UB-04 CLAIM FORM INSTRUCTIONS FOR LTC PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility.	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**If you require the patient control number for posting, include it here.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**If you require the medical record number for posting, include it here.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: ***FOR NURSING FACILITY PROVIDERS:*** *1st Digit - Type of Facility* 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF Technology Dependent Care) (LOC = SNF Infectious Disease) (LOC = NF Rehab) (LOC = NF Complex Care) Skilled Nursing/ Intermediate Care (LOC = Case Mix)	

Locator #	Description	Instructions	Alerts
		2nd Digit – Classification 1 = Skilled Nursing – Inpatient ***FOR ICF-DD PROVIDERS:*** *1st Digit - Type of Facility* 6 = Intermediate Care (LOC = ICF/MR) *2nd Digit - Classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II ***FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:*** *1st Digit - Type of Facility* 8 = Special Facility (LOC = Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) ***FOR NURSING FACILITY, ICF-DD, AND ADHC PROVIDERS:*** *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment.	**2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by NUBC. Use 2nd Digit "1" instead.**

Locator #	Description	Instructions	Alerts
		3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	

Locator #	Description	Instructions	Alerts
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	
17	Patient Status	**Required.** This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure** 01 = Discharged to home or self care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility	**Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**

Locator #	Description	Instructions	Alerts
		(SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 = Discharged/transferred to a long term care hospital	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Leave blank.**	
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). *80 = Covered days 81 = Non-covered days 82 = Co-insurance days (required only for Medicare crossover claims) 83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field. ***No other value code is required for processing LTC claims.**	**Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.** **Please read the instructions carefully for entering the new number of days information in the Value Code fields.** **Value Codes 81, 82, and 83 are not used for Medicaid billing.**
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: **FOR ALL PROVIDERS (Excluding ADHC Providers):** <u>Revenue Code & Description</u> <u>Leave of Absence</u>	

Locator #	Description	Instructions	Alerts
		183 = Leave of Absence – Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence – Subcategory Nursing Home (for Hospitalization) **FOR NURSING FACILITIES**: Revenue Code & Description *(Corresponding Level of Care)* 022 = Skilled Nursing Facility Prospective Payment System (RUGS) *(88 = Case Mix -- Formerly LOC 20, 21, 22)* 118 = Room & Board-Private Subacute Rehabilitation *(31 = NF Rehabilitation* *20 = SNF/Hospice in Nursing Facility* *21 = ICF I/Hospice in Nursing Facility* *22 = ICF II)* 193 = Subacute Care Level III (Complex Care) *(32 = NF Complex Care)* 194 = Subacute Care Level IV *(28 = SNF Technology Dependent Care)* 199 = Other Subacute Care *(30 = SNF Infectious Disease)* **FOR ICF-DDs**: Revenue Code & Description *(Corresponding Level of Care)*	

Locator #	Description	Instructions	Alerts
		ICAP Revenue codes to be used: 193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39) 191 = Limited Level of Care (ICAP Score 40-69) 190 = Intermittent Level of Care (ICAP Score 70-99) **NOTE:** Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file. **FOR ADULT DAY HEALTH CARE (ADHC):** Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	**Leave blank.**	

Locator #	Description	Instructions	Alerts
45	Service Date	**Required.** Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 6 – 12, the Service Date should be entered 07-12, -- **If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).** **Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service.** **Required**. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**

Locator #	Description	Instructions	Alerts
46	Units of Service	**Required.** Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of Care revenue code, description, and service date. Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. **Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Form Locator 45.** Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank. **Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.**	
47	Total Charges	**Leave blank.**	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	

Locator #	Description	Instructions	Alerts
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI FIELD	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	

Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	

Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the	**To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**

Locator #	Description	Instructions	Alerts
		adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits**	

Locator #	Description	Instructions	Alerts
		required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.	
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Leave blank.**	
77	Operating	**Leave blank.**	
78	Other	**Leave blank.**	
79	Other	**Leave blank**.	
80	Remarks	**Situational.** Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.	**Enter any special handling instructions here.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Weeping Willow Nursing Home 2246 Cypress Lane Rain Forest, LA 71111		1234567890 b. MED. REC. # 9876543	213
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 10/01/07 THROUGH 10/31/07

8 PATIENT NAME	9 PATIENT ADDRESS
a Bright, Sunny	a 123 Anywhere Street
b	b Anywhere c LA d 71111 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
01/01/01	F	10/01/06					30			

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a 80 31 00		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	CASE MIX		01-20	20			1
2	194	SNF TDC		21-31	11			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____		CREATION DATE 11/01/07	TOTALS			23

SAMPLE OF LEVEL OF CARE CHANGE
NURSING FACILITY

NPI

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A				TPL Amount if appropriate		1234567890	A
B						57 OTHER PRV ID 1234567	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Bright, Sunny		1234567890123	TPL Carrier code if applicable	A
B				B
C				C

Recipient #

Provider #

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX	A	B	C	D	E	F	G	H	68
436.12	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC
	a
	b
	c
	d

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Weeping Willow Nursing Home 2246 Cypress Lane Rain Forest, LA 71111		1234567890 b. MED. REC. # 9876543	213
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 10/01/07 THROUGH 10/31/07

8 PATIENT NAME	9 PATIENT ADDRESS
a Bright, Sunny	a 123 Anywhere Street
b	b Anywhere c LA d 71111 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01/01/01	F	10/01/06					30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a 80	31 00				
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	CASE MIX		01-31	31			1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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16								16
17								17
18								18
19								19
20							NPI	20
21								21
22								22
23		PAGE ____ OF ____		CREATION DATE 11/01/07	TOTALS			23

SAMPLE OF ROUTINE BILLING
NURSING FACILITY

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A				TPL Amount if applicable		1234567890	A
B						57 OTHER PRV ID 1234567	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A Bright, Sunny		1234567890123	TPL Carrier code if applicable		A
B					B
C					C

Recipient #

Provider #

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	A	B	C	D	E	F	G	H	68
436.12	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

OMB APPROVAL PENDING

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Weeping Willow Nursing Home 2246 Cypress Lane Rain Forest, LA 71111		1234567890 b. MED. REC. # 9876543	213
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 11/01/07 THROUGH 11/28/07

8 PATIENT NAME	9 PATIENT ADDRESS
a Bright, Sunny	a 123 Anywhere Street
b	b Anywhere c LA d 71111 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
01/01/01	F	10/01/06					01			

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a 80 27 00		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	CASE MIX		01-28	27			1
2	183	Home Leave Days		11-27				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____		CREATION DATE 12/01/07	TOTALS			23

SAMPLE OF DISCHARGE TO HOME
NURSING FACILITY

NPI

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A				TPL Amount if appropriate		1234567890	A
B						57 OTHER PRV ID 1234567	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Bright, Sunny		1234567890123	TPL Carrier code if applicable	A
B				B
C				C

Recipient #

Provider #

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX	A	B	C	D	E	F	G	H	68
436.12	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC
	a
	b
	c
	d

OMB APPROVAL PENDING

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Blooming ICF-DD Facility 2246 Cypress Lane Rain Forest, LA 71111		1234567890 b. MED. REC. # 9876543	653
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 11/01/07 THROUGH 11/30/07

8 PATIENT NAME	9 PATIENT ADDRESS
a Bright, Sunny	a 123 Anywhere Street
b	b Anywhere c LA d 71111 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
01/01/01	F	10/01/06					30			

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a 80	30 00				
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	193	Pervasive Level of Care		01-30				
2								
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21								
22								
23		PAGE ____ OF ____	CREATION DATE	12/01/07	TOTALS			

SAMPLE OF ICF-DD
ROUTINE BILLING

NPI

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A				TPL Amount if appropriate		1234567890	A
B						57 OTHER PRV ID 1234567	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Bright, Sunny		1234567890123	TPL Carrier code if applicable	A
B				B
C				C

Recipient #

Provider #

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX	A	B	C	D	E	F	G	H	68
436.12	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC	
	a	
	b	
	c	
	d	

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OMB APPROVAL PENDING

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.