

KYHealth Choices CMS1500 CROSSOVER EOMB FORM

Members Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

EOMB Date: \_\_\_\_\_

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount

Line	Allowed/Deduct Amount	Coinsurance Amount	Provider Pay Amount