CMS1500 CROSSOVER EOMB FORM

Member Name: ________________________________ **Member ID:** _________________

EOMB Date: ___________________________

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt

Line____ Deduct/Pat Resp Amt | Coinsurance/Co-pay Amt | Provider Pay Amt