UB-04 claim form requirements

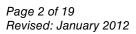
All hospitals participating with Regence are required to submit *UB-04* claims in electronic format except for Type of Bill XX7. Following are instructions and requirements for completing a *UB-04* claim form.

	Form	
Requirements	Locator	Description
Required	1:	Provider Name and Address, and Telephone Number
		Enter provider's name, address, ZIP code and
		phone number.
	2:	Pay-to Name, Address, and Secondary Identification
		Fields
		Leave blank.
Required	3:	Patient Control Number
		Enter patient's control number or patient account number.
Required	4:	Type of Bill (TOB)
		Enter type of bill code.
		Valid type of bill codes:
		Hospital – Inpatient 11X 12X 18X
		Hospital – Outpatient 13X 14X
		Skilled Nursing – Inpatient 21X 22X
		Skilled Nursing – Outpatient 23X
		Home Health 32X 33X 34X
		Clinic 71X 72X 73X 74X 75X
		76X 79X
		Special Facility 81X 82X 83X 85X
		Valid third digit codes:
		Admit through discharge claim 1
		Interim - First claim 2
		Interim - Continuing claim 3
		Interim - Last claim 4
		Late charges only claim 5
		Replacement of prior claim 7 (submit on paper)
		Void/cancel prior claim 8 (submit on paper)
Required	5:	
		Enter your federal tax identification number.
Required	6:	Statement Covers Period (From-Through)
		Enter statement covers from and through date. Must be in
		CCYYMMDD format.
	7:	Untitled
		Not used

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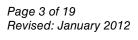


	Form	
Requirements	Locator	Description
Required	8:	Patient's Name
riequirea	0.	Enter patient's last name, first name and middle initial.
Required	9:	Patient Address
riequirea	3.	Enter patient's full mailing address including street
		number, city, state and zip code.
Required	10:	Patient Birth Date
ricquirca	10.	Enter patient's date of birth. Must be in MMDDCCYY
		format.
Required	11:	Patient Sex
noqui ou		Enter "M" (male) or "F" (female).
Required	12:	Admission Date
noqui ou		Enter date patient is admitted for this stay. Must be in
		MMDDCCYY format.
Required for	13:	Admission Hour
inpatient claims		Enter the admission hour code.
		Valid Admission Hour Codes.
		00 = 12:00-12:59 midnight 12 = 12:00-12:59 noon
		01 = 01:00-01:59
		02 = 02:00-02:59
		03 = 03:00-03:59
		04 = 04:00-04:59
		05 = 05:00-05:59
		06 = 06:00-06:59
		07 = 07:00-07:59
		08 = 08:00-08:59
		09 = 09:00-09:59
		10 = 10:00-10:59
		11 = 11:00-11:59
		99 = Unknown
Required for	14:	Type of Admission/Visit
inpatient claims		Enter the type of admission code. This code indicates the
-		priority of this admission.
		Valid type of admission codes:
		1 = Emergency
		2 = Urgent 3 = Elective
		4 = Newborn
		5 = Trauma Center
		9 = Information not available
		U = Information not available





	Form	
Requirements	Locator	Description
Required	15:	Point of Origin for Admission or Visit
		Enter the code indicating the source of the referral for this
		admission or visit.
		Valid source of admission codes:
		1 = Non-Health Care Facility
		2 = Clinic
		3 = Reserved for national assignment
		4 = Transfer from a hospital (different facility)
		5 = Transfer from a skilled nursing facility or Intermediate
		Care Facility
		6 = Transfer from another health care facility
		7 = Emergency Room (ER) 8 = Court/Law enforcement
		9 = Information not available
		B = Transfer from another home health agency
		C = Readmission to same home health agency
		D = Transfer from hospital inpatient in the same facility
		resulting in a separate claim to the payer
		E = Transfer from ambulatory surgery center
Required for	16:	
inpatient claims		Enter the discharge hour code.
		V " 1 D: 1
		Valid Discharge Hour Codes.
		00 = 12:00-12:59 midnight 12 = 12:00-12:59 noon
		01 = 01:00-01:59
		02 = 02:00-02:59 03 = 03:00-03:59 15 = 03:00-03:59
		04 = 04:00-04:59 16 = 04:00-04:59
		05 = 05:00-05:59 17 = 05:00-05:59
		06 = 06:00-06:59
		07 = 07:00-07:59
		08 = 08:00-08:59 20 = 08:00-08:59
		09 = 09:00-09:59
		10 = 10:00-10:59
		11 = 11:00-11:59
		99 = Unknown

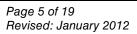




	Form	
Requirements	Locator	Description
Required for inpatient claims	17:	Patient Status Required for outpatient claims if the patient status code is other than 01. Enter patient status code.
		Valid Patient Status Codes: 01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another acute short-term general hospital for inpatient care 03 = Discharged/transferred to a SNF 04 = Discharged/transferred to an ICF 05 = Discharged/transferred to another type of institution not defined elsewhere in this code list 06 = Discharged/transferred to home under care organized home health service organization 07 = Left against medical advice or discontinued care 08 = Reserved for National Assignment 09 = Admitted as an inpatient to this hospital 20 = Expired 30 = Still patient or expected to return for outpatient services
		The following are used only on hospice claims: 40 = Expired at home 41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice 42 = Expired – place unknown 43 = Discharged/transferred to a federal health care facility 50 = Discharged/transferred to Hospice – home 51 = Discharged/transferred to Hospice – medical facility 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 62 = Discharges/transferred to an inpatient rehabilitation facility including distinct part units of a "hospital" 63 = Discharged/transferred to long term care hospital 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 = Discharged/transferred to a Critical Access Hospital

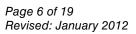


	Form	
	Locator	Description
Recommended	18 – 28:	Condition Codes Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. We can only accept up to 10 condition codes.
Recommended	18 - 28	Valid Condition Codes 02 = Condition is Employment Related 03 = Patient Covered by Insurance Not Reflected 04 = Information Only Bill 05 = Lien Has Been 06 = ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance 07 = Treatment of Non-terminal Condition for Hospice Patient 08 = Beneficiary Would Not Provide Information Concerning Other Insurance Coverage. 09 = Neither Patient Nor Spouse is Employed 10 = Patient and/or Spouse is Employed but no EGHP Coverage 11 = Disabled Beneficiary But no Large Group Health Plan 12-14 = Payer codes reserved for internal use only by third party payers. 17 = Patient is Homeless 18 = Maiden Name Retained 19 = Child Retains Mother's Name 20 = Beneficiary Requested 21 = Billing for Denial Notice 26 = VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility 27 = Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test (Sole Community Hospitals only). 28 = Patient and/or Spouse's EGHP is Secondary to Medicare 29 = Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare 30 = Qualifying Clinical Trials Student Status 31 = Patient is a Student (Full-Time - Day) 32 = Patient is a Student (Full-Time - Night) 34 = Patient is a Student (Part-Time) Accommodation



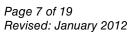


	Form	
Requirements	Locator	Description
Requirements		36 = General Care Patient in a Special Unit (Not used by hospitals under PPS 37 = Ward Accommodation at Patient's Request (Not used by hospitals under PPS.) 38 = Semi-private Room Not Available (Not used by hospitals under PPS 39 = Private Room Medically Necessary (Not used by hospitals under PPS) 40 = Same Day Transfer 41 = Partial Hospitalization 42 = Continuing Care Not Related to Inpatient Admission 43 = Continuing Care Not Provided Within Prescribed Post Discharge Window 44 = Inpatient Admission Changed to Outpatient 46 = Non-Availability Statement on File 47 = Reserved for TRICARE 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs) 49 = Product replacement within product Skilled Nursing Facility Information 55 = SNF Bed Not Available 56 = Medical Appropriateness 57 = SNF Readmission 58 = Terminated Managed Care Organization Enrollee 59 = Non-primary ESRD Facility
		67 = Beneficiary Elects Not to Use Lifetime Reserve (LTR) 69 = IME/DGME/N&A Payment Only Renal Dialysis Setting 71 = Full Care in Unit 72 = Self-Care in Unit 73 = Self-Care Training 74 = Home 75 = Home 100-percent 76 = Back-up In-Facility Dialysis 77 = Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full 78 = New Coverage Not Implemented by Managed Care Plan 79 = CORF Services Provided Off-Site 80 = Home Dialysis-Nursing Facility A9 = Second Opinion Surgery AA = Abortion Performed due to Rape AB = Abortion Performed due to Incest



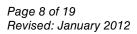


	Form	
Requirements	Locator	Description
		AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
		AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself AE = Abortion Performed due to Physical Health of Mother that is not Life Endangering AF = Abortion Performed due to Emotional/psychological Health of the Mother AG = Abortion Performed due to Social Economic Reasons AH = Elective Abortion Self AI = Sterilization Self-explanatory AJ = Payer Responsible for Copayment AK = Air Ambulance AL = Specialized Treatment/bed Unavailable AM = Non-emergency Medically Necessary Stretcher Transport Required AN = Preadmission Screening Not Required
		B1 = Beneficiary is Ineligible for Demonstration Program B2 = Critical Access Hospital Ambulance Attestation B3 = Pregnancy Indicator B4 = Admission Unrelated to Discharge
		Quality Improvement Organization (QIO) C1 = Approved as Billed C3 = Partial Approval C4 = Admission Denied C5 = Post-payment Review Applicable C6 = Preadmission/Pre-procedure C7 = Extended Authorization D0 = Changes to Service Dates D1 = Changes to Charges D2 = Changes to Revenue Codes/HCPCS/HIPPS Rate Code D3 = Second or Subsequent Interim PPS Bill D4 = Changes In ICD-9-CM Diagnosis and/or Procedure Code D5 = Cancel to Correct HICN or Provider ID D6 = Cancel Only to Repay a Duplicate or OIG
		Overpayment D7 = Change to Make Medicare the Secondary Payer D8 = Change to Make Medicare the Primary Payer D9 = Any Other Change



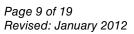


	Form	
Requirements	Locator	Description
110quii oiiioiiio	2004101	DR = Disaster related
		E0 = Change in Patient Status
		G0 = Distinct Medical Visit
		H0 = Delayed Filing, Statement Of Intent Submitted
Required for	29	Accident State
automobile		Two-digit state abbreviation of the state where the
accidents		accident occurred.
	20	
	30	Untitled
Docommonded	31 – 41:	Not used. Occurrence Codes and Dates
Recommended	31 – 41:	Required when there is a condition code that applies to
Required for all accidents		this claim. Form locators 31, 32, 33, and 34 – allow both
accidents		an occurrence codes and a date. Dates must be in
		MMDDYY format. The Occurrence Span Code can contain
		an occurrence code where the "Through" date would not
		contain an entry.
		Valid Occurrence Codes
		Accident Related Codes
		01 = Accident/Medical Coverage
		02 = No-Fault Insurance Involved
		03 = Accident/Tort Liability
		04 = Accident/Employment Related
		05 = Accident/No Medical or Liability Coverage
		06 = Crime Victim
		Medical Condition Codes
		09 = Start of Infertility Treatment Cycle
		10 = Last Menstrual Period
		11 = Onset of Symptoms/Illness (Outpatient claims only.)
		12 = Date of Onset for a Chronically Dependent Individual
		(CDI) (HHA Claims Only
		Insurance Related Codes
		16 = Date of Last Therapy
		17 = Date Outpatient Occupational Therapy Plan
		Established or Reviewed
		18 = Date of Retirement Patient/Beneficiary.
		19 = Date of Retirement Spouse
		20 = Guarantee of Payment Began (Part A hospital claims
		only
		21 = UR Notice Received (Part A SNF claims only.) 22 = Date Active Care Ended
		23 = Date Active Care Ended 23 = Date of Cancellation of Hospice Election Period
		20 - Date of Carlochation of Flospice Election (endu





	Form	
Requirements	Locator	Description
		24 = Date Insurance Denied 25 = Date Benefits Terminated by Primary Payer 26 = Date SNF Bed Available 27 = Date of Hospice Certification or Re-Certification 28 = Date CORF Plan Established or Last 29 = Date OPT Plan Established or Last Reviewed
		30 = Date Outpatient Speech Pathology Plan Established or Last Reviewed
		 31 = Date Beneficiary Notified of Intent to Bill (Accommodations) 32 = Date Beneficiary Notified of Intent to Bill (Procedures or Treatments) 33 = First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP 34 = Date of Election of Extended Care Services 35 = Date Treatment Started for Physical Therapy 36 = Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s) 37 = Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant 38 = Date treatment started for Home IV Therapy 39 = Date discharged on a continuous course of IV 40 = Scheduled Date of Admission 41 = Date of First Test for Pre-admission Testing 42 = Date of Discharge (Hospice claims only 43 = Scheduled Date of Cancelled Surgery 45 = Date Treatment Started for Speech Therapy 46 = Date Treatment Started for Cardiac 47 = Date Cost Outlier Status Begins
		Service Related Codes A1 = Birth Date-Insured A The birth-date of the insured in whose name the insurance is carried. A2 = Effective Date-Insured A Policy A3 = Benefits Exhausted A4 = Split Bill Date B1 = Birth Date-Insured B B2 = Effective Date-Insured B Policy B3 = Benefits Exhausted C1 = Birth Date-Insured C C2 = Effective Date-Insured C Policy C3 = Benefits Exhausted 70 = Qualifying Stay Dates (Part A claims for SNF level of care only



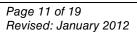


tor	Description
	71 = Hospital Prior Stay Dates (Part A claims only
	72 = First/Last Visit
	74 = Non-covered Level of Care
	Codes 76 and 77 apply to most non-covered care 76 = Patient Liability The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary.
	77 = Provider Liability- Utilization Charged The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care
	M2 = Dates of Inpatient Respite From/Through dates of a period of inpatient M3 = ICF Level of Care
	M4 = Residential Level of Care
37:	Untitled
	Not used.
38:	Responsible Party Name and Address
- 41	
- d:	Enter value code. Amount is required when a value code is entered. If value code 45 is entered then amount needs to reflect an admission hour (see Form Locator 13).
	Valid Value Codes
	01 = Most common semi-private rate
	02 = Hospital has no semi-private rooms
	03 = Inpatient professional component charges which are combined billed
	04 = Inpatient professional component charges which are combined billed
	05 = Professional component included in charges and also billed separate to carrier
	06 = Medicare blood deductible
	08 = Medicare life time reserve amount in the first calendar year
	09 = Medicare coinsurance amount in the first calendar year
	10 = Lifetime reserve amount in the second calendar year
	11 = Coinsurance amount in the second calendar year
	12 = Working aged beneficiary/spouse with employer group health plan.

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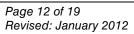


	Form	
Requirements	Locator	Description
riequirements	Locator	 13 = ESRD beneficiary in a Medicare coordination period with an employer group health plan 14 = No fault, including auto/other 15 = Worker's compensation
		16 = PHS or other federal agency
Required	39 – 41	•
	a - d:	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '
		22 = Surplus
		23 = Recurring monthly income 24 = Medicaid rate code
		24 = Medicald rate code
		Reserved Codes
		31 = Patient liability amount
		32 = Multiple Patient Ambulance Transport
		37 = Pints of blood furnished
		38 = Blood deductible pints
		39 = Pints of blood replaced
		40 = New coverage not implemented by HMO (for inpatient service only)
		41 = Black Lung
		42 = VA
		43 = Disabled beneficiary under age 65 with LGHP
		44 = Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received, then a Medicare secondary
		payment is due 45 = Accident Hour
		46 = Number of grace days
		47 = Any liability insurance
		48 = Hemoglobin reading
		49 = Hematocrit reading
		50 = Number of physical therapy visits from onset (at the billing provider through this billing period)
		51 = Number of occupational therapy visits from onset of
		symptoms (at the billing provider through this billing period)
		52 = Number of speech therapy visits from onset of symptoms (at the billing provider)
		53 = Number of cardiac rehabilitation visits (at the billing provider through this billing period)
		54 = Newborn birth weight in grams





	Form	
Requirements	Locator	Description
		Home Health Specific Codes 56 = Skilled nursing - home visit hours (HHA only) 57 = Home health aide - home visit hours (HHA only) 58 = Arterial blood gas value 59 = Oxygen saturation value 60 = HHA branch MSA
		61 = Place of residence where service is furnished (HHA and Hospice) 67 = Peritoneal dialysis 68 = Number of units of EPO drug administered and/or supplied 71 = Funding of ESRD Networks 72 = Flat Rate Surgery Charge 73 = Drug deductible 74 = Drug coinsurance 76 = Provider's Interim Rate 80 = Covered days 81 = Non-covered days 82 = Co-insurance days 83 = Lifetime Reserve days
		Deductible Coinsurance Codes A1 = Deductible amount Payer A B1 = Deductible amount Payer B C1 = Deductible amount Payer C A2 = Coinsurance amount Payer A B2 = Coinsurance amount Payer B C2 = Coinsurance amount Payer C A3 = Estimated responsibility Payer A B3 = Estimated responsibility Payer B C3 = Estimated responsibility Payer C D3 = Estimated responsibility Payer C
		A4 = Covered self-administrable drugs – emergency A5 = Covered self-administrable drugs – not self- administrable in form and situation furnished to patient A6 = Covered Self-Administrable Drugs – Diagnostic Study and Other (For use with Revenue Code 0637) A7 = Co-payment Payer A B7 = Copayment Payer B C7 = Copayment Payer C



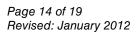


	Form	
Requirements	Locator	Description
		A8 = Patient Weight
		A9 = Patient Height
		G8 = Facility where inpatient hospice service is delivered
Required for	42:	Revenue Code
each charge		An accommodation revenue code (0100-0219) is required
entered		for all inpatient type of bill (TOB).
Optional	43:	Revenue Description
		A narrative description of the related revenue categories
		included on the claim. Abbreviations may be used.
Recommended	43:	Revenue Description for National Drug Code (NDC)
		information
		Enter the two-digit Product ID Qualifier "N4" in the first two positions, immediately followed by the 11-digit NDC code
		with no hyphens. Directly following the last digit of the
		NDC (no delimiter), enter the two-digit Unit of
		Measurement Qualifier. Immediately following the Unit of
		Measurement Qualifier, enter the nine-digit quantity. The
		nine digits consist of six digits for the whole number,
		followed by the three-digit decimal portion of the number.
		Valid Unit of Measurement Qualifiers are:
		F2 – International unit
		GR – Gram ML – Milliliter
		UN – Unit
		OT OTHE
		Please see the <u>Healthy Options Administrative Manual</u>
		section for additional Healthy Options NDC requirements.
		The HCPCS code should be entered in Form Locator 44
		and the Units in Form Locator 46.
Required	44:	HCPCS/Rates/HIPPS Rate Codes
		A CPT or HCPCS code is required for outpatient services
Doguisod	45:	or supplies. Service Date
Required	45:	Enter the date that the services were provided. Must be in
		MMDDCCYY format.
Required	46:	Units of Service
ricquireu	70.	Enter the number of units rendered for each service. Units
		can be hours, days/sessions, tests/services or items.
Required for	47:	Total Charges
each revenue		Enter total charges Enter total charges pertaining to the
code entered		related revenue code for the current billing period. Zeros
		are valid.
L	<u> </u>	l.

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	Form	
Requirements	Locator	Description
Optional	48:	Non-Covered Charges
Optional	40.	Enter non-covered charges.
	49:	Untitled
	43.	Not used.
	51	Health Plan ID
	a- c:	Ticaliti Tiairib
Required	52	Release of Information Certification Indicator
nequired	a – c:	A "Y" code indicates that the provider has on file a signed
	a – c.	statement permitting it to release data to other
		organizations in order to adjudicate the claim. This is
		required when state or federal laws do not supersede the
		HIPAA Privacy Rule by requiring that a signature be
		collected. An "I" code indicates informed Consent to
		Release Medical Information for Conditions or Diagnoses
		Regulated by Federal Statutes.
Optional	53	Assignment of Benefits Certification Indicator
	a – c:	
Optional	54	Prior Payments-Payers and Patient
	a – c:	Enter the amount of the prior payments from other
		insurance.
Optional	55	Estimated Amount Due from patient
	a – c:	
Required	56:	Billing Provider National Provider ID (NPI)
		Enter the billing provider's NPI.
	57:	Other Provider ID (primary, secondary, and/or tertiary)
		Use this field to report your Regence provider identification
		number if submitting a paper claim without an NPI.
		Marke A.B
		Note: A Regence provider number may no longer be used
		on electronic or paper-submitted claims after
		December 31, 2011.
Required	58	Insured's Name
	a – c:	Enter the insured's last name, first name and middle initial
		as it appears on the member card.





	Form	
Requirements	Locator	Description
Required	59	Patient's Relationship to Insured
•	a – c:	Enter patient's relationship to insured code.
		01 = Spouse
		18 = Self
		19 = Child
		20 = Employee 21 = Unknown
		39 = Organ Donor
		40 = Cadaver Donor
		53 = Life Partner
		G8 = Other Relationship
Required	60	Insured's Unique Identification (ID)
•	a – c:	Enter insured's identification number as shown on member
		card.
Optional	61	Insured's Group Name
	a – c:	
Required	62	Insurance Group Number
	a – c:	Enter the insured's group number as shown on the
		member card.
		Everytion, if a manch of court from another Divisions
		Exception: If a member card from another Blue Cross
		and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric
		(e.g., 9999999)
Required for	63:	Treatment Authorization Code
Home Health	00.	
Regence		
MedAdvantage		
claims		
Optional	64:	Document Control Number (DCN)
Optional	65:	Employer Name
Optional	66:	Diagnosis and Procedure Code Qualifier (ICD Version
		Indicator)
		The qualifier denotes the version of <i>International</i>
		Classification of Diseases (ICD) reported. The following
		qualifier code reflects the edition portion of the ICD 9 –
.		Ninth Revision
Required	67:	Principal Diagnosis Code and Present on Admission Indicator
		Enter the ICD-9 diagnosis code for the principal diagnosis.
		The principal diagnosis is the condition established after
		study to be chiefly responsible for this hospital admission.
		The code must be the full ICD-9 diagnosis code, including
		The code must be the full lob-s diagnosis code, including

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	Form	
Requirements	Locator	Description
		all five digits where applicable. Do not include the decimal between the third and fourth digits. "V" codes are acceptable as principal diagnoses.
		This field is eight positions long. The principal diagnosis is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
Required	67A –	Other Diagnoses Codes
	67Q:	Enter up to seventeen ICD-9 diagnosis codes for the other diagnoses. The codes must be the full ICD-9 diagnosis codes, including all five digits where applicable. Do not include the decimal between the third and fourth digits. Both "V" and "E" codes may be entered as other diagnoses, though E codes are preferably billed in form locator 72.
		There are 17 Other Diagnosis fields. Each Other Diagnosis field is eight positions long. The diagnosis code is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
		Diagnosis codes must be carried to their highest degree of detail. Do not duplicate the principal diagnosis in this field.
	68:	Untitled Not used.
Required for	69:	Admitting Diagnosis
inpatient type of bills		Must be a valid ICD diagnosis code. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.
Required for outpatient if applicable	70 a – c:	Patient's Reason for Visit Required for all unscheduled outpatient visits for outpatient bills.
Optional	71:	Prospective Payment System (PPS) Code
Required if applicable	72:	External Cause of Injury Code (E-Code) Enter up to three E-Codes if an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. The codes must be the full ICD-9 E-code, including all five digits where applicable. Do not include the decimal between the fourth
		and fifth positions.

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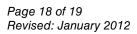


	Form	
Doguiromento	Locator	Description
Requirements	Locator	Description There are 2.5. Code fields. Each 5. Code field is eight
		There are 3 E-Code fields. Each E-Code field is eight positions long. The E-Code is entered in positions 1 - 4 or
		5, as needed. Present on Admission (POA) is entered in
		position 8. The POA area is shaded on the paper form.
	73:	Untitled
	73.	Not used.
Required for	74:	Principal Procedure Code and Date
-	74.	Enter the principal procedure code and date. The
inpatient type of		procedure code must a valid ICD-9 procedure code. Do
bills		not include the decimal between the second and third
if applicable		
De maine el ferr	74.6	digits. The date must be in the MMDDYY format. Other Procedure Codes and Dates
Required for	74A –	
inpatient type of	74E:	Enter up to five other procedure codes and dates. The
bills well		procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third
if applicable		
	75	digits. The date must be in the MMDDYY format.
	75:	Untitled
D	70	Not used.
Required	76:	Attending Provider Name and Identifiers (including NPI)
		Enter the unique provider's NPI and the name of the
		attending physician for inpatient bills or the physician that
		requested the outpatient services.
		requested the outputtent services.
		Definition of attending provider: The provider who is the
		individual who has overall responsibility for the patient's
		medical care and treatment reported in this
		claim/encounter.
Optional	77:	Operating Provider Name and Identifiers (including NPI)
Optional	78 and	Other Provider Name and Identifiers (including NPI)
Optional	70 and 79:	
Required under	80:	Remarks
circumstances	00.	1. If revenue code 0450, 0456 or 0459 are entered in
listed		Form Locator 42, remarks should clarify
listea		circumstances for emergency room visit, i.e. who,
		what, when, where, why, how and time of day. Use
		of E-Code and Occurrence codes are valid.
		2. If CPT codes are used in place of HCPCS codes
		with any of the following revenue codes entered in
		Form Locator 44, remarks should specify the type of
		, , , , , , , , , , , , , , , , , , , ,
		drug, implant, or device:
		0254 = Drugs incident to other diagnostic service
		0255 = Drugs incident to radiology

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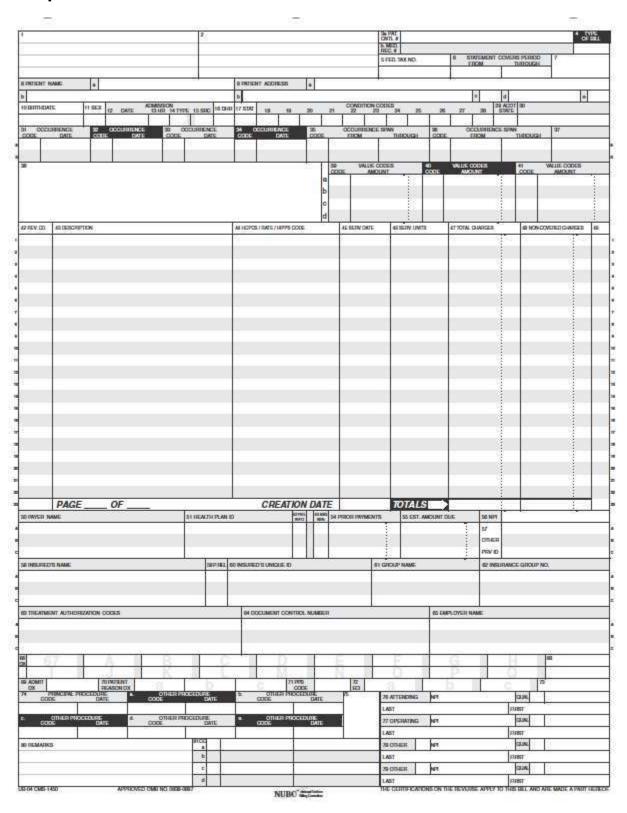


	Form	
Requirements	Locator	Description
		0256 = Experimental drugs
		0259 = Other pharmacy
		0274 = Prosthetic device
		0278 = Other implants
		0279 = Other supplies/devices
		0623 = Surgical dressings
		0624 = Investigational device
		0636 = Drugs requiring detailed coding
		0637 = Self-administrable drugs
		5. If CPT codes are used in place of HCPCS codes
		with any of the following revenue codes entered in
		Form Locator 44, remarks should specify the type of
		equipment and for rental equipment, the period of
		rental:
		0290 = General Classification
		0291 = Rental
		0292 = Purchase of new equipment
		0293 = Purchase of used equipment
		0294 = Supplies/drugs for DME effectiveness
		0299 = Other equipment
Required	81:	Code-Code Field
if applicable		Enter for the following:
		A1 = NUBC Condition Codes (FL 18-28)
Taxonomy code		A2 = NUBC Occurrence Codes/Dates
is required for		A3 = NUBC Occurrence Span
Regence		A4 = NUBC Value Codes (FL 39-41)
MedAdvantage		B3 = Health Care Provider Taxonomy Code
and Healthy		
Options		Note: An institutional provider submitting a Medicare
		Advantage claim for their primary facility and its
		subparts must include the taxonomy code.
		Institutional claims received without a taxonomy
		code will be denied and must be resubmitted with a
		taxonomy code.





Sample UB-04 claim form



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