UB-04 claim form requirements

All facilities participating with Regence are required to submit *UB-04* claims in electronic form. Following are instructions and requirements for completing a *UB-04* claim form.

Requirements	Form 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 Void/cancel prior claim 8
Required	**5:**	**Federal Tax Number** 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
Required	**8:**	**Patient's Name** Enter patient's last name, first name and middle initial.

Requirements	Form Locator	Description
Required	**9:**	**Patient Address** Enter patient's full mailing address including street number, city, state and zip code.
Required	**10:**	**Patient Birth Date** Enter patient's date of birth. Must be in MMDDCCYY format.
Required	**11:**	**Patient Sex** Enter “M” (male) or “F” (female).
Required	**12:**	**Admission Date** Enter date patient is admitted for this stay. Must be in MMDDCCYY format.
Required for inpatient claims	**13:**	**Admission Hour** 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 13 = 01:00-01:59 02 = 02:00-02:59 14 = 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 18 = 06:00-06:59 07 = 07:00-07:59 19 = 07:00-07:59 08 = 08:00-08:59 20 = 08:00-08:59 09 = 09:00-09:59 21 = 09:00-09:59 10 = 10:00-10:59 22 = 10:00-10:59 11 = 11:00-11:59 23 = 11:00-11:59 99 = Unknown
Required	**14:**	**Type of Admission/Visit** 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

Requirements	Form 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 inpatient claims	**16:**	**Discharge Hour** Enter the discharge hour code. **Valid Discharge Hour Codes.** 00 = 12:00-12:59 midnight 12 = 12:00-12:59 noon 01 = 01:00-01:59 13 = 01:00-01:59 02 = 02:00-02:59 14 = 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 18 = 06:00-06:59 07 = 07:00-07:59 19 = 07:00-07:59 08 = 08:00-08:59 20 = 08:00-08:59 09 = 09:00-09:59 21 = 09:00-09:59 10 = 10:00-10:59 22 = 10:00-10:59 11 = 11:00-11:59 23 = 11:00-11:59 99 = Unknown

Requirements	Form Locator	Description
Required	**17:**	**Patient Status** 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 = Discharge/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
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.

Requirements	Form Locator	Description
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 (Cooperative/Work Study Program) 33 = Patient is a Student (Full-Time - Night) 34 = Patient is a Student (Part-Time) Accommodation 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.)

Requirements	Form Locator	Description
		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 AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality

Requirements	Form Locator	Description
		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 DR = Disaster related E0 = Change in Patient Status G0 = Distinct Medical Visit H0 = Delayed Filing, Statement Of Intent Submitted

Requirements	Form Locator	Description
Required for automobile accidents	29	**Accident State** Two-digit state abbreviation of the state where the accident occurred.
	30	Untitled Not used.
Recommended Required for all accidents	**31 – 41:**	**Occurrence Codes and Dates** Required when there is a condition code that applies to this claim. Form locators 31, 32, 33, and 34 – allow both 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 of Cancellation of Hospice Election Period 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

Requirements	Form Locator	Description
		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 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.

Requirements	Form Locator	Description
		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
Required	**39 – 41 a - d:**	**Value Codes and Amounts** 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. 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

Requirements	Form Locator	Description
Required	**39 – 41 a - d:**	**Medicaid Specific Codes** 21 = Catastrophic 22 = Surplus 23 = Recurring monthly income 24 = Medicaid 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 **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

Requirements	Form Locator	Description
		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 patient 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 A8 = Patient Weight A9 = Patient Height G8 = Facility where inpatient hospice service is delivered
Required for each charge entered	**42:**	**Revenue Code** An accommodation revenue code (0100-0219) is required for all inpatient type of bill (TOB).

Requirements	Form Locator	Description
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 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 or supplies.
Required	**45:**	**Service Date** Enter the date that the services were provided. Must be in MMDDCCYY format.
Required	**46:**	**Units of Service** Enter the number of units rendered for each service. Units can be hours, days/sessions, tests/services or items.
Required for each revenue code entered	**47:**	**Total Charges** Enter total charges Enter total charges pertaining to the related revenue code for the current billing period. Zeros are valid.
Optional	48:	Non-Covered Charges Enter non-covered charges.
	49:	Untitled Not used.
	51 a- c:	Health Plan ID

Requirements	Form Locator	Description
Required	52 a – c:	**Release of Information Certification Indicator** A "Y" code indicates that the provider has on file a signed 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 a – c:	Assignment of Benefits Certification Indicator
Optional	**54 a – c:**	**Prior Payments-Payers and Patient** Enter the amount of the prior payments from other insurance.
Optional	55 a – c:	Estimated Amount Due from patient
Required	**56:**	**Billing Provider National Provider ID (NPI)** The billing provider NPI must be entered on all electronic claim submissions. We recommend that claims submitted on paper also indicate an 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. *Note:* A Regence provider number may no longer be used on electronic or paper-submitted claims after December 31, 2011.
Required	**58 a – c:**	**Insured's Name** Enter the insured's last name, first name and middle initial as it appears on the member card.
Required	**59 a – c:**	**Patient's Relationship to Insured** 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 a – c:**	**Insured's Unique Identification (ID)** Enter insured's identification number as shown on member card.
Optional	61	Insured's Group Name

Requirements	Form Locator	Description
	a – c:	
Required	**62 a – c:**	**Insurance Group Number** Enter the insured's group number as shown on the member card. **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., 99999999)
Required for Home Health Regence MedAdvantage claims	**63:**	**Treatment Authorization Code**
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 *International 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 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.

Requirements	Form Locator	Description
Required	**67A – 67Q:**	**Other Diagnoses Codes** 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 inpatient type of bills	**69:**	**Admitting Diagnosis** 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. 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 Not used.

Requirements	Form Locator	Description
Required for inpatient type of bills if applicable	**74:**	**Principal Procedure Code and Date** Enter the principal procedure code and date. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
Required for inpatient type of bills well if applicable	**74A – 74E:**	**Other Procedure Codes and Dates** Enter up to five other procedure codes and dates. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
	75:	Untitled 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. 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 79:	Other Provider Name and Identifiers (including NPI)
Required under circumstances listed	**80:**	**Remarks** 1. Enter accident information if occurrence codes 01-05 are entered and/or diagnosis codes 800-959.9, E800-849, E880-E929, E969-E999 are entered. 2. Specify the type of drug, implant, or device if a HCPCS code cannot identify them. 3. Specify if ionic or non-ionic contrast media was used for revenue codes 0255, 0350, 0351, 0352, or 0359. 4. Enter information relating to emergency room visit if revenue code 0450 or 0459 is used. 5. Enter description of service, training schedule or name of educational program if revenue code 0942 is used. 6. Facilities with programs for partial day and intensive outpatient programs should indicate "full" partial, "half" partial, or intensive outpatient program. This additional information will help

Requirements	Form Locator	Description
		determine the correct benefits when processing the claim.
Recommended Taxonomy code is required for Regence MedAdvantage **Taxonomy code will be required for all claims effective July 1, 2013**	**81:**	**Code-Code Field** Enter for the following: A1 = NUBC Condition Codes (FL 18-28) A2 = NUBC Occurrence Codes/Dates A3 = NUBC Occurrence Span A4 = NUBC Value Codes (FL 39-41) B3 = Health Care Provider Taxonomy Code **Note:** An institutional provider submitting a Medicare Advantage claim for their primary facility and its subparts must include the taxonomy code. Medicare Advantage Institutional claims received without a taxonomy code will be denied and must be resubmitted with a taxonomy code. Effective with dates of service on or after July 1, 2013, all commercial institutional claims received without a taxonomy code will be denied and must be resubmitted with a taxonomy code.

Sample *UB-04* claim form