ARKANSAS DEPARTMENT OF HUMAN SERVICES

CMS 1500/UB04

MEDICARE EOMB INFORMATION

Please attach this document to claim form CMS-1500 or CMS-1450 (UB04).

Provider #:		Provider Name:			
Beneficiary #:		Beneficiary Name:			
Billed Amount:		From DOS:		To DOS:	

Please complete only one of the following sections:

CMS-1500:

Medicare Paid Amount:		Medicare Allowed Amount:	
Co-Insurance Amount:		Deductible Amount:	
Amount Medicare Not Covered:		Medicare Paid Date:	
Psych Reduction Amount:			

CMS-1450 (UB04):

Medicare Paid Amount:		Medicare Allowed Amount:	
Co-Insurance Amount:		Deductible Amount:	
Amount Medicare Not Covered:		Medicare Paid Date:	
Blood Deductible Amount:			

Please mail the completed national form and this attachment to:

Gainwell Technologies
PO Box 34440
Little Rock, AR 72203