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:**

DXC Technology
PO Box 34440
Little Rock, AR 72203