

# Reporting “Other Insurance” in CHAMPS

## Commercial Insurance – Billing Co-Insurance Amount

Total Submitted Charges = \$79.00

Does the beneficiary have insurance other than Medicaid?  Yes  No

### OTHER INSURANCE INFORMATION

#### Other Subscriber Information

Payer Responsibility Code:	P-Primary *	Subscriber Member ID:					
Payer ID Number:	00029005 *	First Name:	Test	MI:		Suffix:	
Subscriber Last Name:	Provider	Gender:	F-Female				
Date of Birth:	mm dd yyyy 09 23 1958	Beneficiary's Relationship:	18-Self				
Insured's Group or Policy Number:	123456789 *	Total COB Payer Paid Amount:	\$ 49.88 *	<a href="#">Add Another</a>			
Claim Filing Indicator :	BL-Blue Cross/Blue Shield *						

### OTHER INSURANCE INFORMATION

#### 1. Service Line Other Payer Information

Primary Payer Responsibility:	1#P#00029005#BL-Blue Cross/Blue Shield *	Amount Paid: \$	49.88 *			
1. Reason Code:	45	Amount: \$	9.14	Adjustment Quantity:		<a href="#">Add Another Reason Code</a>
2. Reason Code:	2	Amount: \$	20.00	Adjustment Quantity:		

[Add Another Payer](#)

# Medicare Deductible

Total Submitted Charges = \$327.00

Yes  No Does the beneficiary have insurance other than Medicaid?

**OTHER INSURANCE INFORMATION**  
**Other Subscriber Information**

Payer Responsibility Code:	<input type="text" value="P-Primary"/>	Subscriber Member ID:	<input type="text"/>				
Payer ID Number:	<input type="text" value="44444444"/>	First Name:	<input type="text" value="Test"/>	MI:	<input type="text"/>	Suffix:	<input type="text"/>
Subscriber Last Name:	<input type="text" value="Provider"/>	Gender:	<input type="text" value="F-Female"/>				
Date of Birth:	<input type="text" value="09"/> <input type="text" value="23"/> <input type="text" value="1958"/>	Beneficiary's Relationship:	<input type="text" value="18-Self"/>				
Insured's Group or Policy Number:	<input type="text" value="123456789A"/>	Total COB Payer Paid Amount:	<input type="text" value="\$0.00"/>	<a href="#">Add Another</a>			
Claim Filing Indicator :	<input type="text" value="MB-Medicare Part B"/>						

**OTHER INSURANCE INFORMATION**  
**1. Service Line Other Payer Information**

Primary Payer Responsibility:  \* Amount Paid: \$  \*

1. Reason Code:	<input type="text" value="45"/>	Amount:	<input type="text" value="\$217.94"/>	Adjustment Quantity:	<input type="text"/>	<a href="#">Add Another Reason Code</a>
2. Reason Code:	<input type="text" value="1"/>	Amount:	<input type="text" value="\$109.06"/>	Adjustment Quantity:	<input type="text"/>	

[Add Another Payer](#)

## Other Insurance Not Covered

Total Submitted Charges = \$1,050.00

Yes  No

### OTHER INSURANCE INFORMATION

#### Other Subscriber Information

Payer Responsibility Code:	<input type="text" value="P-Primary"/>	*	Subscriber Member ID:	<input type="text"/>				
Payer ID Number:	<input type="text" value="00056190"/>	*	First Name:	<input type="text" value="Test"/>	MI:	<input type="text"/>	Suffix:	<input type="text"/>
Subscriber Last Name:	<input type="text" value="Provider"/>		Date of Birth:	<input type="text" value="09"/> <input type="text" value="23"/> <input type="text" value="1958"/>	Gender:	<input type="text" value="F-Female"/>		
Insured's Group or Policy Number:	<input type="text" value="123456789"/>	*	Beneficiary's Relationship:	<input type="text" value="18-Self"/>				
Claim Filing Indicator :	<input type="text" value="CI-Commercial Insurance Co."/>	*	Total COB Payer Paid Amount:	\$	<input type="text" value="0.00"/>	*	<a href="#">Add Another</a>	

Top

### OTHER INSURANCE INFORMATION

#### 1. Service Line Other Payer Information

Primary Payer Responsibility:	<input type="text" value="1#P#00056190#CI-Commercial Insurance Co."/>	*	Amount Paid: \$	<input type="text" value="0.00"/>	*	
1. Reason Code:	<input type="text" value="98"/>	Amount:	\$ <input type="text" value="1,050.00"/>	Adjustment Quantity:	<input type="text"/>	<a href="#">Add Another Reason Code</a>
2. Reason Code:	<input type="text"/>	Amount:	\$ <input type="text"/>	Adjustment Quantity:	<input type="text"/>	

[Add Another Payer](#)

# Reporting Primary and Secondary Insurance other than Medicaid

Total Submitted Charges = \$920.00

Does the beneficiary have insurance other than Medicaid?  Yes  No

## OTHER INSURANCE INFORMATION

### Other Subscriber Information

Payer Responsibility Code:  \*

Payer ID Number:  \* Subscriber Member ID:

Subscriber Last Name:  First Name:  MI:  Suffix:

Date of Birth:    Gender:

Insured's Group or Policy Number:  \* Beneficiary's Relationship:

Claim Filing Indicator:  \* Total COB Payer Paid Amount: \$  \* [Add Another](#)

### 2. Other Subscriber Information

Payer Responsibility Code:  \*

Payer ID Number:  \* Subscriber Member ID:

Subscriber Last Name:  First Name:  MI:  Suffix:

Date of Birth:    Gender:

Insured's Group or Policy Number:  \* Beneficiary's Relationship:

Claim Filing Indicator:  \* Total COB Payer Paid Amount: \$  \* [Delete](#)

## OTHER INSURANCE INFORMATION

### 1. Service Line Other Payer Information

Primary Payer Responsibility:  \* Amount Paid: \$  \*

1. Reason Code:  Amount: \$  Adjustment Quantity:  [Add Another Reason Code](#)

2. Reason Code:  Amount: \$  Adjustment Quantity:

[Add Another Payer](#)

### 2. Service Line Other Payer Information

Primary Payer Responsibility:  \* Amount Paid: \$  \* [Delete Payer](#)

1. Reason Code:  Amount: \$  Adjustment Quantity:  [Add Another Reason Code](#)

2. Reason Code:  Amount: \$  Adjustment Quantity:

3. Reason Code:  Amount: \$  Adjustment Quantity:  [Delete](#)