

CMS1500 CROSSOVER EOMB FORM

Member Name: _____ Member ID: _____

EOMB Date: _____

Line ___ Deduct/Pat Resp Amt

Coinsurance Amount

Provider Pay Amount

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Line ___ Deduct/Pat Resp Amt

Coinsurance Amount

Provider Pay Amount

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Line ___ Deduct/Pat Resp Amt

Coinsurance Amount

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