' SPECIFICATIONS

CONTENT

Your Outpatient Claims for Part B (Medical Insurance)

B. Definitions of Columns

GLOBAL SPECIFICATIONS

POSITION

The subsection usually begins (0″, 0.94″) or 28 points from the baseline of the Section Title subsection. The content area is full-page or 540 points in width but is divided into two columns, each column 259 points in width with 22 point gutter in between. The height is variable, depending on the length of the content, which is determined by the member of the extended family to which the MSN belongs. The left column should always be longer than the right column. If a definition is split between the columns, there should be at least two lines on both left and right columns.

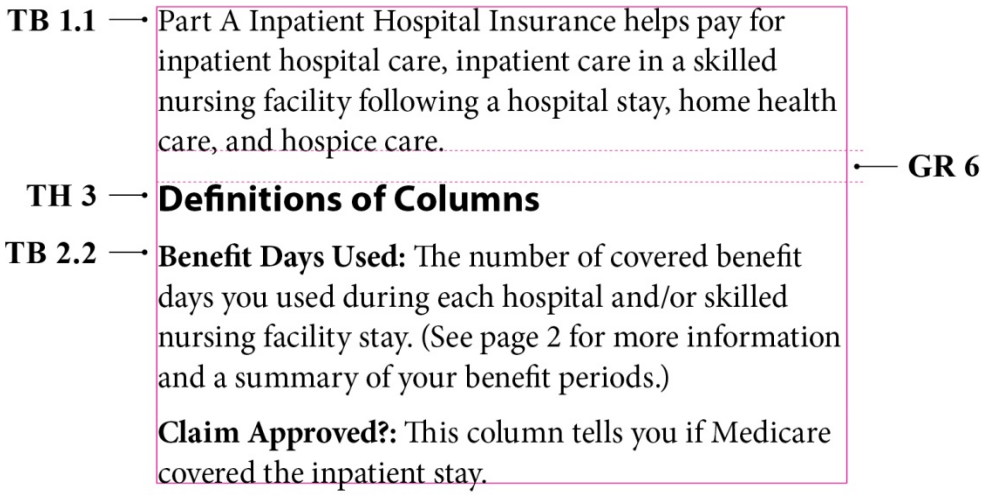

figure 10.3.6.B

FORMATTING

[TB 1.1] first paragraph and body text of subsequent paragraphs
[GR 6] space between paragraph
[TH 3] column-definition title
[GR 6] space between paragraph
[TB 1.2] definition terms, through colon [TB 1.1] definition

Note: The column header is bolded with the rest of the type usually in regular Roman text. There are a few instances where there may be additional bolded words within the body text.

DYNAMIC RULES

The language in this section differs for each member of the extended family of MSNs. See the specific content specifications below for details.

PART A INPATIENT SPECIFICATIONS

CONTENT

Part A Inpatient Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.
Definitions of Columns

Benefit Days Used: The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

Claim Approved?: This column tells you if Medicare covered the inpatient stay.

Non-Covered Charges: This is the amount Medicare didn't pay.

Amount Medicare Paid: This is the amount Medicare paid your inpatient facility.

Maximum You May Be Billed: The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

For more information about Medicare Part A coverage, see your "Medicare & You" handbook.

HOSPICE SPECIFICATIONS

CONTENT

Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the hospice service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you. This is usually $0, but can include copayments for outpatient prescription drugs, as well as 5% of the Medicare- approved amount for inpatient respite care. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

HOME HEALTH SPECIFICATIONS
CONTENT

Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the home health service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you. This is usually $0. For durable medical equipment, it can include 20% of the Medicare-approved amount. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

PART B ASSIGNED SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

PART B UNASSIGNED SPECIFICATIONS

CONTENT

Medicare claims may be assigned or unassigned. Your claims below are **unassigned** - meaning the provider hasn't agreed to accept the Medicare-approved amount as payment in full.

Do Unassigned Claims Cost More? Maybe. A provider who doesn't accept assignment may charge you up to 15% over the Medicare-approved amount. This is known as the **limiting charge**. You may have to pay this amount, or it may be covered by another insurer.

For a list of providers that always accept Medicare assignment, visit www.medicare.gov/physician or call 1-800-MEDICARE (1-800-633- 4227). You may save money by choosing providers who accept assignment.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. Since your provider hasn't agreed to accept assignment, you might be charged up to 15% more than this amount. Medicare usually pays 80% of the Medicare-approved amount.

Medicare Paid You: When a provider doesn't accept assignment, Medicare pays you directly. You'll usually get 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

'B OF A' SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for outpatient care provided by certified medical facilities, such as hospital outpatient departments, renal dialysis facilities, and community health centers.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the outpatient service.

Amount Facility Charged: This is the facility's fee for this service.

Medicare-Approved Amount: This is the amount a facility can be paid for a Medicare service. It may be less than the actual amount the facility charged. The facility has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the facility. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the facility is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

DME ASSIGNED SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for durable medical equipment and other health care services.

Definitions of Columns

Item/Service Approved?: This column tells you if Medicare covered this item or service.

Amount Supplier Charged: This is your supplier's fee for this item or service.

Medicare-Approved Amount: This is the amount a supplier can be paid for a Medicare item or service. It may be less than the actual amount the supplier charged. Your supplier has agreed to accept this amount as full payment for covered items or services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This column shows the amount Medicare paid the supplier. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the supplier is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

DME UNASSIGNED SPECIFICATIONS

CONTENT

Medicare claims may be assigned or unassigned. Your claims below are **unassigned** - meaning the supplier hasn't agreed to accept the Medicare-approved amount as payment in full.

Do Unassigned Claims Cost More? Maybe. A supplier who doesn't accept assignment may charge you up to 15% over the Medicare-approved amount. This is known as the **limiting charge**. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment. You may have to pay this amount, or it may be covered by another insurer.

For a list of suppliers that always accept Medicare assignment, visit www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633- 4227). You may save money by choosing suppliers who accept assignment.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the item or service.

Amount Provider Charged: This is your supplier's fee for this item or service.

Medicare-Approved Amount: This is the amount a supplier can be paid for a Medicare item or service. It may be less than the actual amount the supplier charged. Since your supplier hasn't agreed to accept assignment, you might be charged more than this amount (see "Do Unassigned Claims Cost More" to your left). Medicare usually pays 80% of the Medicare-approved amount.

Medicare Paid You: When a supplier doesn't accept assignment, Medicare pays you directly. You'll usually get 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the supplier is allowed to bill you and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

For more information about Medicare assignment, see your "Medicare & You" handbook.

C. Claim Header

GLOBAL SPECIFICATIONS

This subsection contains the name and contact information for the provider and/or referrer of each claim. It also lists the date (or dates) of service for the claim. See Exhibit 2.5 for multiple examples of this section, showing provider and contact

information variations among extended family members. See Exhibit 2.6 for multiple examples of claim headers indicating multiple dates of service.

The sort order for claims is determined by the date of service listed in this section. Claims should be listed by earliest date of service, using the first date of service in a given claim.

For multiple claims with the same earliest date of service, the claims are sorted chronologically by last date of service.

For multiple claims with the same first and last date of service, the claims are sorted alphabetically by billing facility name, provider last name, or supplier name.

For multiple claims with the same first and last date of service and the same billing provider, the claims are sorted by Maximum You May be Billed Amount, with the claim with the lowest amount listed first.

POSITION

This subsection is full-page or 540 points in width and starts 19 points below the definitions of columns. The height is variable, depending on the length of the content, which may be three or four lines high.

Indent in 8 points all around for content area. Note: Space after the black rule should be 8 points, rather than the typical 6 points specified in the style sheet.

The facility/provider/supplier line has a maximum of 40 characters, same as on page 1 on the 'Facility/Provider/Supplier List' subsection. The phone number has a maximum of 30 characters, to include area code and/or any international numbers for U.S. territories. The address line has a maximum of 80 characters. If the address exceeds the maximum character limit, truncate the second address line to fit the address in one line. The referred or ordering provider line also has a maximum of 40 characters.

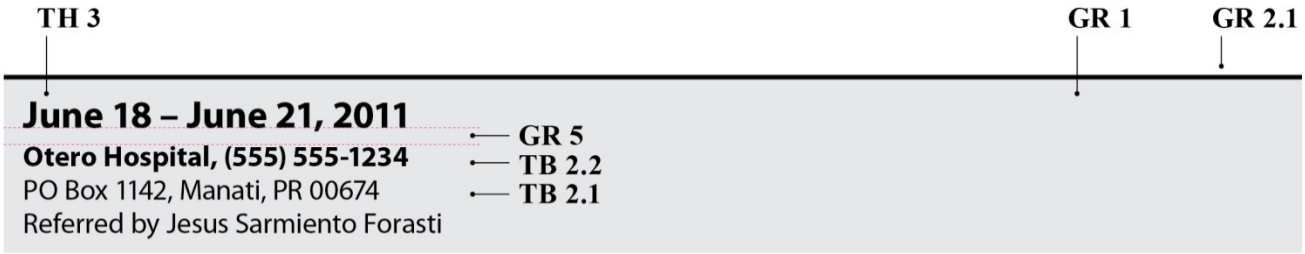

figure 10.3.6.C

PART A INPATIENT, HOSPICE, HOME HEALTH AND 'B OF A' SPECIFICATIONS

FORMATTING

[GR 1] gray fill
[GR 2.1] black rule
[TH 4] Claim Service Date
[GR 5] space after text
[TB 2.2] facility/provider name and telephone number
[TB 2.1] facility/provider address
[TB 2.1] referring provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Facility Name

Print the complete name of the inpatient facility, hospice facility or provider, or home health provider that filed the claim for services.

Facility Phone Number

Print the facility or provider's 10-digit phone number, preceded by a comma to separate it from the facility or provider name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the facility or provider that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the facility or provider. If no phone number for the facility or provider is available, suppress this content element and its preceding comma.

Facility Address

Print the facility or provider's street address, city, state abbreviation, and ZIP code +4. Insert a comma between the street address and city, and between the city and state abbreviation.

If available, print the physical address of the facility or provider. If the physical address is not available, print the mailing or billing address for the facility or provider. If no address for the facility or provider is available, suppress this content element.

Referring Provider

If the beneficiary was referred by a provider, print the provider's full name here, preceded by the phrase "Referred by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Referring physician name and any suffix should be separated by a comma.

CONTENT

> **{Date(s) of Service}**
>
> **{Facility/Provider Name}, {10-digit phone number for facility/provider}**
> {Facility/Provider Street Address}{Facility/Provider State}{Facility/Provider ZIP+4}
>
> Referred by {Provider Title}{Provider Given Name}{Provider Middle Initial}{Provider Family Name}

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

FORMATTING

[GR 1] gray fill
[GR 2.1] black rule
[TH 4] Claim Service Date
[GR 5] space after text
[TB 2.2] provider name and telephone number
[TB 2.1] provider practice name and address
[TB 2.1] referring provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Provider Name

Print the complete name of the provider that filed the claim for services. When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." The name and any suffix should be separated by a comma.

Provider Phone Number

Print the provider's 10-digit phone number, preceded by a comma to separate it from the provider name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the provider that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the provider. If no phone number for the provider is available, suppress this content element and its preceding comma.

Provider Practice Name and Address

If applicable, print the name of the practice or facility associated with the provider. Print the provider's street address, city, state abbreviation, and zip code +4. Insert a comma between the practice name, street address and city, and between the city and state abbreviation.

Whenever possible, the address that is printed should be the physical address of the provider. If the physical address is not available, use the mailing or billing address for the provider. If no address for the provider is available, suppress this content element.

Referring Provider
If the beneficiary was referred to the provider by another provider, print the referring provider's full name here, preceded by the phrase "Referred by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Referring provider name and any suffix should be separated by a comma.

CONTENT

{Date(s) of Service}

{Provider Title}{Provider Given Name}{Provider Middle Initial}{Provider Family Name} {, Provider Suffix}, {10-digit phone number for provider}

{Provider Practice Name}{Provider Street Address}{ Provider State}{ Provider ZIP+4}

Referred by {Provider Title}{Provider Given Name}{Provider Middle Initial}{Provider Family Name}

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

FORMATTING
[GR 1] gray fill
[GR 2.1] black rule
[TH 4] Claim Service Date
[GR 5] space after text
[TB 2.2] supplier name and telephone number
[TB 2.1] supplier practice name and address and any referring/ordering provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Supplier Name

Print the complete name of the supplier that filed the claim for services. If the supplier is a physician, when printing a degree suffix (e.g., M.D.) with the name, place a period after the “M” and after the “D.” The name and any suffix should be separated by a comma.

Supplier Phone Number

Print the supplier 10-digit phone number, preceded by a comma to separate it from the supplier name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the supplier that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the supplier. If no phone number for the supplier is available, suppress this content element and its preceding comma.

Supplier Address

Print the supplier's street address, city, state abbreviation, and ZIP code +4. Insert a comma between the practice name, street address and city, and between the city and state abbreviation.

If available, print the physical address of the supplier. If the physical address is not available, print the mailing or billing address for the supplier. If no address for the supplier is available, suppress this content element.

Ordering Provider

If the beneficiary's supplies were ordered by a provider, print the ordering provider's full name here, preceded by the phrase "Ordered by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Ordering physician name and any suffix should be separated by a comma. If the NPI submitted on the claim is not on file, use the name as shown on the claim. Suppress the "Ordered by" line if not able to identify the doctor. For *A/B MACs (B)*, if the ordering physician is the same as any performing physician on the claim, suppress the ordering physician line. If the NPI submitted on the claim is not on the *A/B MAC (B)*'s file, suppress the "Ordered by" line.

CONTENT

{Date(s) of Service}

{Supplier Name}, {10-digit phone number for supplier}

{Supplier Street Address}{Supplier State}{Supplier ZIP+4}

Ordered by {Provider Title} {Provider Given Name}{Provider Middle Initial}{Provider Family Name}

D. Claim Column Titles

The language used for the column headers differs for each member of the extended family of MSNs. See the specific content specifications below for details.

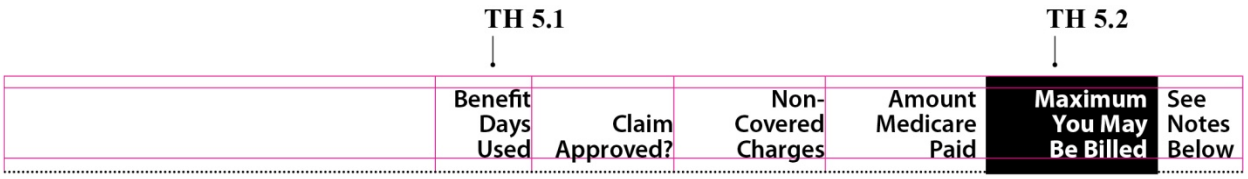

figure 10.3.6.D1

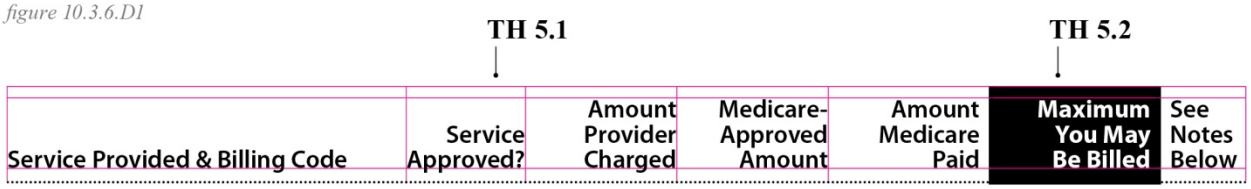

figure 10.3.6.D2

PART A INPATIENT SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D1 and Exhibit 1.1 for reference.

Listed below are widths and formatting for each column:

Column 1: 188 points wide, no content
Column 2: 42 points wide, [TH 5.1] right aligned
Column 3: 62 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

(blank)
Benefit Days Used
Claim Approved?
Non-Covered Charges
Amount Medicare Paid
Maximum You May Be Billed
See Notes Below

HOSPICE *AND HOME HEALTH* SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2, Exhibit *1.3*, and Exhibit *1.4* for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned
Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

The content in this subsection is static.

CONTENT

Quantity & Service Provided
Service Approved?
Amount Provider Charged
Medicare-Approved Amount
Amount Medicare Paid
Maximum You May Be Billed
See Notes Below

PART B ASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2, Exhibit 1.5 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned
Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

The content in this subsection is static.

CONTENT

Service Provided & Billing Code
Service Approved?
Amount Provider Charged
Medicare-Approved Amount
Amount Medicare Paid
Maximum You May Be Billed
See Notes Below

PART B UNASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit *1.6* for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned
Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Service Provided & Billing Code
Service Approved?
Amount Provider Charged
Medicare-Approved Amount
Medicare Paid You
Maximum You May Be Billed
See Notes Below

‘B OF A’ SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit 1.2 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned
Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Service Provided & Billing Code
Service Approved?
Amount Facility Charged
Medicare-Approved Amount
Amount Medicare Paid
Maximum You May Be Billed
See Notes Below

DME ASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit *1.7* for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned
Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Quantity, Item/Service Provided & Billing Code
Item/Service Approved?
Amount Supplier Charged
Medicare-Approved Amount
Amount Medicare Paid
Maximum You May Be Billed
See Notes Below

DME UNASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit *1.8* for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned
Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned
Column 4: 66 points wide, [TH 5.1] right aligned
Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent
Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column
Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Quantity, Item/Service Provided & Billing Code
Item/Service Approved?
Amount Provider Charged
Medicare-Approved Amount
Medicare Paid You
Maximum You May Be Billed
See Notes Below

E. Claim Content Lines

The content in the claim lines is beneficiary-specific and also differs for each member of the extended family of MSNs. See the specific content specifications below for details.

POSITION

This subsection is directly after the claim column titles subsection. It is full-page or 540 points in width and has a variable height, depending on the number of service line items in the given claims. There are seven columns, corresponding to the column titles subsection. All content is top aligned.

PART A INPATIENT *SPECIFICATIONS*

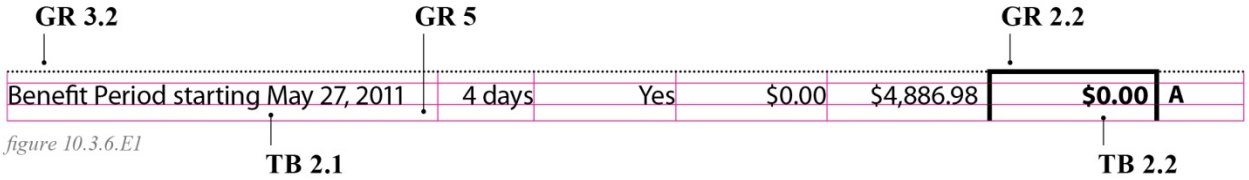

figure 10.3.6.E1

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Column 1: [TB 2.1] benefit period, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved t, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: When there is more than one service line, start with [GR 3.2] dotted rule to allow distinction between the services by the dotted rule.

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Description of Part A Inpatient Service

This column should contain the associated benefit-period start date. Language options include:

Benefit period starting {Month DD, YYYY}

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If there is no active benefit period because the claims are rejected, leave this field blank.

Benefit Days Used

This column shows the number of benefit days used during the hospital or skilled nursing facility admission, it indicates that a claim did not use benefit days because all the beneficiary's benefit days for the given period have been exhausted, or there was no active benefit period because the claim was rejected. Language options include:

1 day
{#} days
none remain
none

See Exhibit 2.7 for an example of the "none remain" option.

Claim Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Non-Covered Charges

This column lists the amount of any claim charges that Medicare did not cover. Non-covered services will include beneficiary-liable as well as provider-liable charges. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid
This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed
This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three

indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Inpatient hospital benefit period starting Month DD, YYYY} [or] {Skilled nursing facility benefit period starting Month DD, YYYY}

1 day [or] {#} days [or] none remain
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO** - **adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

or

[blank]
none
Yes [or] ***NO*** *[or] Yes -* ***adjusted*** *[or]* ***NO - adjusted***
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

HOSPICE SPECIFICATIONS

See Exhibit 1.3 for layout reference.

[The below figure has been revised.]

GR 3.2 GR 5 GR 3.3 GR 2.2

4 Routine Home Care, weeks	Yes	$2,000.00	$0.00	$0.00	**$0.00**	**A**
12 Skilled Nursing Visits						
12 Medical Social Visits						
40 Continuous Home Health Care, hours	Yes	3,000.00	0.00	0.00	**0.00**	**A**
5 Skilled Nursing Visits						

figure 10.3.6.E2

TB 2.1 TB 2.2 TB 2.2

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: *[TB 2.2] quantity and level of care description, left aligned or [TB 2.] quantity and service visit description, left aligned*
Column 2: *[TB 2.1] approved status for level of care,* right aligned
Column 3: [TB 2.1] amount charged *for level of care,* right aligned
Column 4: [TB 2.1] amount approved *for level of care,* right aligned
Column 5: [TB 2.1] amount paid *for level of care, right* aligned, with 5 point indent
Column 6: [TB 2.2] maximum *for level of care,* right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator *for level of care,* left aligned, with 5 point indent

NOTE: *Columns 2 through 7 should be filled only for level of care. They should be left blank for service visit lines.*

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: *Between level of care and service visit lines, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.*

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity & Service Provided

This column should contain the quantity or number of level of care provided, followed by the description of the level of care provided in bold. Then items below should contain the quantity or number of service visit provided, followed by the description of the service visit provided. There may be multiple service visit types per one level of care.

Whenever possible, the number of level of care and service visit provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49). Use the most-recent level of care and service visit descriptions. Suppress the billing code.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure *field has a maximum of 11 characters,* including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This *field has a maximum of 11 characters,* including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This *field has a maximum of 11 characters,* including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed
This column lists the beneficiary's total liability for the claim item. *This field has a maximum of 11 characters,* including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of *six* notes are allowed per service, so no more than six note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Level of care description}
{Service *visit* description}
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

HOME HEALTH SPECIFICATIONS

See Exhibit 1.4 for layout reference.

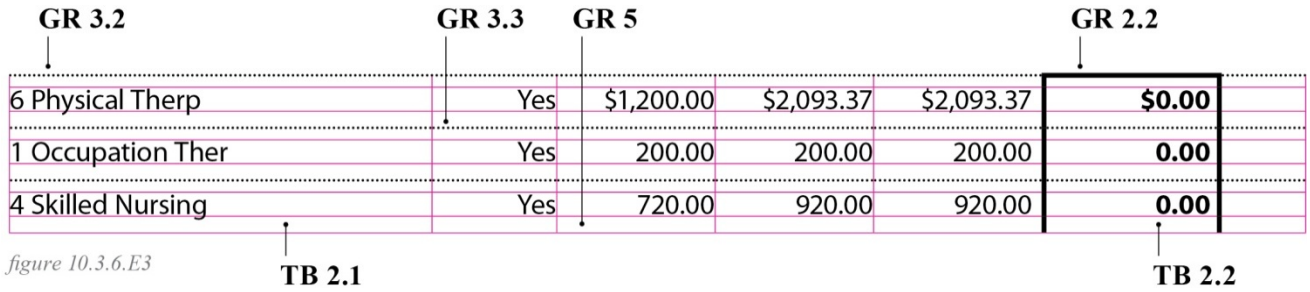

figure 10.3.6.E3

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] quantity and service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information
[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity & Service Provided

This column should contain the quantity or number of services provided, followed by the description of the service provided.

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most-recent consumer-friendly HCPCS service descriptions, which can be found at
http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/MedHCPCSGeninfo/

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged
This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed
This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})
Yes [or] ***NO*** *[or] Yes -* ***adjusted*** *[or]* ***NO - adjusted***
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

PART B *ASSIGNED* SPECIFICATIONS

See Exhibit 1.5 for layout reference.

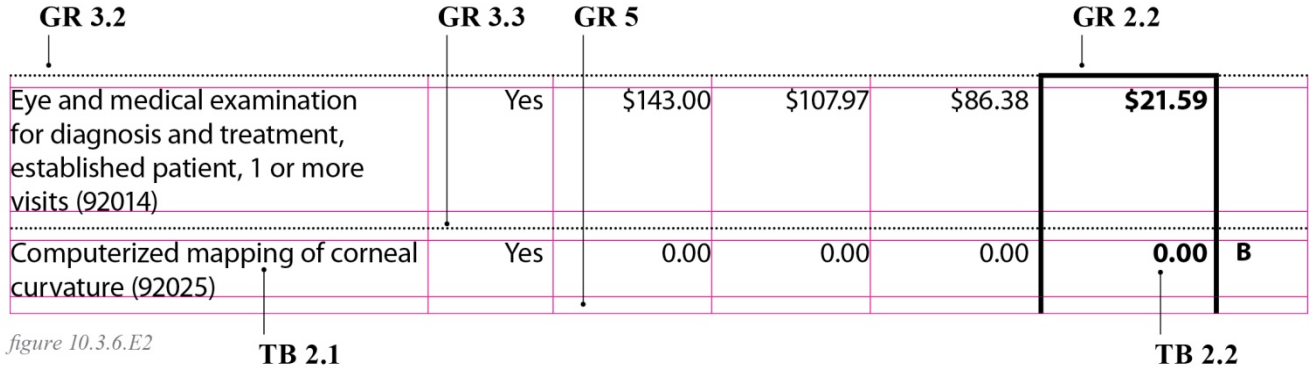

figure 10.3.6.E2

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information
[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided & Billing Code

This column should contain the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Use the most-recent *HCPCS service descriptions,* consumer-friendly *version for level 1 CPT codes and the long descriptions for level 2, which can be found on the CMS systems mainframe. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.*

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

The revenue code may have up to four 2-character modifier codes, followed by 2 modifier descriptors. The modifier descriptors have a maximum of 30 characters.

If a procedure code modifier is present in any of the four modifier fields on the claim detail, the following Modifier Descriptors will print:

Modifier	*English*	*Spanish*
80, 81, 82	*Assistant surgeon*	*Cirujano asistente*
26	*Professional charge*	*Cargo profesional*
TC	*Technical charge*	*Cargo técnico*
RR	*Rental*	*Renta*
NR	*Purchase*	*Compra*
RP	*Replacement/repair*	*Reemplazo/arreglo*
55	*Care after operation*	*Cuidado despues de operación*
56	*Care before operation*	*Cuidado antes de la operación*
MS	*Maintenance/service*	*Mantenimiento/servicio*
SG	*Surgery Center fee*	*Cargo del centro de cirugía*

***NOTE**: When a specialty 59 provider submits a claim with modifiers RP, NR, RR and SG the Modifier Descriptors on the Medicare Summary Notice will be suppressed as they are not applicable to the services provided.*

Keep current practice of listing modifier code and modifier descriptors.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount
This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If,

however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

PART B UNASSIGNED SPECIFICATIONS

See figure 10.3.6.E2 or Exhibit 1.*7* for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):
[TH 5.1] date or provider information
[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided *& Billing Code*

This column should contain the *description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.*

Use the most-recent HCPCS service descriptions, consumer-friendly version for level 1 CPT codes and the long descriptions for level 2, which can be found on the CMS systems mainframe. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

The revenue code may have up to four 2-character modifier codes, followed by 2 modifier descriptors. The modifier descriptors have a maximum of 30 characters.

If a procedure code modifier is present in any of the four modifier fields on the claim detail, the following Modifier Descriptors will print:

Modifier	*English*	*Spanish*
80, 81, 82	*Assistant surgeon*	*Cirujano asistente*
26	*Professional charge*	*Cargo profesional*
TC	*Technical charge*	*Cargo técnico*
RR	*Rental*	*Renta*
NR	*Purchase*	*Compra*
RP	*Replacement/repair*	*Reemplazo/arreglo*
55	*Care after operation*	*Cuidado despues de operación*
56	*Care before operation*	*Cuidado antes de la operación*
MS	*Maintenance/service*	*Mantenimiento/servicio*
SG	*Surgery Center fee*	*Cargo del centro de cirugía*

***NOTE**: When a specialty 59 provider submits a claim with modifiers RP, NR, RR and SG the Modifier Descriptors on the Medicare Summary Notice will be suppressed as they are not applicable to the services provided.*

Keep current practice of listing modifier code and modifier descriptors.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

'B OF A' SPECIFICATIONS

See Exhibit 1.*2* for layout reference.

[The below figure is new.]

GR 3.2 GR 5 GR 2.2

Liver function blood test panel (80076)	Yes	$69.46	$69.46	$69.46	**$0.00**	**A**
Liver function blood test panel (80076)	Yes	69.46	69.46	69.46	**0.00**	**A**
Liver function blood test panel (80076)	Yes	69.46	69.46	69.46	**0.00**	**A**

figure 10.3.6.E4

TB 2.1 TB 2.2

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved t, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided & Billing Code

This column should contain the description of the service provided and, in parentheses, the *billing code* for that service*, followed by any modifier code and modifier descriptor.*

Use the most-recent *HCPCS service descriptions, consumer-friendly version for level 1 CPT codes and the long descriptions for level 2, which can be found on the CMS systems mainframe. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.*

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount Facility Charged

This column lists the amount of the charge the outpatient facility submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount **Medicare Paid**

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Service description} ({Revenue Code})
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

DME ASSIGNED SPECIFICATIONS

See Exhibit 1.*7* for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] quantity and item/service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

NOTE: *For multiple dates subtitle, insert the following before corresponding service lines(s):*

[TH 5.1] date or provider information
[GR 5] space after

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity, Item/**Service Provided & Billing Code**

This column should contain the *quantity or number of services provided*, the description of the service provided and, in parentheses, *the billing code for that service, followed by any modifier code and modifier descriptor.*

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most-recent *HCPCS* service descriptions*, the long descriptions for level 2, which can be found on the CMS systems mainframe. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.*

Item/**Service Approved?**

This column indicates if a claim item or service was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount *Provider* Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid
This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

The first line of claim will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates Subtitles

If a single claim includes services provided on multiple dates, then a dynamic date subtitle should be introduced into the claim body, separating the individual claim items into clusters by date. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

The preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted

chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

CONTENT

{Item or Service description} ({Revenue Code})
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

DME *UN*ASSIGNED SPECIFICATIONS

See Exhibit *1.8* for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule
Column 1: [TB 2.1] quantity and item/service description, left aligned
Column 2: [TB 2.1] approved status, right aligned
Column 3: [TB 2.1] amount charged, right aligned
Column 4: [TB 2.1] amount approved, right aligned
Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

NOTE: For multiple dates subtitle, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information
[GR 5] space after

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity, Item/Service Provided & Billing Code

This column should contain the quantity or number of services provided, the description of the service provided and, in parentheses, *the billing* code for that service, followed by any modifier code *and modifier descriptor.*

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most-recent *HCPCS* service descriptions*, the long descriptions for level 2,* which can be found *on the* CMS *systems mainframe. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.*

Item/Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes
NO
Yes - **adjusted**
NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:
${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed
This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates Subtitles

If a single claim includes services provided on multiple dates, then a dynamic date subtitle should be introduced into the claim body, separating the individual claim items into clusters by date. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

The preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

CONTENT

{Service description} ({Revenue Code})
Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

F. Claim Total Line

The Claim Total Line subsection is the default subsection to follow the Claim Content Lines subsection. If a single claim is splitting across pages, suppress this subsection and replace with the continuation footer instead. Each claim will have only one instance of claim total line. Reference section I. Breaking Claims - Continuation Footer for specifications regarding the alternate option.

POSITION

This subsection is directly after the claim content lines subsection with fixed content area. It is full-page or 540 points in width and 21 points in height. There are six columns. The five right-most columns correspond to the columns in the Claims Content Lines subsection; the first column, containing the claim number, is equivalent in width to the first and second columns in the Claims Content Lines subsection. All content is to be top aligned.

PART A INPATIENT *SPECIFICATIONS*

See Exhibit 1.1 for layout reference.

[The below figure is new.]

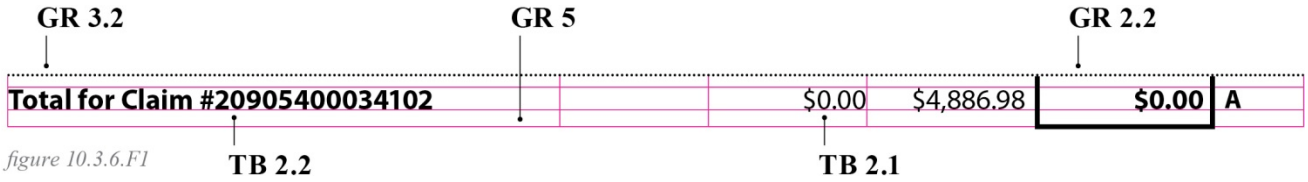

figure 10.3.6.F1

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: (blank)
Column 4: [TB 2.1] non-covered total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on both sides and the bottom of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the control number for the claim, preceded by a static text phrase:

Total for Claim #{*Claim* Number}

Insert dashes in the control number as indicated by the system.
Total of Non-Covered Charges

This column lists the sum of the line-item amounts above for any claim charges that Medicare did not cover. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. *A maximum of six* notes are allowed per total line.

CONTENT

Total for Claim #{*Claim* Number}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

HOSPICE* AND *HOME HEALTH SPECIFICATIONS

See Exhibit 1.3 and Exhibit 1.4 for layout reference.

[The below figure is new.]

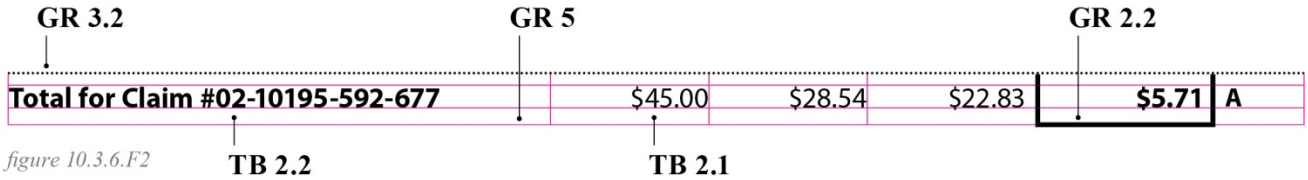

figure 10.3.6.F2

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{*Claim* Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of *six* notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

PART B ASSIGNED SPECIFICATIONS

See Figure 10.3.6.F2 and Exhibit 1.5 for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. *A maximum of six notes are allowed per total line.*

CONTENT

Total for Claim #{*Claim* Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

PART B UNASSIGNED SPECIFICATIONS

See figure 10.3.6.F2 or Exhibit 1.*6* for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid You

This column lists the sum of the line-item amounts above for what Medicare paid the beneficiary toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. *A maximum of six notes are allowed per total line.*

CONTENT

Total for Claim #{Claim Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

'B OF A' SPECIFICATIONS

See Exhibit 1.*2* for layout reference. [The below figure is new.]

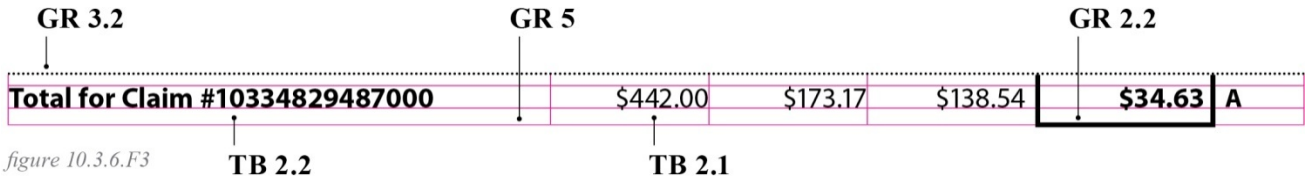

figure 10.3.6.F3

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number
This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{*Claim* Number}

Insert dashes in the claim number as indicated by the system.

Total Amount *Facility* Charged

This column lists the sum of the line-item amounts above of the charges the facility submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.** *If the field has more than 11 characters, replace with "see note" and list the amount in the notes.*

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of *six* notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

DME ASSIGNED SPECIFICATIONS

See figure 10.3.6.F3 or Exhibit 1.*7* for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{*Claim* Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Supplier Charged

This column lists the sum of the line-item amounts above of the charges the supplier submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the item or service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable. See the description in the Claim Content Lines specifications for detailed instructions. Note that the Claim Total Line differs from the Claim Content Lines in regards to claim notes: A maximum of three notes are allowed per total line, rather than the five notes allowed for a content line. No more than three note indicators should ever be listed here.

CONTENT

Total for Claim #{*Claim* Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

DME UNASSIGNED SPECIFICATIONS

See figure 10.3.6.F2 or Exhibit 1.*8* for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: [TB 2.1] amount charged total, right aligned
Column 4: [TB 2.1] approved total, right aligned
Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent
Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent
Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{*Claim* Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Supplier Charged

This column lists the sum of the line-item amounts above of the charges the supplier submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the item or service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid You

This column lists the sum of the line-item amounts above for what Medicare paid the beneficiary toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable. See the description in the Claim Content Lines specifications for detailed instructions. Note that the Claim Total Line differs from the Claim Content Lines in regards to claim notes: A maximum of three notes are allowed per total line, rather than the five notes allowed for a content line. No more than three note indicators should ever be listed here.

CONTENT

Total for Claim #{*Claim* Number}
${###,###.##}
${###,###.##}
${###,###.##}
${###,###.##}
{NOTE INDICATOR(S)}

G. Notes for Claims Above

This subsection is dynamically generated when any of the claim line items on the page has an explanatory note. Note that the notes are limited to only those claim items on each page. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of the relationship between claims data and claim notes.

POSITION

This subsection is built dynamically from bottom up in relation to the claim section above. It is full-page or 540 points in width with a variable height depending on the content length. Indent in 16 points from the right margin to start notes text.

There should be a minimum of 12 points space between the top of this subsection and Claim Total Line subsection. If there is a continuation box, see next subsection, 10.3.6.I, for spacing specifications.

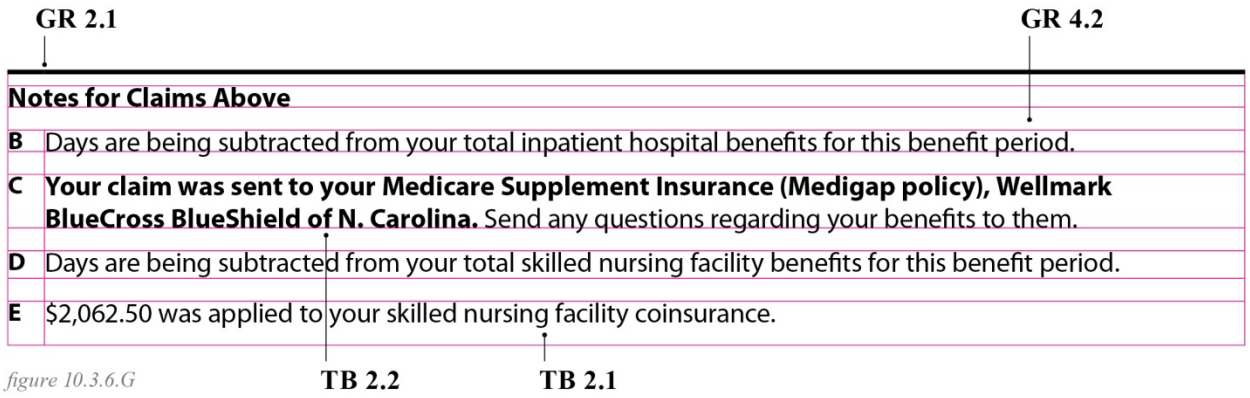

figure 10.3.6.G

FORMATTING

[GR 2] black rule
[TB 2.2] subsection header
[GR 4.2] space after
[TB 2.2] alphabetic note indicator(s) [TB 1.1] note body text

NOTE: If there are multiple notes, insert [GR 4.2] space before the note indicator and body text.

DYNAMIC RULES

This subsection is dynamically generated when any of the claim line items on the page is linked to an explanatory note. If there are no messages to be printed, suppress the entire Notes for Claims Above subsection. Do not print the Notes for Claims Above subsection without at least one complete message following it on the same page.

The section includes three elements:

Static Subsection Header

See the content section below for this language.

Note Indicator(s)

See the description in the Claim Content Lines specifications for detailed instructions on the generation of the alphabetic note indicators. Those instructions should be followed here, with the exception that each individual note indicator should be placed on a separate line.

List the note indicators in alphabetic order.

Identical notes should <u>not</u> be repeated. For example, even if the note indicator “F” appears on multiple occasions in the claim lines on the page, the F indicator and the explanatory note linked to F should only appear once in this section.

Explanatory Note

Each note indicator should be followed by an explanatory note relating to the claim data on the page. These explanatory notes are linked to the claim items in the system, and a complete list of the note text is available *on the CMS website at:* http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html.

CONTENT

Notes for Claims Above
{Note Indicator(s)} {Explanatory Note(s)}

H. Continued Claims - Continuation Box

This section is dynamically generated when the claims continue on the next page or a claim is split across the page. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This element is fixed in size, 84 points in width and 18 points in height. The white type and glyph arrow are centered horizontally and vertically within the black filled box. The horizontal position is fixed, but the vertical position is dynamic. The element is right aligned on top right of the Notes for Claims Above subsection.

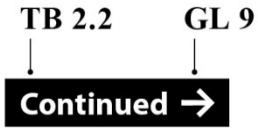

figure 10.3.6.H

FORMATTING

[TB 2.2] Continued [GL 9] arrow, right aligned, white on black fill

DYNAMIC RULES

If the claim above splits across pages, also include the continued footer at the bottom of the claim in addition to this element.

CONTENT

Continued [arrow glyph]

I. Breaking Claims - Continuation Footer

This section is dynamically generated when a claim is split across the page. When there is a split, include this subsection instead of the Claim Total Line subsection. The specifications of the columns are the same, dependent on MSN type, with dynamic claim number and static text. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This subsection is directly after the claim content lines subsection with fixed content area. It is full-page or 540 points in width and 21 points in height. There are six columns. The five right-most columns correspond to the column sizes in the Claims Content Lines subsection; the first column, containing the claim number, is equivalent in width to the first and second columns in the Claims Content Lines subsection. All content is to be top aligned.

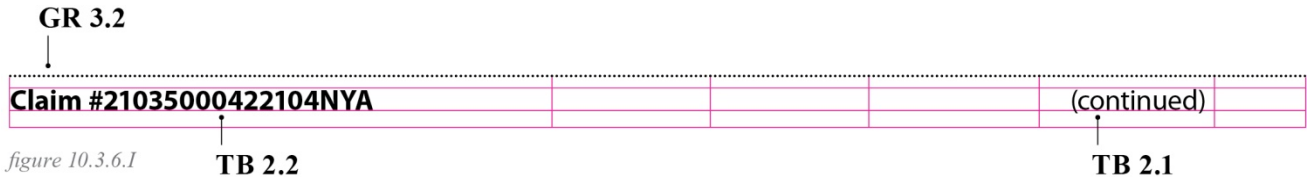

figure 10.3.6.I

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule
Columns 1-2: [TB 2.2] claim number, left aligned
Column 3: (blank)
Column 4: (blank)
Column 5: (blank)
Column 6: [TB 2.2] continued tag, right aligned, with 3.5 point indent
Column 7: (blank)

NOTE: There are no black rules to highlight Column 6 as the Claim Total Line subsection.

DYNAMIC RULES

Repeat at the bottom of the claim as needed if the Claim Total Line subsection is not on the page.

CONTENT

Claim #{Claim Number}
(continued)

J. Breaking Claims - Continuation Header

This section is dynamically generated when a claim is split across two or more pages. When there is a split, include this subsection on subsequent pages at the top of the page before continuing the claims followed by the Claim Column Titles subsection and Claim Content Lines subsection. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This subsection is directly after the page header. It is fixed in size, full-page or 540 points in width and 25 points in height.

figure 10.3.6.J

FORMATTING

[GR 2.1] black rule
[TB 2.2] date / provider continued…
[GR 3.4] dotted rule w/ space before
DYNAMIC RULES
Repeat header on subsequent pages as needed if the Claim Total Line subsection is not on the page.

PART A INPATIENT AND'B OF A' SPECIFICATIONS

CONTENT

{Date of Service} / {Facility name} continued…

HOSPICE, HOME HEALTH AND PART *B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS*

CONTENT

{Date of Service} / {Provider name} continued…

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

{Date of Service} / {Supplier name} continued…

10.3.7 - Claims Calculations

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

This section provides calculations for correctly displaying dollar amounts in certain columns of the MSN.

NOTE THAT THE FOLLOWING SECTION HAS BEEN UPDATED TO REFLECT NEW COLUMN NAMES, BUT HAS NOT OTHERWISE BEEN ALTERED FROM THE FORMER ITERATION OF CHAPTER 21. *SSMs ARE TO CONTINUE CURRENT PRACTICE FOR CALCULATIONS UNTIL ACCURATE REVISIONS COULD BE MADE AT A FUTURE DATE.*

- Part A - "Claim Approved?" column is new; Is the "Amount Medicare Paid" column comparable to the old "Deductible and Coinsurance" column? If not, it needs new instructions. Date of Service now shows up at top of claim, not in its own column; first column now shows Benefit Period date.

- Part B - "Service Approved?" column is new; Date of Service now shows up at top of claim, not in its own column

- Unassigned Part B - "Service Approved?" column is new; Date of Service now shows at top of claim, not in its own column.

- B of A - "Service Approved?" column is new; Are the "Medicare-Approved Amount" and "Amount Medicare Paid" columns comparable to the old "Non-Covered Charges" and "Deductible and Coinsurance" columns? If not, these need instructions. Date of Service now shows up at top of claim, not in its own column.

- DME - "Item/Service Approved?" column is new; Date of Service now shows up at top of claim, not in its own column.

A. Part A Calculations

"Maximum You May Be Billed" Column

The following chart is to be used to display the "Maximum You May Be Billed" amounts for each service line on outpatient claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary. See the Medicare Secondary Payer Manual, Chapter 5, if the Medicare secondary payment is less than the amount Medicare would pay if it were primary.

Calculations for Completing "Maximum You May Be Billed" Column - Outpatient Claims	Instructions/Source of Dollar Amount for Calculations
A. Service line billed amount	This is the service line billed amount. This amount

Calculations for Completing "Maximum You May Be Billed" Column - Outpatient Claims	Instructions/Source of Dollar Amount for Calculations
	should be shown in the "Amount Provider Charged" column of the MSN.
B. Psychiatric reduction	B = A x .375 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after psychiatric reduction	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Amount charged less deductible	E = C - D.
F. Less Medicare copayment amount	Depending upon the service, F may equal any of: 1. E - where services are paid at 100% of the approved amount; 2. 80% of E - where coinsurance is based on approved amount; 3. E minus 20% of E - where coinsurance is based on charges; or 4. OPPs payment amount minus the fixed beneficiary copayment where hospital outpatient PPS is involved.
G. Amount after deductible, copayment and psychiatric reduction	G = E - F.
H. Of the billed amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover shown in the "Non-Covered Charges" column on the MSN. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it

Calculations for Completing "Maximum You May Be Billed" Column - Outpatient Claims	Instructions/Source of Dollar Amount for Calculations
	was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "Maximum You May Be Billed" column for service lines on outpatient claims. Claims submitted with a beneficiary paid amount require the additional calculations shown in Subsection C below.

Display of the "Maximum You May Be Billed" Column for MSP Claims
If the Medicare secondary payment plus the amount the primary insured paid equals or exceeds what Medicare would have paid, the "Maximum You May Be Billed" column for each approved service should display "$0.00."

If the primary insurer paid amount is less than what Medicare would have paid, the amount shown in "Maximum You May Be Billed" column for each service line needs to be reduced using the following formula.

For the first service line, the amount "Maximum You May Be Billed" = Deductible + Coinsurance - Primary Paid Amount + Non-Covered Charges.

For the second service line, the same formula would be followed with the Primary Amount equaling the Primary Paid minus the Deductible + Coinsurance from the first line.

Continue in this manner until the primary paid amount equals either $0.00 or the Deductible + Coinsurance equals $0.00.

Display of the "Maximum You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount:

If a claim is submitted with a beneficiary paid amount, the amount(s) in the "Maximum You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount shown for the "Maximum You May Be Billed" column, subtract the amount the beneficiary paid from that amount, and display the difference in the "Maximum You May Be Billed" column for that service line.

Step 2: If the amount the beneficiary paid is greater than the amount calculated for the "Maximum You May Be Billed" column, subtract the "Maximum You May Be Billed" amount for the first service line from the amount the beneficiary paid, and show zero in the "Maximum You May Be Billed" column.

Repeat these steps with any remaining beneficiary paid amounts. If a balance remains after all services lines have been considered, that amount should match the check amount to the beneficiary on that claim. If payment was made to the beneficiary, the balance should be shown in the appropriate blank of message 34.4. If a check was not issued, print message 34.2.

B. Part B Calculations

"Medicare Paid You/Provider" Column - Assigned and Unassigned Claims

The following chart is to be used to display the Medicare paid amount for each service line on assigned and unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	Instructions/Source of Dollar Amounts
A. Service line approved amount	This is the approved amount for the service. Do not include interest amounts paid or applied to the service line.
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only for services subject to the outpatient mental health treatment limitation. For all other services, B = 0.
C. Amount remaining after mental health treatment limitation	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less	E = C - D.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	Instructions/Source of Dollar Amounts
deductible	
F. Less Medicare copayment	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Less 10% for late filing	H = G x .10 If service line is part of an unassigned claim or there is no reduction for late filing, H = 0.
I. Payment after reduction	I = G - H.
J. Less Balanced Budget Law Reduction	The total Balanced Budget Law reductions applied to the service line. If no reduction, J = 0.
K. Payment after reduction	K = I - J.
L. Medicare paid amount	L = K - Display this amount in the "Medicare Paid You/Provider" column.

"MAXIMUM You May Be Billed" Column - Assigned Claims

The following chart is to be used to display the "Maximum You May Be Billed" amounts for each service line on assigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing "Maximum You May Be Billed" Column - Assigned Claims	Instructions/Source of Dollar Amount for Calculations
A. Service line approved amount	This is the service line approved amount. This amount should be shown in the "Medicare Approved" column of the MSN.
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after mental health treatment limitation	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less deductible	E = C - D.
F. Less Medicare copayment amount	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.

Calculations for Completing "Maximum You May Be Billed" Column - Assigned Claims	Instructions/Source of Dollar Amount for Calculations
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Of the approved amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover and the beneficiary is liable. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials or reductions such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "Maximum You May Be Billed" column for service lines on assigned claims. Claims submitted with a beneficiary paid amount require additional calculations. See Subsection F below.

"Maximum You May Be Billed" Column - Unassigned Claims

The following chart is used to display the “Maximum You May Be Billed” amounts for each service line on unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing “Maximum You May Be Billed” Column - Unassigned Claims	Instructions/Source of Dollar Amount for Calculations
A. Of the total charges	The billed amount for the service line.
B. Approved amount	The service line approved amount.
C. Amount exceeding limiting charge	For unassigned services subject to the limiting charge, this is the actual dollar amount by which the limiting charge is exceeded. If the amount is less than $1.00, C = 0. Do not include services being reduced or denied for any of the conditions under E.
D. Net Responsibility	D = A - C.

Calculations for Completing "Maximum You May Be Billed" Column - Unassigned Claims	Instructions/Source of Dollar Amount for Calculations
E. Less charges beneficiary is not liable for	This step represents charges that were denied or reduced and the beneficiary is not liable for the denial or the reduction. Include dollar amounts for denials or reductions such as: • Services determined not to be medically necessary, and the beneficiary was not informed in writing in advance that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • The claim did not have an ICD-9 code listed, or the service was not linked to an ICD-9 code; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel, or bundled code; • The service was denied because of utilization reasons; or • Rebundling of services when the minor service was paid before the major service was billed. Use the amount allowed for the minor service in step E, or Reductions due to coverage.
F. Beneficiary Responsibility	F = D - E Display this amount in the "Maximum You May Be Billed" column for unassigned claims. Claims submitted with a beneficiary paid require additional calculations, therefore, proceed to §10.3.10.2(f).

Display of the "Medicare Paid You" and "Medicare Paid Provider" Columns for MSP Claims

Medicare secondary payment is computed by the MSP pay module based on claim totals.

However, the MSN displays calculations by service line. In order to complete the "Medicare Paid Provider" and "Medicare Paid You" columns for MSP claims, the MAC must apportion the total amount Medicare paid on the claim among the approved service lines.

For the first approved service line, show the lesser of 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount, less any deductible applied, or the amount Medicare actually paid on the claim.

For the second approved service line, show the lesser of:

- 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount less any deductible applied, or

- The actual amount Medicare paid on the claim minus the amount shown under Medicare Paid for the prior approved service lines.

Continue on following lines in this manner until the entire Medicare secondary payment for the claim has been exhausted.

Display of the "Maximum You May Be Billed" Column for MSP Claims

1. Assigned Claims

If the Medicare secondary payment plus the amount the primary insurer paid equals or exceeds the Medicare approved amount, display "$0.00" in the "Maximum You May Be Billed" column for each approved service line.

If the Medicare secondary payment plus the amount the primary insurer paid is less than the Medicare approved amount, A/B MACs (B)/DME MACs calculate the total beneficiary responsibility for approved services by subtracting the sum of the primary insurer's payment and the Medicare secondary payment from the total Medicare approved amount for those services.

Amount Medicare Approved on Claim - (Primary Insurer Payment + Medicare Payment) = Total Beneficiary Responsibility

For the first approved service line, A/B MACs (B)/DME MACs show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the Medicare approved amount or the beneficiary's total responsibility for all approved services on the claim.

For the second approved service line, A/B MACs (B)/DME MACs show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the approved amount for the line or the beneficiary's total responsibility for approved services minus the amount shown for the prior approved service line.

Continue in this manner until the entire beneficiary responsibility has been exhausted.

Enter $0.00 in the "Maximum You May Be Billed" column for denied services for which the beneficiary is not liable.

Enter the amount charged in the "Maximum You May Be Billed" column for denied services for which the beneficiary is responsible.

NOTE: If there is an "obligated to accept" amount submitted on the claim, and that amount is greater than zero but less than the Medicare approved amount, use the "obligated to accept" amount in place of the Medicare approved amount when performing the above calculations.

2. Unassigned Claims

The amount in the "Maximum You May Be Billed" column for approved services is the amount charged or the limiting charge, whichever is less.

NOTE: If there is an "obligated to accept" amount submitted on the claim and that amount is greater than zero but less than the amount charged or the limiting charge, use the "obligated to accept" amount when performing this calculation.

Enter $0.00 in the "Maximum You May Be Billed" column for denied services for which the beneficiary is not liable. Enter the amount charged in the "Maximum You May Be Billed" column for denied services for which the beneficiary is responsible.

Display of the "Maximum You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount

1. Assigned Claims

If an assigned claim is submitted with a beneficiary paid amount, the amount(s) in the "Maximum You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount as indicated below to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: Subtract the amount of the beneficiary check, if any, from the patient amount submitted on the claim. Use the difference as the new patient paid amount. If there was

no check to the beneficiary, use the patient paid amount submitted on the claim for remaining steps.

Step 2: If the new patient paid amount is less than or equal to the amount calculated for the “Maximum You May Be Billed” column, subtract the new patient paid amount from the original “Maximum You May Be Billed” amount, and display the difference in the “Maximum You May Be Billed” column for that service line.

Step 3: If the new patient paid amount is greater than the amount calculated for the “Maximum You May Be Billed” column, subtract the original “Maximum You May Be Billed” amount for the first service line from the new patient paid amount, and show zero in the “Maximum You May Be Billed” column.

Repeat these steps with any remaining beneficiary paid amounts.

2. Unassigned Claims

If an unassigned claim is submitted with a beneficiary paid amount, the amount(s) in the “Maximum You May Be Billed” column will be reduced by the amount the beneficiary prepaid the provider. Apply the beneficiary paid amount for each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount calculated for the “Maximum You May Be Billed” column, subtract the amount the beneficiary paid from that amount, and display the difference in the “Maximum You May Be Billed” column for that service line.

Step 2: If the amount the beneficiary paid amount is less than or equal to the amount calculated for the “Maximum You May Be Billed” column, subtract the “Maximum You May Be Billed” amount for the first service line from the amount the beneficiary paid, and show zero in the “Maximum You May Be Billed” column for that service line.

Repeat these steps with any remaining beneficiary paid amounts.

If there is a balance after all service lines have been considered on unassigned claims, that amount is what the beneficiary overpaid the provider. A/B MACs (B)/DME MACs have the option of printing claim level message 34.3 in this situation if their system permits.

Print message 34.2 on assigned claims when the beneficiary paid amount does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.

Display of the “Medicare Paid You” Column for Unassigned Claims with a Previous Overpayment Amount Withheld

The "Medicare Paid You" column should show the actual amount that would have been paid if no previous overpayment had been withheld from the check issued to the beneficiary. Use message 32.1 to show the amount by which the check is reduced to recover an overpayment from the beneficiary.

Display of the "Medicare Paid You" Column for Assigned and Unassigned Adjustment Claims

Show all service lines for the adjustment claim. The "Medicare Approved" and "Medicare Paid" columns will display the same allowed and paid amounts as were shown on the original MSN for service lines that are not subject to adjustment.

The "Medicare Approved" and "Medicare Paid" columns for adjusted service lines will show the total combined amount approved and paid for both the original and adjusted claim. Likewise, "Claim Total" lines for adjusted claims will reflect the combined total amounts approved and paid for the original and adjusted claim.

The "Maximum You May Be Billed" column will show the beneficiary's total responsibility. The MAC uses message 31.13 on all adjustments where a partial payment was previously made.

C. Suppression of Claims From MSNs

A/B MACs (A), (B), (HHH), and DME MACs have the option to suppress claims from MSNs when **all** of the following three conditions apply:

- The claim is a coordination of benefits (crossover) claim for Medicaid;
- There is no resulting beneficiary liability; and
- Suppression of the MSN is cost effective.

In addition, if the MAC's system denies an exact duplicate of a claim, the MAC may suppress the claim from the MSN. An exact duplicate claim is one in which every field of the duplicate claim matches every field of the original claim.

Since appeal rights are not affected, do not display claims on MSNs for services paid at 100 percent of the fee schedule where no deductible or coinsurance is applied, e.g., diagnostic laboratory services. If other services on that claim will appear on the MSN, include all services being paid.

Upon the beneficiary's request, create and send MSNs for previously suppressed claims.

Do not suppress claims from MSNs when **any** of the following conditions apply:

- One or more services were denied because one of the exclusions from Medicare coverage in 1862(a)(1) of the Social Security Act (the Act) applies;

- The claim is denied as not filed within the time limits required by 1842(b)(3) of the Act;

- The claim is denied in full or in part because the beneficiary was not enrolled in Part A or B of Medicare when the services in question were provided; or

- An initial determination is made on a claim not later than the 45-day period beginning on the date the A/B MAC (A), (B), (HHH), or DME MAC receives a claim.

10.3.8 - Specifications for Section 4 (Last Page): Denials and Appeals

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

This section of the MSN helps beneficiaries understand how to handle denied claims; it also explains how and when to file an appeal. This section should be printed in its entirety on exactly one page, and it should always appear on the MSN's final page. It can appear on either the front or reverse of a sheet.

A. Section Title

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 5″), 7 points from the baseline of Headers of Other Pages subsection. It is full-page or 540 points in width and 24 points in height.

figure 10.3.8.A

FORMATTING

[GR 2.1] black rule
[TH 2] section header

DYNAMIC RULES
N/A - this section is static

CONTENT
How to Handle Denied Claims or File an Appeal

B. Get More Details

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 0.94″) or 28 points from the baseline of the Section Title subsection. It is one-column or 259 points in width and 167 points in height.

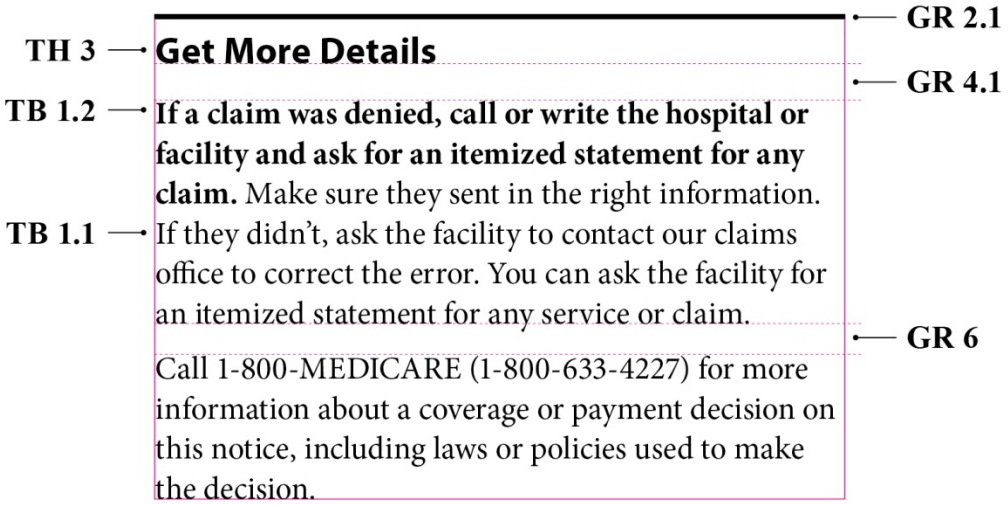

figure 10.3.8.B

FORMATTING

[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.2] highlight first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text

DYNAMIC RULES

N/A - this section is static

PART A INPATIENT AND 'B OF A' SPECIFICATIONS

CONTENT

Get More Details

If a claim was denied, call or write the hospital or facility and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the facility to contact our claims office to correct the error. You can ask the facility for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

PART B *(ASSIGNED AND UNASSIGNED),* HOSPICE, AND HOME HEALTH *SPECIFICATIONS*

CONTENT

Get More Details

If a claim was denied, call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

Get More Details

If a claim was denied, call or write the supplier and ask for an itemized statement for any claim. Make sure they sent in the right information. If they did not, ask the supplier to contact our claims office to correct the error. You can ask the supplier for an itemized statement for any item or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

C. If You Disagree

POSITION

The position of this subsection is dynamic. The content area begins 19 points from the baseline of the Get More Details subsection. It is one-column or 259 points in width and 132 points in height. The last line has a black rule around the appeal due date. The date field is 158 points wide.

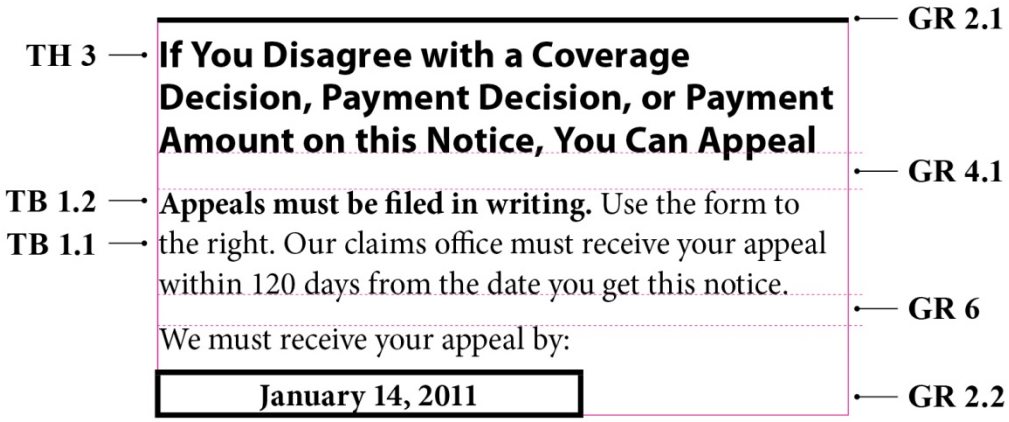

figure 10.3.8.C

Formatting

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[TB 1.2] highlight first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text
[TB 1.2] appeals due date, center aligned [GR 2.2] highlight edges of Column 2

DYNAMIC RULES

This subsection contains a dynamically generated date: the beneficiary's appeal deadline. The date printed should be 125 days from the notice date in the Notice Details subsection of Part 1. The date is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

CONTENT

> **If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal**
>
> **Appeals must be filed in writing.** Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.
>
> We must receive your appeal by:
> **{Month DD, YYYY}**

D. If You Need Help Filing Your Appeal

GLOBAL SPECIFICATIONS

POSITION

The position of this subsection is dynamic. The content area begins 19 points from the baseline of the If You Disagree subsection. It is one-column or 259 points in width and 190 points in height.

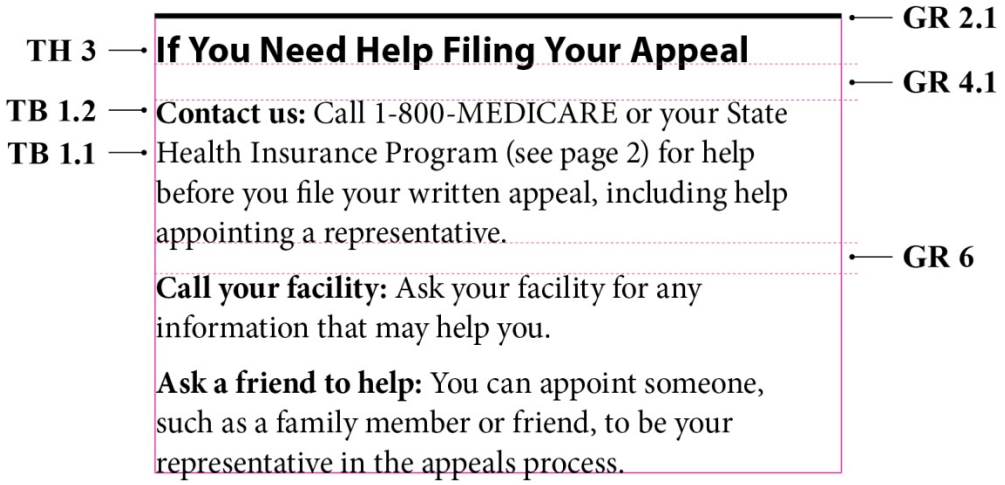

figure 10.3.8.D

FORMATTING

[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.2] highlight first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] highlight first sentence, [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] highlight first sentence [TB 1.1] body text

DYNAMIC RULES

If the mailing address *is that of the legal representative, the beneficiary's address state should be used to identify the SHIP contact number, not that of the legal representative.*

***NOTE**: If the mailing address is that of the legal representative and the beneficiary's address indicates that the beneficiary lives outside of the 50 U.S. states and U.S. territories, then the final paragraph on page 2 should be suppressed. See alternate language in the Content specifications below.*

When there is a combined MSN that has Part A Inpatient claims with Hospice and/or Home Health claims, use the content for Part A Inpatient specification.

PART A INPATIENT *AND 'B OF A' SPECIFICATIONS*

CONTENT

If You Need Help Filing Your Appeal
Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Or, if the MSN mailing address is outside the 50 states, use the following language:
If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

PART B (ASSIGNED AND UNASSIGNED), HOSPICE, AND HOME HEALTH *SPECIFICATIONS*

CONTENT

If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Or, if the MSN mailing address is outside the 50 states, use the following language:

If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your supplier: Ask your supplier for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Or, if the MSN mailing address is outside the 50 states, use the following language:

If You Need Help Filing Your Appeal

Contact us: Call 1-800-MEDICARE for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

E. Find Out More

POSITION

The position of this subsection is dynamic. The content area begins 19 points from the baseline of the If You Need Help Filing Your Appeal subsection. It is one-column or 259 points in width and 72 points in height.

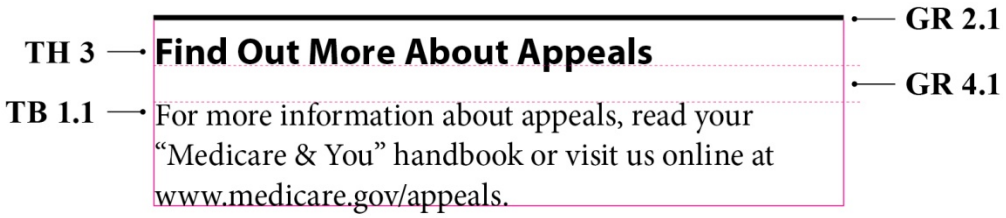

figure 10.3.8.E

FORMATTING

[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.1] body text

CONTENT

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook, or visit us online at www.medicare.gov/appeals.

F. File an Appeal in Writing

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

This subsection begins (3.9″, 0.94″). This should top align with the Get More Details subsection in the left column. It is one-column or 259 points in width and 652 points in height.

Indent in 8 points top and left and 16 points from right to begin content area. Tab 12 points from left to start appeal instructions and fill-in boxes.

The beneficiary fill-in boxes in Step 3 are 218 points in width and 22 points in height.

The telephone number fields are split further, with 19 points of width for each number and 7 points of space in between the fields. Any space after the 10 digit fields should be left as gray fill.

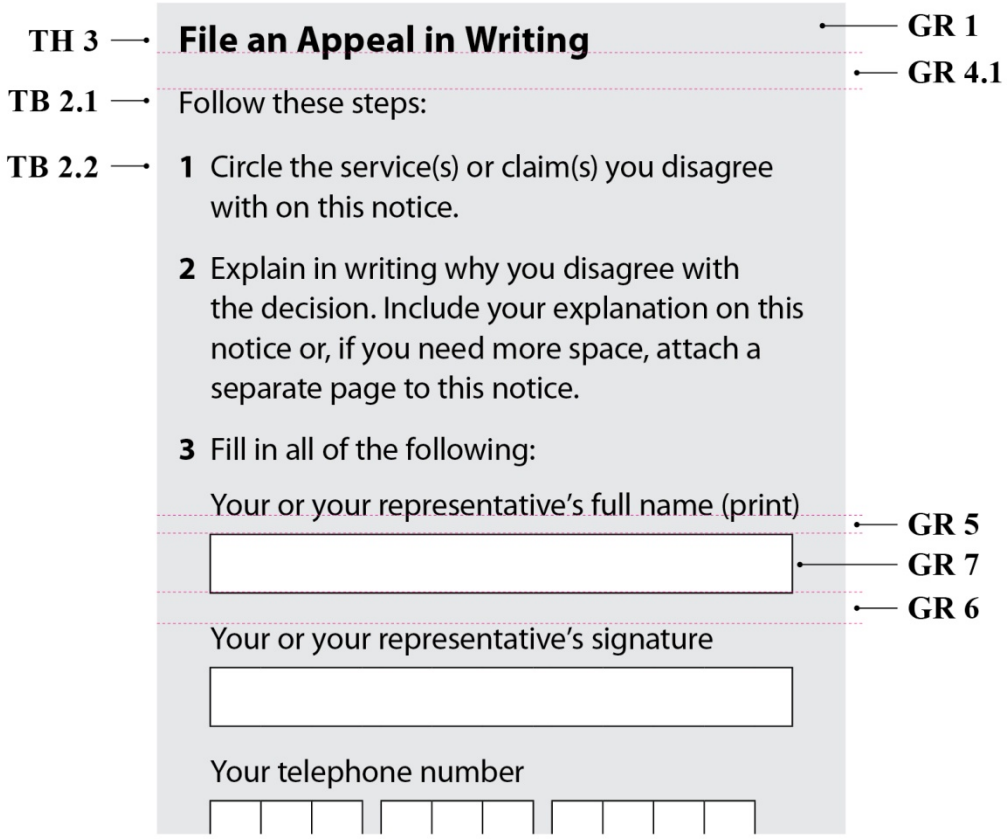

figure 10.3.8.F

FORMATTING

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[TB 2.2] step 2 [TB 2.1] body text
[GR 4.1] space after header
[TB 2.2] step 3 [TB 2.1] body text
[GR 4.1] space after header
[TB 2.1] fill in category
[GR 5] space after text
[GL 7] fill in box
[GR 6] space after text
[TB 2.1] fill in category
[GR 5] space after text
[GL 7] fill in box
[GR 4.1] space after header

[TB 2.2] steps 4 - 7 [TB 2.1] body text
[GR 4.1] space after header
[TB 2.2] MAC address

DYNAMIC RULES

In Step 7 of the File an Appeal in Writing subsection, beneficiaries are instructed where to mail their appeals material. The mailing address listed should be the preferred mailing address of the *MAC* generating the MSN.

The address should appear in the following format:

First Line:	Medicare Claims Office (static text)
Second Line:	c/o { *A/B MAC (A), (B), (HHH), or DME MAC* Name}
Third Line:	{ *MAC* Street Address or PO Box*, Suite Number*}
Fourth Line:	{ *MAC* City}, {ST} {ZIP+4}

If the MAC uses another name to refer to the 'Medicare Claims Office,' add an additional line after the second line with an 'attn:' to refer to the department. The first line should stay static for all return addresses.

First Line:	*Medicare Claims Office (static text)*
Second Line:	*c/o {A/B MAC (A), (B), (HHH), or DME MAC Name}*
Third Line:	*attn: {Appeals Department Name}*
Fourth Line:	*{MAC Street Address or PO Box, Suite Number}*
Fifth Line:	*{MAC City}, {ST} {ZIP+4}*

When there is a combined MSN that has Part A Inpatient claims with Hospice and/or Home Health claims, use the content for Part A Inpatient specification.

PART A INPATIENT *AND* 'B OF A' *SPECIFICATIONS*

CONTENT

File an Appeal in Writing

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your facility for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o {*A/B MAC (A), (B), (HHH), or DME MAC* Name}
{*MAC* Street Address}
{*MAC* City}, {ST} {ZIP+4}

PART B *(ASSIGNED AND UNASSIGNED),* HOSPICE, AND HOME HEALTH *SPECIFICATIONS*

CONTENT

File an Appeal in Writing

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o {*A/B MAC (A), (B), (HHH), or DME MAC* Name}
{*MAC* Street Address}
{*MAC* City}, {ST} {ZIP+4}

DME *(ASSIGNED AND UNASSIGNED) SPECIFICATIONS*

CONTENT

File an Appeal in Writing

1 Circle the item(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your supplier for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o {*A/B MAC (A), (B), (HHH), or DME MAC* Name}
{*MAC* Street Address}
{*MAC* City}, {ST} {ZIP+4}

10.3.9 - Specifications for Pay MSN Cover Sheet & Check

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

From time to time, beneficiaries may receive an MSN that includes a check, refunding an overpayment made (most often) for Part B services, either assigned or unassigned. The instructions below describe the cover sheet and check page. This page is inserted before the notice itself.

The MACs are not required to change their process of producing checks, but encouraged to revise fonts and formatting to reflect the redesign. The check must have the DHHS seal, not the CMS logo as previously used.

A. Recipient Address

POSITION

This subsection contains information of a variable size. The following specification is the same as Section 10.3.3.C, Recipient Address subsection.

The content area begins (0″, 1.35″) with 32 point indent from left margin. It is 1-column or 259 points in width with variable height, from 3 to 6 lines of text, not to exceed 82 points at 6 lines. See figure 10.3.3.C for layout reference.

The name and address information is listed with 9-point clearance around the address when inserted into window envelope, to meet U.S. Postal Service regulations. For specifications on window size and position, see section 10.3.8.A.

FORMATTING

[TB 1.1] all text, all caps

DYNAMIC RULES

All of the content in this subsection is dynamically generated. It should be identical to the recipient address printed on page 1 of the MSN. Please see Section 10.3.3, part C, for detailed dynamic rules for the recipient address.

CONTENT

The recipient address printed here should be identical to the recipient address printed on page 1 of the MSN. Please see Section 10.3.3, part C, for detailed information on the content of the recipient address.

B. Check Notification

This subsection contains a high-priority message to beneficiaries indicating that a check is enclosed.

POSITION
This subsection contains static text content.

The content area begins (0″, 4″), is one-column or 259 points in width with 64 points in height.

MEDICARE PART B CHECK

DO NOT DESTROY

PLEASE CASH AS SOON AS POSSIBLE

figure 10.3.9.B

FORMATTING

[TH 4] Big Header, all caps, center aligned

DYNAMIC RULES

N/A - this section is static.

CONTENT

MEDICARE PART B CHECK
DO NOT DESTROY
PLEASE CASH AS SOON AS POSSIBLE

C. Check

This subsection contains the check refunding funds to the beneficiary. The positioning, formatting, and content of this dynamic content is variable, depending on the check-printing practices of each *MAC*. The one consistent element is the DHHS seal, described below.

POSITION

Align to the top of the top of the check content area. Content should be centered horizontally.

The content area is 193 points in width with 53 points in height.

See Exhibit 2.13 for layout reference.

figure 10.3.9.C

FORMATTING

[GL 3] Check logo

DYNAMIC RULES

As noted above, the dynamic content on the check is variable, depending on the check-printing practices of each *MAC*.

CONTENT

As noted above, the dynamic content on the check is variable, depending on the check-printing practices of each *MAC*.

D. Notice Title on Check Page

Depending on the check-printing practices of the *MAC*, the Notice Title subsection on the MSN may be repeated on the check page. Glyph files, GL 4 (Part A), GL5 (Part B) and GL6 (Part A and B combined), are available as flash images of the 3 different types of Titles. See Section 10.3.3.A for detailed specifications.

10.3.10 - Specifications for Envelopes

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

The envelopes in which MSNs are mailed will be consistent in format, rather than varying depending on which *MAC* is responsible for printing and mailing the MSN.

The envelopes will feature the DHHS seal, not the individual MAC logo or the CMS logo. Content will be printed using Minion for the address and Myriad in all caps for any additional information. Both the DHHS seal and the content will be printed in CMS blue, or Pantone 300 U.

The MSN may be mailed in one of three sizes of envelopes: standard #10 (4.125” x 9.5″), half size (6” x 9″), or full size (9” x 12”).

All MACs are encouraged to print on customized envelopes with adjusted window position to show the recipient address of the MSN when inserted in the envelope. Therefore, coversheets or address labels will no longer be needed for any of the envelope sizes. (The only exception is in the case of Pay MSNs, where the check will be part of a

cover sheet containing the beneficiary's mailing address; see the section above for check cover-sheet instructions, and see below for specifications for the front of Pay MSN envelopes.)

See Exhibit 2.14 for examples of the three different sizes of non-pay envelopes and the Pay MSN envelope.

A. Front of Non-Pay MSN Envelopes

POSITION OF CONTENT

The front of the envelope contains information of a fixed size. It does not vary in overall width or length.

The Department of Health & Human Services seal, an imported image, is located (0.375″, 0.25″). It measures 57 points in width and 57.5 points in height.

The text element starts (1.25″, 0.3″), indented 6 points from the seal. It measures 210 points in width and 75 points in height.

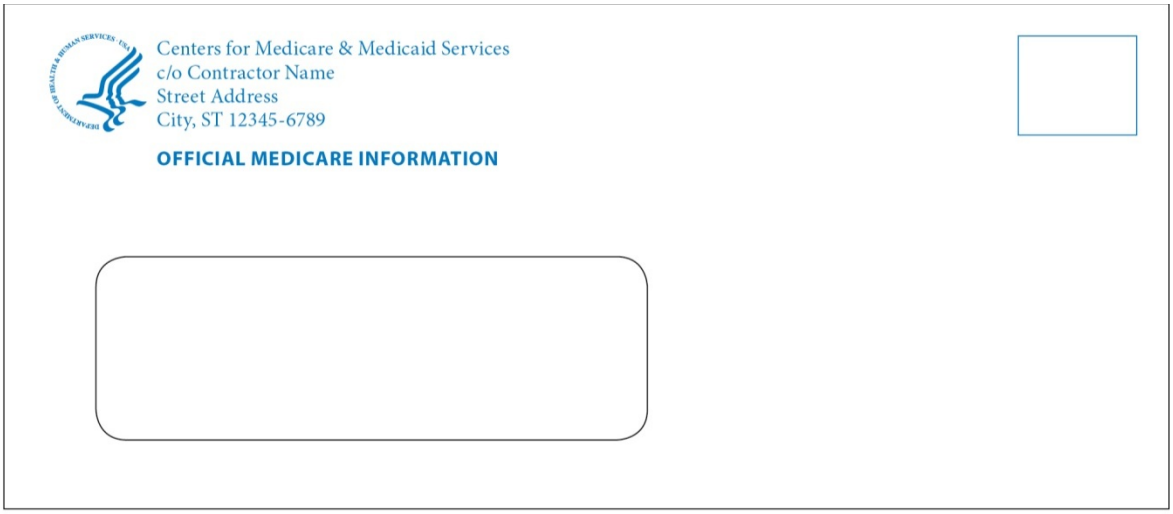

figure 10.3.10.A1

POSITION OF ADDRESS WINDOW

For all sizes of the envelope, the window measures 4.5 inches in width and 1.5 inches in height with rounded corners.

On standard #10 and half-size envelopes, the window is located at (0.75″, 2.06″) from left top corner. *To meet USPS requirements, the window on the standard #10 envelope should be placed 0.625" from the bottom.*

[The below figure has been revised.]

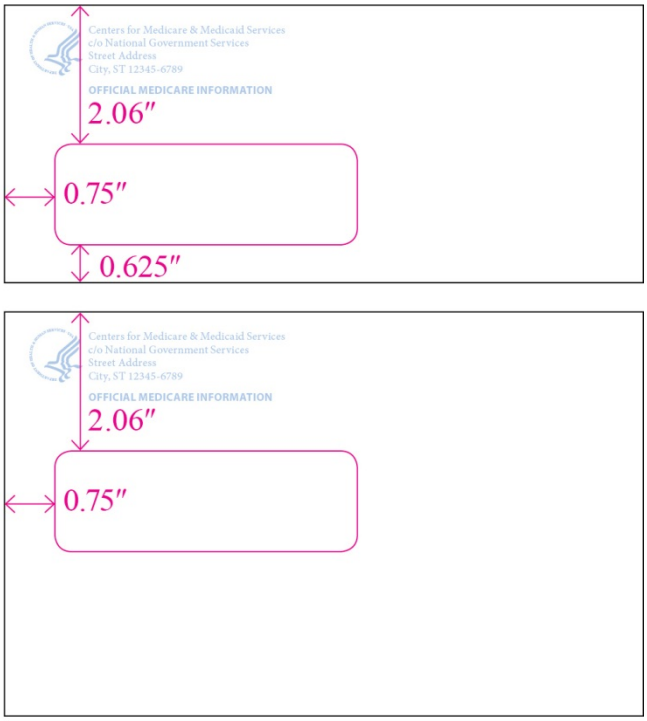

figure 10.3.10.A2

On full-size envelopes, the window is located at (0.5″, 2″) from left top corner.

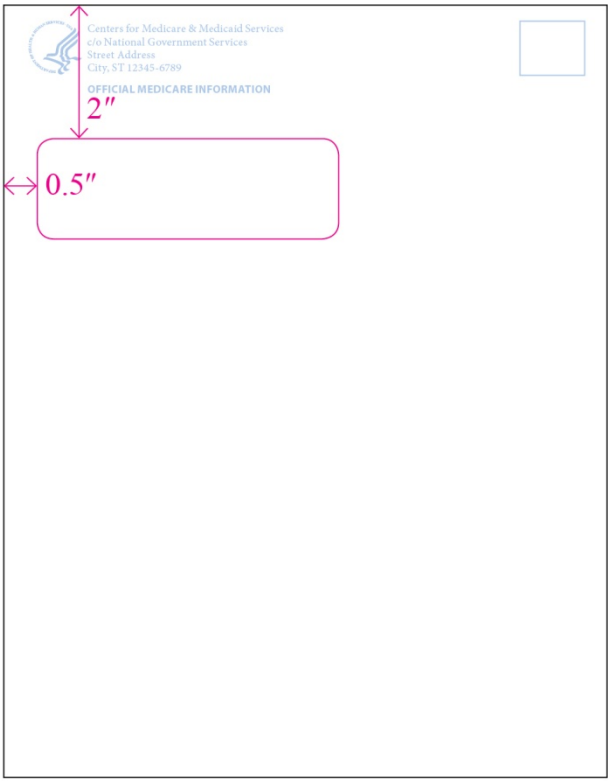

figure 10.3.10.A3

[The below figure is new.]

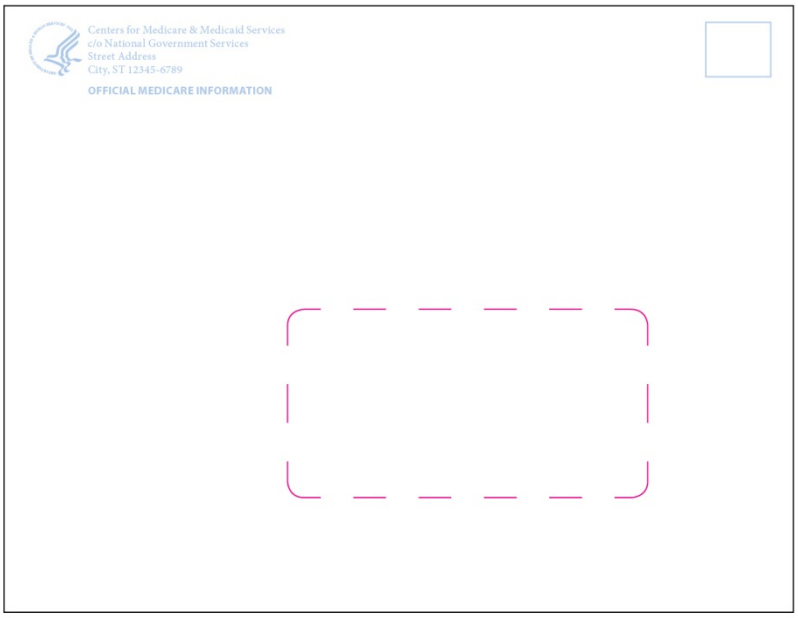

figure 10.3.10.A4

See Exhibit 2.14 for layout reference.

FORMATTING

[GL 7] Department of Health & Human Services seal
[TB 1.1] return address
[GR 4.1] space after
[TB 2.2] notification line (in all capital letters)

DYNAMIC RULES

n/a

CONTENT

The return mailing address listed should be the preferred mailing address of the *MAC* generating the MSN. Complete content is as follows:

[GL 7]

Centers for Medicare & Medicaid Services
c/o {*A/B MAC (A), (B), (HHH), or DME MAC* Name}
{*MAC* Street Address}
{*MAC* City}, {ST} {ZIP+4}

OFFICIAL MEDICARE INFORMATION

B. Front of Pay MSN Envelopes

POSITION OF CONTENT

The front of the envelope contains information of a fixed size. It does not vary in overall width or length.

The Department of Health & Human Services seal, an imported image, is located (0.375″, 0.25″). It measures 57 points in width and 57.5 points in height.

The address text element starts (1.25″, 0.3″), indented 6 points from the seal. It measures 210 points in width and 75 points in height.

The return-service text element starts (5″, 0.5″). It measures 191 points in width and 26 points in height.

See Exhibit 2.14 for layout reference.

[Figure 10.3.10B has been replaced with figure 10.3.10B1.]

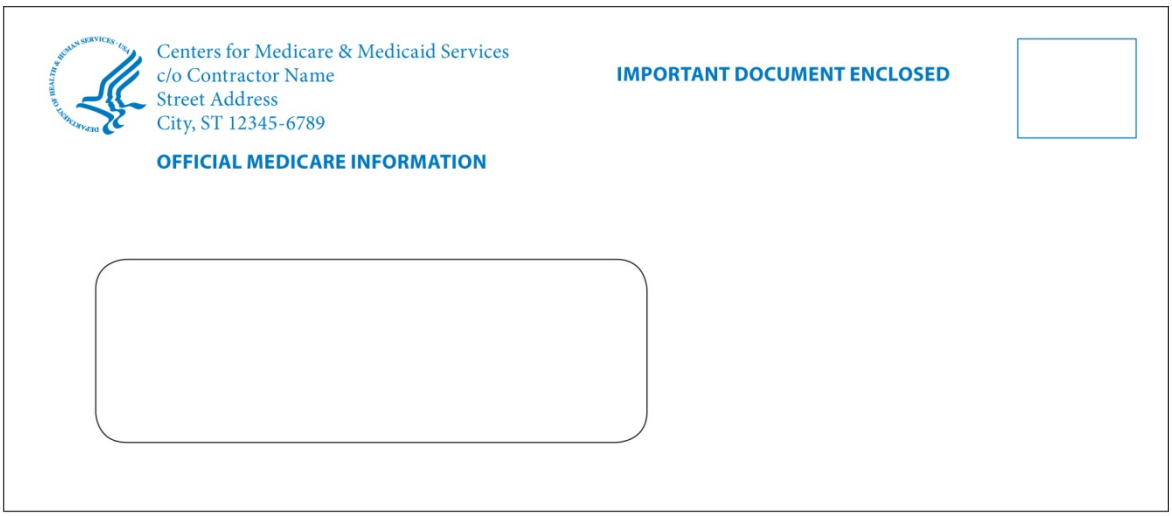

figure 10.3.10.B1

[The below figure is new.]

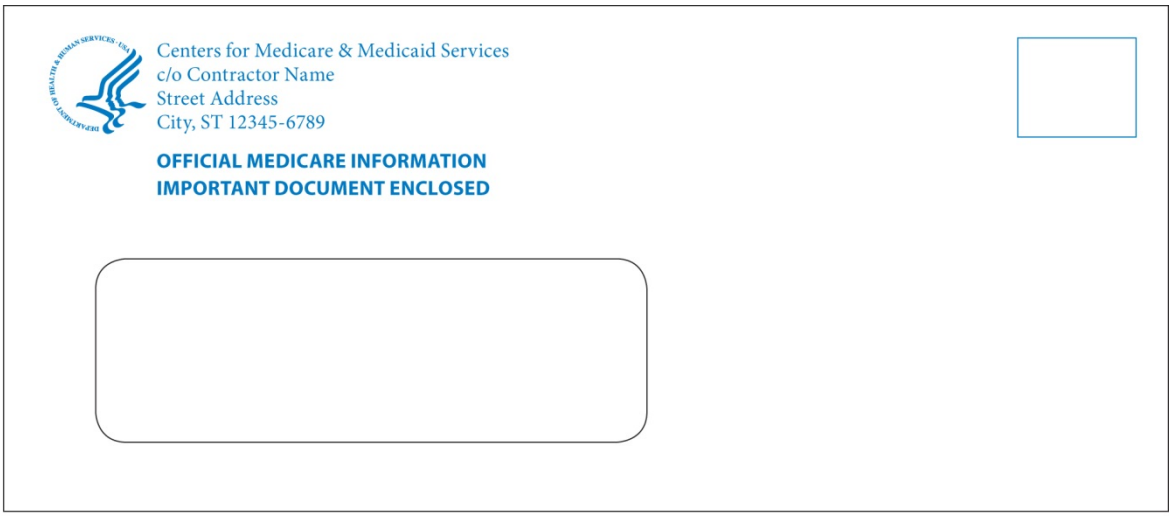

figure 10.3.10.B2

POSITION OF ADDRESS WINDOW

Reference specifications on Section 10.3.10.A for window position.

FORMATTING

[GL 7] Department of Health & Human Services seal
[TB 1.1] return address
[GR 4.1] space after
[TB 2.2] notification line (in all capital letters)
[TB 2.2] *important document line* (in all capital letters)

***NOTE**: For alternate layout of the important document line, it can be below the notification line.*

DYNAMIC RULES

n/a

CONTENT

The return mailing address listed should be the preferred mailing address of the *MAC* generating the MSN. Complete content is as follows:

[GL 7]

Centers for Medicare & Medicaid Services
c/o {*A/B MAC (A), (B), (HHH), or DME MAC* Name}
{*MAC* Street Address}
{*MAC* City}, {ST} {ZIP+4}

OFFICIAL MEDICARE INFORMATION
IMPORTANT DOCUMENT ENCLOSED

C. Back of All Envelopes

POSITION

The back of the envelope contains information of a fixed size. It does not vary in overall width or length.

On standard #10 envelopes, the content area begins 0.375 inches from the top margin and is centered to the width of the envelope. It is 459 points in width and 48 points in height. The vertical position may be adjusted slightly depending on the shape and height of the envelope flap.

On half- and full-size envelopes, the content area begins 0.5 inches from the top margin and is centered to the width of the envelope. It is 433 points in width and 48 points in height. The vertical position may be adjusted slightly depending on the shape and height of the envelope flap.

See Exhibit 2.14 for layout reference.

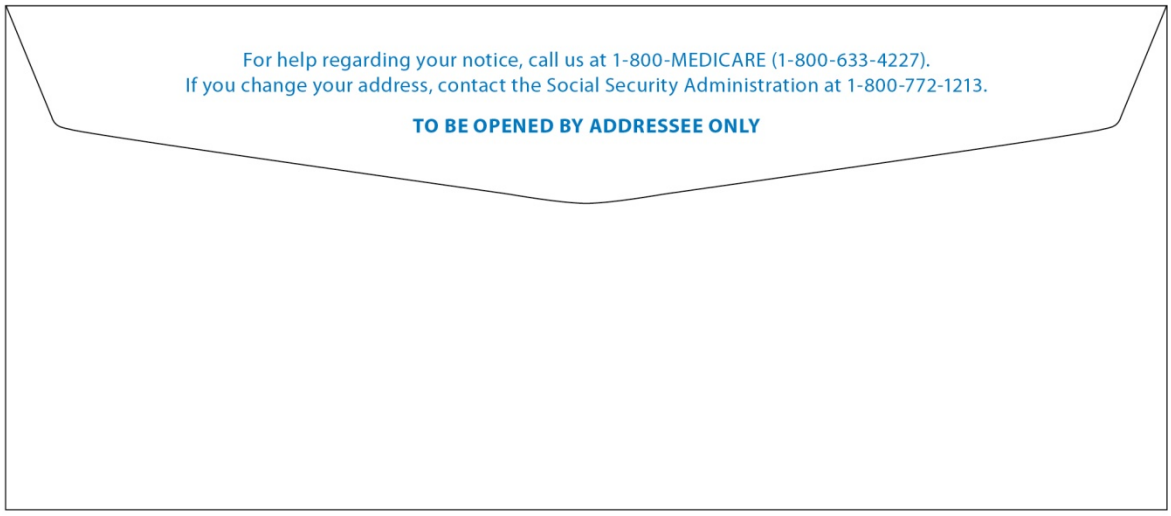

figure 10.3.10.C

FORMATTING

[TB 2.1] instructions, center aligned
[GR 4.1] space after
[TB 2.2] notification line, all caps, center aligned

DYNAMIC RULES

n/a

CONTENT

For help regarding your notice, call us at 1-800-MEDICARE (1-800-633-4227).

If you change your address, contact the Social Security Administration at 1-800-772-1213.

TO BE OPENED BY ADDRESSEE ONLY

D. Envelope Liner

All Pay envelopes must have a security liner inside the envelope to ensure the inserted check cannot be seen through. Shown below is a suggested pattern using the DHHS seal. The artwork will be provided as GL 8 in vector and flash image formats. *The MACs may also use a standard pattern if the recommended custom pattern will be costly to implement.*

figure 10.3.10.D

E. Coversheet

All MACs are encouraged to print on customized envelopes without coversheets. However, if there is a need to have coversheets, the address block should follow the same specifications to those on the MSN. See 10.3.3.C "Recipient Address" subsection for specifications.

10.3.11 - *Specifications for RRB Specialty MAC MSNs*

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

RRB Specialty MAC (S MAC) MSNs produced by Palmetto GBA will follow the design Specifications for the Medicare MSNs. Since RRB is an independent Federal agency, the DHHS seal and Medicare contact numbers/website will be replaced by appropriate content for RRB. Exceptions are noted below.

See Exhibit 1.9 for an example of RRB S MAC MSN in English and Exhibit 3.9 for RRB S MAC MSN in Spanish.

The envelope design and watermark on paper from previous RRB Part BS MAC MSN design will be used as is.

A. Notice Title (10.3.3.A)

Replace RRB logo and descriptive tagline.

[The below figure is new.]

figure 10.3.11.A

FORMATTING
[GL 9] RRB logo
[TH 1.1] notice title
[TH 1.2] notice subtitle, indicating to which Medicare program the notice relates
[GR 8] space after Notice title
[TB 3] notice descriptive tagline

CONTENT
Notices with only claims paid by the RRB S MAC program should have text content as follows:

> ***Medicare Summary Notice***
> *for Part B (Medical Insurance)*
> *The Official Summary of Your Medicare Claims from the RRB Specialty Medicare Administrative Contractor*

B. Foreign Language Footer (10.3.3.J)

Replace 1-800-MEDICARE with RRB's contact number.

[The below figure is new.]

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助，请致电联邦医疗保险，请先说“agent”，然后说”Mandarin”. **1-800-833-4455**

figure 10.3.11.B

FORMATTING
[GL 2-RRB] foreign-language footer

C. How to Report Fraud (10.3.4.C)

Replace 1-800-MEDICARE with RRB's contact number.

[The below figure is new.]

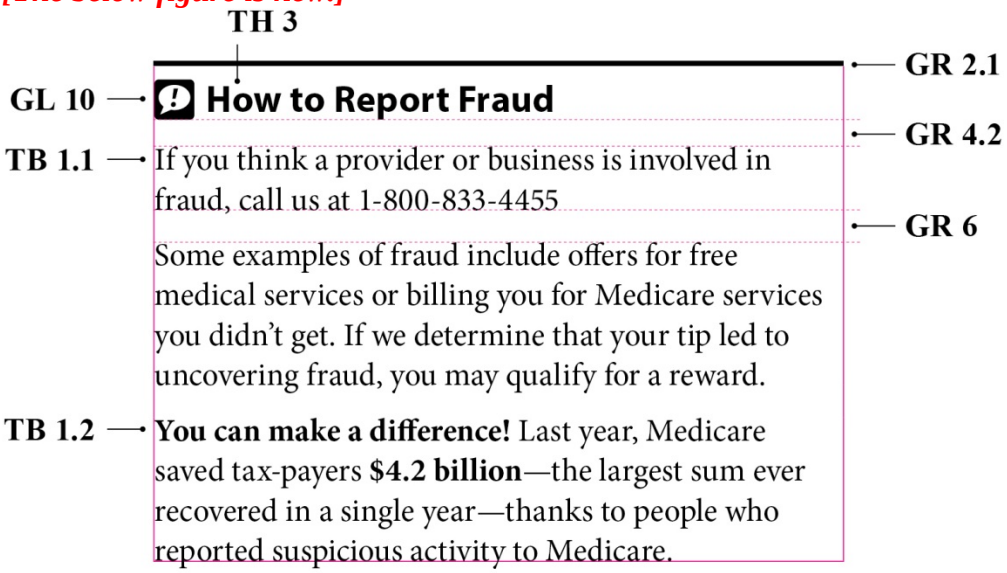

figure 10.3.11.C

CONTENT

How to Report Fraud
If you think a provider or business is involved in fraud, call us at 1-800-833-4455. Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

{CMS fraud message of 185 characters (four lines of text) *The first sentence may be bold, while the remaining text is regular, with occasional bits, such as* ***monetary figures or important words****, highlighted in bold.}*

D. How to Get Help with Your Questions (10.3.4.D)

Replace 1-800-MEDICARE with RRB's contact number.

[The below figure is new.]

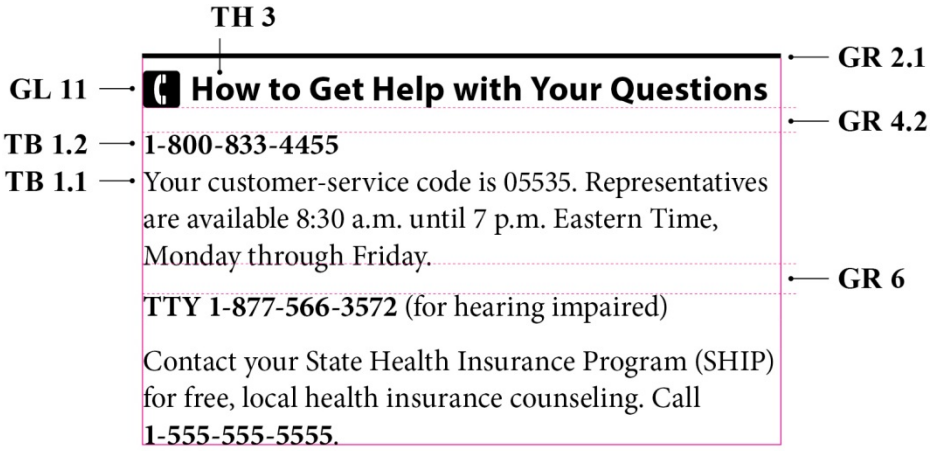

figure 10.3.11.D

CONTENT

How to Get Help with Your Questions
1-800-833-4455

Your customer-service code is {5-DIGIT S MAC ID CODE}. Representatives are available 8:30 a.m. until 7 p.m. Eastern Time, Monday through Friday.

TTY 1-877-566-3572 *(for hearing impaired)*

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE}.

Or, if the MSN mailing address is outside the 50 U.S. states and U.S. territories:
How to Get Help with Your Questions
1-800-833-4455

Your customer-service code is {5-DIGIT S MAC ID CODE}. Representatives are available 8:30 a.m. until 7 p.m. Eastern Time, Monday through Friday.
TTY 1-877-566-3572 *(for hearing impaired)*

E. Get More Details (10.3.8.B)

Replace 1-800-MEDICARE with RRB's contact number.
[The below figure is new.]

TH 3 → **Get More Details**

TB 1.2 → **If a claim was denied, call or write the provider and ask for an itemized statement for any claim.** Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

TB 1.1 →

Call 1-800-833-4455 for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

GR 2.1 — GR 4.1 — GR 6

figure 10.3.11.E

CONTENT

Get More Details
If a claim was denied, call or write the provider and ask for an itemized statement for any claim. *Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.*

Call 1-800-833-4455 for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

F. If You Need Help Filing Your Appeal (10.3.8.D)

Replace 1-800-MEDICARE with RRB's contact number.

[The below figure is new.]

TH 3 → **If You Need Help Filing Your Appeal**

TB 1.2 → **Contact us:** Call 1-800-833-4455 or your State Health

TB 1.1 → Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

GR 2.1 — GR 4.1 — GR 6

figure 10.3.11.F

CONTENT

If You Need Help Filing Your Appeal
Contact us: *Call 1-800-833-4455 or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.*

Call your provider: *Ask your provider for any information that may help you.*

Ask a friend to help: *You can appoint someone, such as a family member or friend, to be your representative in the appeals process.*

Or, if the MSN mailing address is outside the 50 U.S. states and U.S. territories, use the following language:

If You Need Help Filing Your Appeal
Contact us: *Call 1-800-833-4455 for help before you file your written appeal, including help appointing a representative.*

Call your provider: *Ask your provider for any information that may help you.*

Ask a friend to help: *You can appoint someone, such as a family member or friend, to be your representative in the appeals process.*

G. Find Out More (10.3.8.E)

Replace Medicare's website with Palmetto's website.

[The below figure is new.]

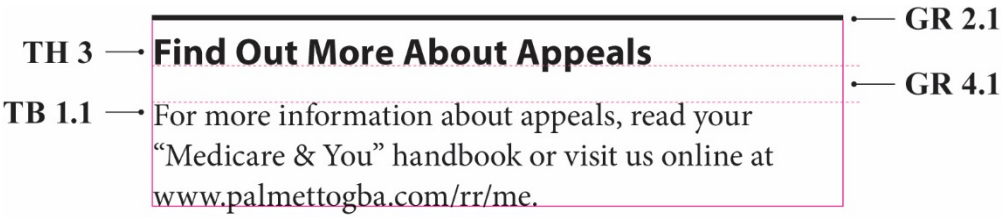

figure 10.3.11.G

CONTENT

Find Out More About Appeals
For more information about appeals, read your "Medicare & You" handbook or visit us online at http://www.palmettogba.com/rr/me.

10.3.12 - *Specifications for SSA Part B MSNs*

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

SSA Part B MSNs produced by Palmetto GBA will follow the design specifications for the Medicare MSNs, including use of DHHS logo and contact numbers.

See Exhibit 1.5 and Exhibit 1.6 for examples of Part B Assigned and Unassigned MSNs.

10.3.13 - *Character Measurements for Fonts*

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

To facilitate coding within the mainframe for variable text fields, the following four charts provide width dimensions for characters used in the MSNs. There are two fonts with two weights each, Minion Regular, Minion Bold, CMS Myriad Regular and CMS Myriad Bold. All character calculations are for 12-point type. Units for the measurements are in points, rounded up to the third decimal digit.

***Note**: Myriad Semibold is used in the design but not listed for width dimensions because it is only used for static text.*

A. MINION REGULAR (SCALE CALCULATION AT 0.99945%)

Decimal Code	*Character*	*Original Width*	*12 pt Width*
32	(space)	227	2.269
33	!	276	2.758
34	"	318	3.178
35	#	480	4.797
36	$	480	4.797
37	%	756	7.556
38	&	711	7.106
39	'	169	1.689
40	(	346	3.458
41	)	346	3.458
42	*	404	4.038
43	+	580	5.797
44	,	228	2.279
45	-	356	3.558

Decimal Code	Character	Original Width	12 pt Width
46	.	228	2.279
47	/	331	3.308
48	0	480	4.797
49	1	480	4.797
50	2	480	4.797
51	3	480	4.797
52	4	480	4.797
53	5	480	4.797
54	6	480	4.797
55	7	480	4.797
56	8	480	4.797
57	9	480	4.797
58	:	228	2.279
59	;	228	2.279
60	<	552	5.517
61	=	580	5.797
62	>	552	5.517
63	?	379	3.788
64	@	753	7.526
65	A	691	6.906
66	B	588	5.877
67	C	665	6.646
68	D	735	7.346
69	E	568	5.677
70	F	529	5.287
71	G	715	7.146
72	H	766	7.656

Decimal Code	Character	Original Width	12 pt Width
73	I	341	3.408
74	J	329	3.288
75	K	673	6.726
76	L	538	5.377
77	M	891	8.905
78	N	743	7.426
79	O	747	7.466
80	P	563	5.627
81	Q	745	7.446
82	R	621	6.207
83	S	474	4.737
84	T	617	6.167
85	U	736	7.356
86	V	703	7.026
87	W	971	9.705
88	X	654	6.536
89	Y	634	6.337
90	Z	603	6.027
91	[	345	3.448
92	\	333	3.328
93	]	345	3.448
94	^	566	5.657
95	_	500	4.997
96	`	400	3.998
97	a	439	4.388
98	b	508	5.077
99	c	423	4.228
100	d	528	5.277

Decimal Code	Character	Original Width	12 pt Width
101	e	425	4.248
102	f	296	2.958
103	g	468	4.677
104	h	534	5.337
105	i	268	2.679
106	j	256	2.559
107	k	496	4.957
108	l	253	2.529
109	m	819	8.185
110	n	547	5.467
111	o	510	5.097
112	p	524	5.237
113	q	511	5.107
114	r	371	3.708
115	s	367	3.668
116	t	305	3.048
117	u	531	5.307
118	v	463	4.627
119	w	685	6.846
120	x	472	4.717
121	y	459	4.587
122	z	420	4.198
123	{	347	3.468
124	|	263	2.629
125	}	347	3.468
126	~	580	5.797
131	É	568	5.677
132	Ñ	743	7.426

Decimal Code	Character	Original Width	12 pt Width
135	á	439	4.388
142	é	425	4.248
146	í	268	2.679
150	ñ	547	5.467
151	ó	510	5.097
156	ú	531	5.307
165	•	390	3.898
173	≠	587	5.867
177	±	580	5.797
178	≤	579	5.787
179	≥	579	5.787
192	¿	379	3.788
193	¡	276	2.758
201	...	970	9.695
208	-	520	5.197
209	—	922	9.215
210	“	398	3.978
211	”	401	4.008
212	‘	224	2.239
213	’	223	2.229
231	Á	691	6.906
234	Í	341	3.408
238	Ó	747	7.466
242	Ú	736	7.356

B. MINION BOLD (SCALE CALCULATION AT 0.99945%)

Decimal Code	Character	Original Width	12 pt Width
32	*(space)*	217	2.169

Decimal Code	Character	Original Width	12 pt Width
33	!	285	2.848
34	"	380	3.798
35	#	500	4.997
36	$	500	4.997
37	%	764	7.636
38	&	715	7.146
39	'	199	1.989
40	(	352	3.518
41	)	352	3.518
42	*	405	4.048
43	+	577	5.767
44	,	254	2.539
45	-	342	3.418
46	.	254	2.539
47	/	327	3.268
48	0	500	4.997
49	1	500	4.997
50	2	500	4.997
51	3	500	4.997
52	4	500	4.997
53	5	500	4.997
54	6	500	4.997
55	7	500	4.997
56	8	500	4.997
57	9	500	4.997
58	:	254	2.539
59	;	254	2.539

Decimal Code	Character	Original Width	12 pt Width
60	<	548	5.477
61	=	577	5.767
62	>	548	5.477
63	?	399	3.988
64	@	766	7.656
65	A	706	7.056
66	B	637	6.366
67	C	676	6.756
68	D	761	7.606
69	E	581	5.807
70	F	554	5.537
71	G	727	7.266
72	H	783	7.826
73	I	378	3.778
74	J	366	3.658
75	K	703	7.026
76	L	551	5.507
77	M	888	8.875
78	N	740	7.396
79	O	766	7.656
80	P	599	5.987
81	Q	758	7.576
82	R	659	6.586
83	S	505	5.047
84	T	641	6.406
85	U	729	7.286
86	V	711	7.106
87	W	979	9.785

Decimal Code	Character	Original Width	12 pt Width
88	X	693	6.926
89	Y	655	6.546
90	Z	619	6.187
91	[	351	3.508
92	\	332	3.318
93	]	351	3.508
94	^	559	5.587
95	_	500	4.997
96	`	400	3.998
97	a	466	4.657
98	b	534	5.337
99	c	422	4.218
100	d	547	5.467
101	e	437	4.368
102	f	331	3.308
103	g	492	4.917
104	h	550	5.497
105	i	295	2.948
106	j	288	2.878
107	k	513	5.127
108	l	278	2.778
109	m	843	8.425
110	n	566	5.657
111	o	525	5.247
112	p	547	5.467
113	q	536	5.357
114	r	404	4.038
115	s	383	3.828

Decimal Code	Character	Original Width	12 pt Width
116	t	339	3.388
117	u	555	5.547
118	v	465	4.647
119	w	683	6.826
120	x	482	4.817
121	y	465	4.647
122	z	445	4.448
123	{	357	3.568
124	|	270	2.699
125	}	357	3.568
126	~	577	5.767
131	É	581	5.807
132	Ñ	740	7.396
135	á	466	4.657
142	é	437	4.368
146	í	295	2.948
150	ñ	566	5.657
151	ó	525	5.247
156	ú	555	5.547
165	•	399	3.988
173	≠	575	5.747
177	±	577	5.767
178	≤	587	5.867
179	≥	587	5.867
192	¿	399	3.988
193	¡	285	2.848
201	...	983	9.825
208	-	511	5.107

Decimal Code	Character	Original Width	12 pt Width
209	—	921	9.205
210	“	445	4.448
211	”	445	4.448
212	‘	242	2.419
213	’	242	2.419
231	Á	706	7.056
234	Í	378	3.778
238	Ó	766	7.656
242	Ú	729	7.286

C. CMS MYRIAD REGULAR (SCALE CALCULATION AT 1.1993%)

Decimal Code	Character	Original Width	12 pt Width
32	(space)	212	2.543
33	!	230	2.758
34	"	337	4.042
35	#	497	5.961
36	$	513	6.152
37	%	792	9.498
38	&	605	7.256
39	'	188	2.255
40	(	284	3.406
41	)	284	3.406
42	*	415	4.977
43	+	596	7.148
44	,	207	2.483
45	-	307	3.682
46	.	207	2.483

Decimal Code	Character	Original Width	12 pt Width
47	/	343	4.114
48	0	513	6.152
49	1	513	6.152
50	2	513	6.152
51	3	513	6.152
52	4	513	6.152
53	5	513	6.152
54	6	513	6.152
55	7	513	6.152
56	8	513	6.152
57	9	513	6.152
58	:	207	2.483
59	;	207	2.483
60	<	596	7.148
61	=	596	7.148
62	>	596	7.148
63	?	406	4.869
64	@	737	8.839
65	A	612	7.340
66	B	542	6.500
67	C	580	6.956
68	D	666	7.987
69	E	492	5.901
70	F	487	5.841
71	G	646	7.747
72	H	652	7.819
73	I	239	2.866

Decimal Code	Character	Original Width	12 pt Width
74	J	370	4.437
75	K	542	6.500
76	L	472	5.661
77	M	804	9.642
78	N	658	7.891
79	O	689	8.263
80	P	532	6.380
81	Q	689	8.263
82	R	538	6.452
83	S	493	5.913
84	T	497	5.961
85	U	647	7.759
86	V	558	6.692
87	W	846	10.146
88	X	571	6.848
89	Y	541	6.488
90	Z	553	6.632
91	[	284	3.406
92	\	341	4.090
93	]	284	3.406
94	^	596	7.148
95	_	500	5.997
96	`	300	3.598
97	a	482	5.781
98	b	569	6.824
99	c	448	5.373
100	d	564	6.764
101	e	501	6.008

Decimal Code	Character	Original Width	12 pt Width
102	f	292	3.502
103	g	559	6.704
104	h	555	6.656
105	i	234	2.806
106	j	243	2.914
107	k	469	5.625
108	l	236	2.830
109	m	834	10.002
110	n	555	6.656
111	o	549	6.584
112	p	569	6.824
113	q	563	6.752
114	r	327	3.922
115	s	396	4.749
116	t	331	3.970
117	u	551	6.608
118	v	481	5.769
119	w	736	8.827
120	x	463	5.553
121	y	471	5.649
122	z	428	5.133
123	{	284	3.406
124	|	239	2.866
125	}	284	3.406
126	~	596	7.148
131	É	492	5.901
132	Ñ	658	7.891
135	á	482	5.781

Decimal Code	Character	Original Width	12 pt Width
142	é	501	6.008
146	í	234	2.806
150	ñ	555	6.656
151	ó	549	6.584
156	ú	551	6.608
165	•	282	3.382
173	≠	596	7.148
177	±	596	7.148
178	≤	596	7.148
179	≥	596	7.148
192	¿	406	4.869
193	¡	230	2.758
201	…	1000	11.993
208	-	500	5.997
209	—	1000	11.993
210	"	354	4.246
211	″	354	4.246
212	‘	207	2.483
213	’	207	2.483
231	Á	612	7.340
234	Í	239	2.866
238	Ó	689	8.263
242	Ú	647	7.759

D. CMS MYRIAD BOLD (SCALE CALCULATION AT 1.1993%)

Decimal Code	Character	Original Width	12 pt Width
32	(space)	202	2.423
33	!	268	3.214

Decimal Code	Character	Original Width	12 pt Width
34	"	397	4.761
35	#	550	6.596
36	$	555	6.656
37	%	880	10.554
38	&	678	8.131
39	'	205	2.459
40	(	314	3.766
41	)	314	3.766
42	*	454	5.445
43	+	596	7.148
44	,	260	3.118
45	-	322	3.862
46	.	260	3.118
47	/	331	3.970
48	0	555	6.656
49	1	555	6.656
50	2	555	6.656
51	3	555	6.656
52	4	555	6.656
53	5	555	6.656
54	6	555	6.656
55	7	555	6.656
56	8	555	6.656
57	9	555	6.656
58	:	260	3.118
59	;	260	3.118
60	<	596	7.148

Decimal Code	Character	Original Width	12 pt Width
61	=	596	7.148
62	>	596	7.148
63	?	445	5.337
64	@	770	9.235
65	A	656	7.867
66	B	604	7.244
67	C	595	7.136
68	D	696	8.347
69	E	534	6.404
70	F	527	6.320
71	G	682	8.179
72	H	689	8.263
73	I	285	3.418
74	J	411	4.929
75	K	614	7.364
76	L	511	6.128
77	M	846	10.146
78	N	690	8.275
79	O	717	8.599
80	P	581	6.968
81	Q	717	8.599
82	R	593	7.112
83	S	540	6.476
84	T	548	6.572
85	U	682	8.179
86	V	636	7.628
87	W	888	10.650
88	X	613	7.352

Decimal Code	Character	Original Width	12 pt Width
89	Y	603	7.232
90	Z	577	6.920
91	[	314	3.766
92	\	330	3.958
93	]	314	3.766
94	^	596	7.148
95	_	500	5.997
96	`	300	3.598
97	a	528	6.332
98	b	598	7.172
99	c	451	5.409
100	d	596	7.148
101	e	528	6.332
102	f	341	4.090
103	g	585	7.016
104	h	586	7.028
105	i	274	3.286
106	j	291	3.490
107	k	542	6.500
108	l	275	3.298
109	m	860	10.314
110	n	586	7.028
111	o	577	6.920
112	p	598	7.172
113	q	595	7.136
114	r	380	4.557
115	s	434	5.205
116	t	367	4.401

Decimal Code	Character	Original Width	12 pt Width
117	u	583	6.992
118	v	530	6.356
119	w	759	9.103
120	x	519	6.224
121	y	523	6.272
122	z	469	5.625
123	{	314	3.766
124	|	283	3.394
125	}	314	3.766
126	~	596	7.148
131	É	534	6.404
132	Ñ	690	8.275
135	á	528	6.332
142	é	528	6.332
146	í	274	3.286
150	ñ	586	7.028
151	ó	577	6.920
156	ú	583	6.992
165	•	338	4.054
173	≠	596	7.148
177	±	596	7.148
178	≤	596	7.148
179	≥	596	7.148
192	¿	445	5.337
193	¡	268	3.214
201	…	1000	11.993
208	-	500	5.997
209	—	1000	11.993

Decimal Code	*Character*	*Original Width*	*12 pt Width*
210	"	*454*	*5.445*
211	″	*454*	*5.445*
212	'	*260*	*3.118*
213	′	*260*	*3.118*
231	*Á*	*656*	*7.867*
234	*Í*	*285*	*3.418*
238	*Ó*	*717*	*8.599*
242	*Ú*	*682*	*8.179*

20 - Specifications for Spanish MSN

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

The Spanish MSN designs generally follow the same specifications as the English versions. Exceptions are noted immediately below.

The actual text of the MSN will be in Spanish. Approved language translations for the Spanish MSN are supplied in the *Spanish exhibits, 3.1 - 3.17. Spanish translations of MSN content are usually 25% longer than the equivalent English text. However, when translation is done from English, translators are encouraged to make them as concise as possible.*

20.1 - *Specifications for Content Variations of Spanish MSNs*

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Language & Style Conventions (Global)

Spanish text does not follow the convention of title case. All headers should follow sentence case, where the first letter of the header (and proper names, such as "Medicare") is capitalized, but all remaining text is lowercase.

Spanish dates with be listed with numeric day, spelled-out month, and complete numeric year with 'de' in between the fields (e.g., 16 de septiembre de 2011).

B. Notice Title (10.3.3:A)

The notice descriptive tagline on Spanish MSNs run in two lines.

[The below figure is new.]

figure 20.1.B

C. Notice Details (10.3.3:D)

The gray highlight box on Spanish MSNs the same width and 137 points height. This will account for the length of the date being longer in Spanish.

Aviso para Andrea Torres

Número de Medicare	**XXX-XX-1234A**
Fecha de este aviso	**16 de septiembre de 2011**
Reclamación procesada entre	**15 de diciembre de 2011 – 15 de marzo de 2012**

figure 20.1.C

D. Be Informed (10.3.3:F)

This subsection can accommodate one message from CMS of up to 375 characters (inclusive of spaces) in Spanish.

E. Foreign Language Footer (10.3.3:J)

The Foreign Language Footer flash image on page 1 is not needed on Spanish MSNs and should be suppressed.

F. How to Report Fraud (10.3.5:C)

The third and final paragraph of this section contains a fraud-specific message from CMS. The message must be a maximum of 225 characters long (inclusive of spaces).

G. Your Messages from Medicare (10.3.5:G)

This subsection can accommodate up to four messages from CMS. First and second messages must be no longer than 225 characters long (inclusive of spaces) and third and fourth messages must be no longer than 300 characters long (inclusive of spaces).

H. CPT code descriptors

Spanish MSNs should keep current practice and use translations from the 28-character short descriptions codes for both level 1 and level 2 HCPCS descriptions. This may change after CMS review (5/11/12).

I. Claim Column Titles (10.3.6:D)

The claim column titles runs in 4 lines in the Spanish MSNs. The height is 50 points but the widths of columns stay the same. Content variation and formatting stays the same as English.

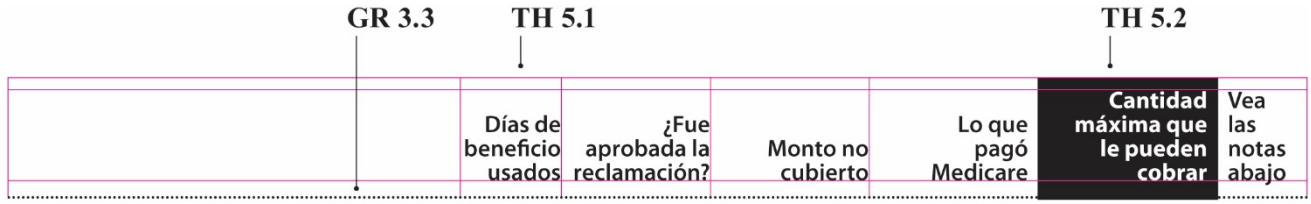

figure 20.1.I1

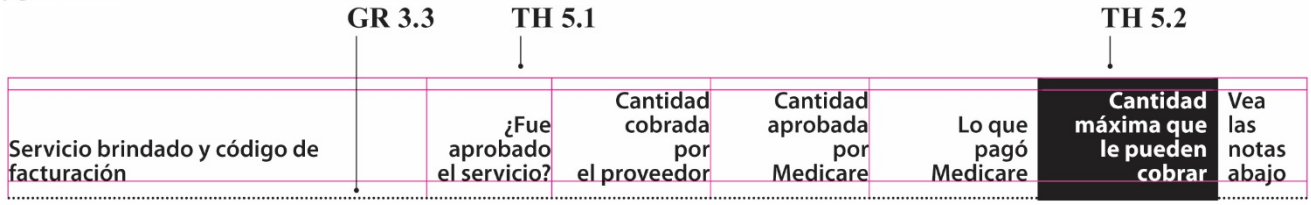

figure 20.1.I2

J. Get More Details (10.3.8:B)

Due to restriction on space, the content area for this subsection begins (0″, 0.97″) or 8 points from the baseline of the "Section Title" subsection.

K. If You Need Help Filing Your Appeal (10.3.8:D)

See Exhibit 3.17 for alternate language for contact when the MSN mailing address is outside the 50 states.

L. Find Out More (10.3.8:E)

Due to space restraints, the Spanish MSNs do not have a header for "Find Out More About Appeals" subsection. Instead only the body content is listed as the last paragraph of the previous subsection, "If You Need Help Filing Your Appeal" (10.3.8.D).

Si necesita ayuda con su pedido

Comuníquese con nosotros: Llame al 1-800-MEDICARE o a su Programa Estatal de Asistencia con el Seguro Médico (vea la página 2) para obtener ayuda con su apelación y para averiguar cómo nombrar un representante.

Llame a su hospital o centro: Pídale cualquier información que pueda ayudarle.

Pídale a un amigo que llame: También puede nombrar a un amigo o familiar para que actúe como su representante durante el proceso de apelación.

GR 6

TB 1.1 Para más información, consulte el manual "Medicare y Usted" o visite www.medicare.gov/appeals.

figure 20.1.K

M. File an Appeal in Writing (10.3.8:F)

Due to restriction on space, the content area for this subsection begins (0", 0.97"). This should top align with the "Get More Details" subsection in the left column.

If the contractor needs 5 lines for the mailing address, delete GR 4.1 space between step 7 and the MAC address to fit the gray box within the page.

documentación para su archivo personal.

7 Envíe este aviso y toda la documentación necesaria a la siguiente dirección:
Medicare Claims Office
c/o First Coast Service Options, Inc.
attn: Appeals Department
Street Address
City, ST 12345-6789

figure 20.1.M

FORMATTINg
[GR 1] gray fill
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.1] body text
[GR 4.1] space after header
[TB 2.2] step 1 [TB 2.1] body text
[GR 4.1] space after header

[TB 2.2] step 2 [TB 2.1] body text
[GR 4.1] space after header
[TB 2.2] step 3 [TB 2.1] body text
[GR 4.1] space after header
[TB 2.1] fill in category
[GR 5] space after text
[GR 7] fill in box
[GR 6] space after text
[TB 2.1] fill in category
[GR 5] space after text
[GL 7] fill in box
[GR 4.1] space after header
[TB 2.2] steps 4 - 7 [TB 2.1] body text
[TB 2.2] MAC address

N. Spanish RRB S MAC MSNs (10.3.12)

The Spanish RRB Part B MSNs follow the same content and specifications variations in this section. See Exhibit 3.9 for translations specific to RRB Part B MSNs.

30 - Exhibits

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

Exhibits are only available electronically. Click on this link to view them:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending
After clicking on the link, scroll down the webpage until you see Chapter 21 listed. The Exhibits are directly below that.

30.1 - Exhibits of the Extended Family of MSNs in Black & White

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

Exhibit 1.1 - Part A, Inpatient
Exhibit 1.2 - 'B of A'
Exhibit 1.3 -Hospice
Exhibit 1.4 -Home Health
Exhibit 1.5 - Part B, Assigned
Exhibit 1.6 - Part B, Unassigned
Exhibit 1.7 - DME, Assigned
Exhibit 1.8 - DME, Unassigned
Exhibit 1.9 - *RRB Part B, Assigned*

30.2 - Exhibits of Alternate Scenarios

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

Exhibit 2.1 - Duplicate MSN Header

Exhibit 2.2 - Multiple Deductible Types on Part B MSN
Exhibit 2.3 - Multiple Deductible Years and Benefit Days on a Part A and Part 'B of A' Combined
Exhibit 2.4 - Provider List with Tag
Exhibit 2.5 - Provider Header Format
Exhibit 2.6 - Multiple Dates and/or Providers Subtitle
Exhibit 2.7 - Part A Inpatient None-Remain Benefit Days
Exhibit 2.8 - Adjusted Claim
Exhibit 2.9 - Continued Claims with Continuation Box
Exhibit 2.10 - Breaking Claims with Long Notes
Exhibits 2.11 - Combined Claims, Part A Inpatient and 'B of A' Combined
Exhibit 2.12 - Combined Claims, Part B Assigned and Unassigned
Exhibit 2.13 - Pay MSN
Exhibit 2.14 - Non-Pay Envelopes
Exhibit 2.15 - Pay Envelope & Envelope Liner
Exhibit 2.16 - Part A Inpatient Claims with no claims on page 3
Exhibit 2.15 - Part B Claims with no claims on page 3

30.3 - Exhibits of MSNs in Spanish

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

Exhibit 3.1 - Spanish Part A, inpatient
Exhibit 3.2 - Spanish 'B of A'
Exhibit 3.3 - Spanish Hospice
Exhibit 3.4 - Spanish Home Health (A)
Exhibit *3.5* - Spanish *Part B, assigned*
Exhibit *3.6* - Spanish Part B, *un*assigned
Exhibit *3.7* - Spanish *DME*, assigned
Exhibit *3.8* - Spanish DME, *un*assigned
Exhibit 3.9 - Spanish *RRB Part B,* assigned
Exhibit 3.10 - Spanish duplicate MSN header
Exhibit 3.11 - Spanish multiple deductible types on Part B MSN
Exhibit 3.12 - Spanish multiple deductible years and benefit days on a Part A Inpatient and 'B of A' combined
Exhibit 3.13 - Spanish provider list with tag
Exhibit 3.14 - Spanish fee line with large amount and none remain benefit days
Exhibit 3.15 - Spanish adjusted claim
Exhibit 3.16 - Spanish Pay MSN
Exhibit 3.17 - Alternate language for SHIP Contact Info

30.4 - Exhibits of the Extended Family of MSNs in Color

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

This chapter's specifications are detailed for black & white printing. Color printing is not being implemented at this time. However, it is possible that *MACs* may be encouraged to print in color in the future.

In regards to the MSN, “color” refers to the usage of blue and black ink only. The approved blue ink color for Centers for Medicare & Medicaid Services publications is PMS 300, in the Pantone Matching System.

For additional color specifications, please refer to the exhibits below.

Exhibit 4.1 - Part A, Inpatient Color
Exhibit 4.2 - Part B, *Assigned Color*
Exhibit 4.3 - DME, Assigned Color

40 - *General Information*, Explanatory, and Denial Messages

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

General Information (GI) messages are used on pages 1 and 2 of the MSN, under the ***Be Informed! How to Report Fraud****, and* ***Your Messages from Medicare*** *sections. GI messages are messages that communicate important information about the Medicare program or that serve as important reminders to beneficiaries. CMS communicates which messages to use, and when to use them, via Technical Direction Letters (TDLs) or Change Requests (CRs).*

Explanatory and Denial messages appear under the claims section of the MSN. Their purpose is to concisely communicate essential information to the beneficiary regarding claim determinations or to serve as an educational tool.

The MSN message file is found at the hyperlink *at the bottom of this section*. Messages are grouped in categories for ease of reference only. Unless specific messages are specified in instructions by CMS, *MACs* should select and use the most appropriate message(s) for each situation to explain the action taken on a service, item, or claim. *MACs* are instructed to use the most appropriate message for each situation regardless of message category.

Use multiple messages as appropriate including ones grouped within different categories. Use the message(s) which best explains the situation(s) in the claim.

All denied or reduced services must have an explanation.

The BBA of 1997 requires the amount of Medicare payment for each service be included on all Part A Benefit notices, including the MSN and Notice of Utilization (NOU.) *MACs* use message 16.53 on all *A/B MAC (A) or (HHH)* generated notices with payments.

The *MAC* may combine “add-on” messages with existing messages to create a single message within its file.

Each message on the file is tied to an alphabetic code on the MSN. Print no more than three alphabetic codes per claim level and three alphabetic codes per service line.

Messages containing fill-in blanks may be left as blanks for filling in by the system or may be entered into the system with blanks pre-filled to create as many specific messages as there are fill-in situations.

The message numbering in this section does not have to be used in *MAC* message generating systems.

Certain messages are mandated. These messages and the situations for which they are mandated are identified in the MSN message file at the hyperlink *at the end of this section*. This does not eliminate the need to use other messages required by instructions elsewhere in the manual.

Beneficiary liability "Add-on" messages should be printed in addition to denial and reduction messages for charges which the beneficiary is determined not liable. Liability "Add-on" messages should print for denials or reductions such as:

- Services that are part of another service or bundled code;
- Services determined not to be medically necessary in situations where the beneficiary was not notified in writing, prior to receipt of the service, that Medicare may not make payment;
- Duplicate charges; and
- Denials for utilization reasons.

The complete list of MSN messages is only available electronically. Click on this link to view them: http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R3210CP	03/03/2015	Final MSN Redesign-Related Update to Chapter 21 of the Medicare Claims Processing Manual	04/16/2015	8626
R3195CP	02/13/2015	Final MSN Redesign-Related Update to Chapter 21 of the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 3210	04/16/2015	8626
R2522CP	08/21/2012	Redesign of the Medicare Summary Notice (MSN)-Final Implementation and Major Update to Chapter 21 of the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2522	07/02/2012	7676
R2419CP	03/07/2012	Redesign of the Medicare Summary Notice (MSN)-Final Implementation and Major Update to Chapter 21 of the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2522	07/02/2012	7676
R2411CP	02/03/2012	Redesign of the Medicare Summary Notice (MSN)-Final Implementation and Major Update to Chapter 21 of the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2419	07/02/2012	7676
R1802CP	08/28/2009	Expansion of the Number of Services Fields in Medicare Summary Notices (MSNs)	01/04/2010	6577
R1579CP	08/21/2008	Modification to Existing Medicare Summary Notices (MSN) Procedures Regarding the MSN Customer Service Information Box, Beneficiary Estate Information and the Appeals Address	07/07/2008	5889

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R1546CP	07/01/2008	Modification to Existing Medicare Summary Notices (MSN) Procedures Regarding the MSN Customer Service Information Box, Beneficiary Estate Information and the Appeals Address - Rescinded and replaced by Transmittal 1579	07/07/2008	5889
R1500CP	05/02/2008	Modification to Existing Medicare Summary Notices (MSN) Procedures Regarding the MSN Customer Service Information Box, Beneficiary Estate Information and the Appeals Address - Rescinded and replaced by Transmittal 1546	07/07/2008	5889
R1491CP	04/11/2008	New Process for Accessing MSN Messages and MSN Message File	05/12/2008	5964
R1467CP	02/29/2008	Modification to Existing Medicare Summary Notice (MSN) Procedures Regarding the MSN Customer Service Information Box	03/31/2008	5959
R1444CP	02/08/2008	Modification to Existing Medicare Summary Notices (MSN) Procedures Regarding the MSN Customer Service Information Box, Beneficiary Estate Information and the Appeals Address – Replaced by Transmittal 1500	07/07/2008	5889
R1420CP	01/25/2008	Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process	02/01/2008	5837
R1399CP	12/19/2007	Handling Personal Identifiable Information on the Medicare Summary Notice	01/07/2008	5770
R1392CP	12/14/2007	New Medicare Summary Notice (MSN) General Information Section Message Regarding Medicare Records for New	01/07/2008	5841

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		Retirees, and Modification to Update the MSN Messages		
R1380CP	11/23/2007	Modification to Update the Medicare Summary Notice (MSN) Messages and the MSN Customer Service Information Box	01/07/2008	5799
R1347CP	09/28/2007	MSN Message: Revised 38.13	10/29/2007	5722
R1106CP	11/09/2006	Outpatient Therapy Cap Clarifications	01/02/2007	5271
R1090CP	10/27/2006	Medicare Summary Notice (MSN) Format Changes for Jurisdiction 3 A/B MAC	04/02/2007	5342
R955CP	05/19/2006	Quarterly Medicare Summary Notice (MSN) Printing Cycle	06/12/2006	5062
R945CP	05/12/2006	Quarterly Medicare Summary Notice (MSN) Printing Cycle	06/12/2006	5062
R922CP	04/28/2006	MSN Format Changes for DMERCs and the DME MAC Transition	07/03/2006	5071
R866CP	02/17/2006	Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs	07/03/2006	4309
R854CP	02/13/2006	MSN Format Changes for DMERCs and the DME MAC Transition	07/03/2006	4341
R839CP	02/06/2006	Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs	07/03/2006	4309
R830CP	02/02/2006	Denial of Claims Not Timely Filed	07/03/2006	4041
R638CP	08/05/2005	New Medicare Summary Notices (MSN) Messages	01/03/2006	3957
R603CP	07/15/2005	Modification to the Appeals Language on the Medicare Summary Notice	10/03/2005	3924

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R587CP	06/17/2005	New Location for Contractor ID Number on Medicare Summary Notices (MSNs)	7/11/2005	3895
R581CP	06/10/2005	New Location for Contractor ID Number on Medicare Summary Notices (MSNs)	07/11/2005	3895
R535CP	04/29/2005	Modification to the Appeals Language on the Medicare Summary Notice	10/03/2005	3808
R450CP	01/27/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R435CP	01/14/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R401CP	12/16/2004	2005 Part B Deductible Update to the Back Page of Medicare Summary Notices	01/24/2005	3600
R393CP	12/10/2004	2005 Part B Deductible Update to the Back Page of Medicare Summary Notices	01/24/2005	3600
R308CP	10/01/2004	Two New Medicare Summary Notice (MSN) Messages for Parenteral Pumps-DMERC Only	10/04/2004	3506
R298CP	09/10/2004	Carriers, Reason and Remark Codes	09/25/2004	2617
R295CP	09/03/2004	Carriers, Reason and Remark Codes	09/25/2004	2617
R249CP	07/23/2004	New Medicare Summary Notice Message for Claim Adjustments	01/03/2005	2989
R227CP	07/09/2004	MSN Message 15.19 Is Updated, and 15.20 Is Manualized for the First Time	08/09/2004	3222
R214CP	06/25/2004	Carriers, Reason and Remark Codes	09/25/2004	2617
R159CP	04/30/2004	Implementation of National 1-800-MEDICARE	06/01/2004	3195

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R094CP	02/06/2004	Additional Information in Medicare Summary Notices (MSNs) to Beneficiaries About Skilled Nursing Facility (SNF) Benefits	07/06/2004	3098
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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