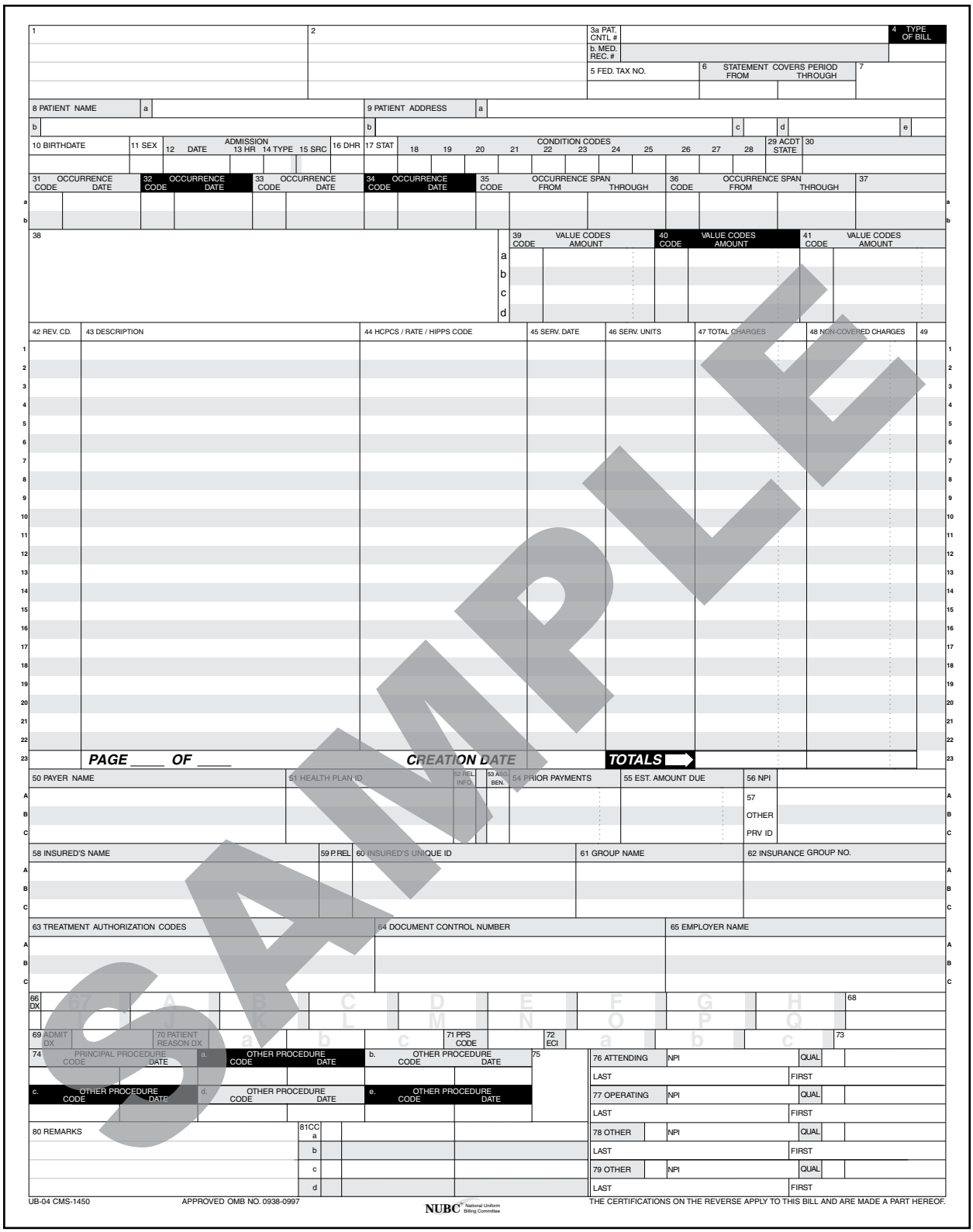
SAMPLE—Do not use.



SAMPLE—Do not use.

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the form locator (FL) information.

FL 1	Provider name, physical address and telephone number **required**
FL 2	Pay-to name and address **required**
FL 3a	Patient control number
FL 3b	Medical/health record number
FL 4	Type of bill (*three-character alphanumeric identifier*)
FL 5	Federal Tax Identification (ID) number
FL 6	Statement covers period (*from–through*). The beginning and ending dates of the period included on the bill are shown in numeric fields (*MM-DD-YY*).
FL 7	Not required
FL 8a-b	Patient's name (*surname first, first name, and middle initial, if any*). Enter the patient's Social Security number (SSN) in field "a." Enter the patient's name in field "b."
FL 9a-e	Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable.
FL 10	Patient's birth date (*MM-DD-YYYY*). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.
FL 11	Patient's sex. This item is used in conjunction with FLs 66–69 (*diagnoses*) and FL 74 a–e (*surgical procedures*) to identify inconsistencies.
FL 12	Admission date
FL 13	Admission hour
FL 14	Type of admission. This code indicates priority of the admission.
FL 15	Source of Admission. This code indicates the source of admission or outpatient registration.
FL 16	Discharge hour
FL 17	Patient status. This code indicates the patient's status as of the "Through" date of the billing period (*FL 6*).
FLs 18–28	Condition codes
FL 29	Accident state
FL 30	Not required
FLs 31–34	Occurrence codes and dates
FLs 35–36	Occurrence span code and dates
FL 37	Not required
FL 38	Responsible party name and address
FLs 39–41	Value codes and amounts
FL 42	Revenue code
FL 43	Revenue description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.
FL 44	HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.
FL 45	Service date. If submitting claims for outpatient services, report a separate date for each day of service.
FL 46	Service units. The entries in this column quantify services by revenue category (*e.g., number of days, a particular type of accommodation, pints of blood*). Up to seven digits may be entered.
FL 47	Total charges
FL 48	Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.
FL 49	Not required
FLs 50A–C	Payer identification. Enter the primary payer on line A.
FLs 51A–C	Health plan ID number
FLs 52A–C	Release of information. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.
FLs 53A–C	Assignment of benefits certification indicator
FLs 54A–C	Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (*last*) line of this column.
FLs 55A–C	Not required

FL 56 National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.
FLs 57A–C Other provider identifier number
FLs 58A–C Insured's name
FLs 59A–C Patient's relationship to insured
FLs 60A–C Insured unique ID/SSN/health insurance claim/ID number
FLs 61A–C Group name. Indicate the name of the insurance group or plan.
FLs 62A–C Insurance group number
FLs 63A–C Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.
FLs 64A–C Document Control Number (DCN). Original DCN number of the claim to be adjusted.
FLs 65A–C Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.
FLs 66 Diagnosis and procedure code qualifier (*ICD Version Indicator*)
FLs 67 Principal diagnosis code. HCFA only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.
FLs 67A–Q Other diagnosis codes
FL 68 Not required
FL 69 Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's hospital admission.
FLs 70a–c Patient's reason for visit
FL 71 Prospective payment system (PPS) code
FLs 72a–c External cause of injury (ECI) code
FL 73 Not required
FL 74 Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.
FLs 74a–e Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (*which is shown in FL 74*). The date of each procedure is shown in the date portion of Item 74, as applicable (*MM-DD-YY*).
FL 75 Not required
FL 76 Attending/referring physician ID
FL 77 Operating physician name and identifiers
FLs 78–79 Other physician ID
FL 80 Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.
FLs 81a–d Code field

Condition Codes

02 Condition is employment related
03 Patient covered by insurance not reflected here
06 End-stage renal disease (ESRD) patient in first 30 months of entitlement covered by employer group health insurance
08 Beneficiary would not provide information concerning other insurance coverage
18 Maiden name retained
19 Child retains mother's name
31 Patient is student (*full time—day*)
33 Patient is student (*full time—night*)
34 Patient is student (*part time*)
36 General care patient in a special unit
38 Semiprivate room not available
39 Private room medically necessary

40 Same-day transfer
41 Partial hospitalization
46 Nonavailability statement on file
48 Psychiatric residential treatment centers for children and adolescents
55 SNF bed not available
56 Medical appropriateness
60 Day outlier
61 Cost outlier
67 Beneficiary elects not to use lifetime reserve days
A0 TRICARE External Partnership Program
A2 Physically Handicapped Children's Program
C1 Approved as billed
C2 Automatic approval as billed based on focused review
C3 Partial approval
C4 Admission/services denied
C5 Post-payment review applicable
C6 Admission pre-authorization
C7 Extended authorization
G0 Distinct medical visit (*OPPS*)

Occurrence Span Codes

01 Auto accident
02 No-fault insurance involved—including auto accident/other
03 Accident/tort liability
04 Accident/employment related
05 Accident/no medical or liability coverage
06 Crime victim
21 Date UR notice received
22 Date active care ended
24 Date insurance denied
25 Date benefits terminated by primary payer
26 Date SNF bed became available
27 Date of hospice certification or recertification
28 Date comprehensive outpatient rehabilitation plan established or last reviewed
29 Date outpatient physical therapy 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 Employer Group Health Plan (EGHP)

Value Codes and Amounts

01 Most common semiprivate rate
02 Hospital has no semiprivate rooms
05 Professional component included in charges and also billed separate to carrier
30 Preadmission testing
31 Patient liability amount
37 Pints of blood furnished
46 Number of grace days