Part A – Pre-Transmittal UB-04 Triple Check Form

Resident Name: _____ Facility: _____
Dates of Service: From _____Through _____ Billing Month/Year: _____

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	1. Beneficiary's name correct per CWF Screen Field 8	Common Working File
	2. Birthday correct per CWF screen Field 10	Common Working File
	3. Sex correct per CWF Field 11	Common Working File
	4. Status Correct—01 Home/02 Hospital/ 03 another SNF/ 04 personal care/ 20 CTB / 30 still a patient Field 17	
	5. MSP form completed on admission and readmission	Financial records
	6. Beneficiary's Medicare number is correct per CWF Field 60	Common Working File
	7. NPI / UPIN number and doctor's name is correct Field 76	**UB04**
	8. Remarks for processing claim are present --N/A unless adjustment Field 80	**UB04**

Business Office, Nursing and Rehab to assess: place a (√) check in the first column when the standard is met. (X) for NOT MET

MET	COMPLIANCE STANDARD	SOURCE
	9. Bill type is correct—211 Admit/DC same mo/ 212 first claim/ 213 continuing claim in series/ 214 admit previous month & d/c current month Field 4	UB-04
	10. Dates of Service are correct Field 6	Medicare/PPS Scheduler Report
	11. Most current admission date matches UB-04 and record Field 12	UB-04 and medical record
	12. Hospital stay dates matches between UB-04 and record (must be the qualifying stay) Field 35	UB-04 & medical record
	13.HIPPS (MDS Section Z) codes match UB-04 Field 44	UB-04 and MDS
	14. For Rehab RUG, PT, OT, ST charges are correct Fields 43/46/47	UB-04 and rehab logs
	15. Significant changes and or OMRAs are billed correctly Fields 43/44/46	MDS and UB-04
	16. MDS ARD matches UB-04 service dates Fields 31/32/33/34	MDS and UB-04
	17. ARD falls within required timeframe	MDS
	18. COTs are completed per requirements	MDS and therapy logs
	19.Number of days billed for each MDS are correct Fields 44/46	Medicare/PPS Scheduler and UB-04
	20. Pharmacy charges are only for legend meds used during the dates of services billed Fields 42/47	Pharmacy Invoice
	21. Med surg charges are only for coverable items used during the dates of services billed Fields 42/47	Supply invoices
	22. Nursing documentation supporting Medical necessity	MDS, medical record
	23. MDS Sections G is supported in the record	MDS and medical record
	24. MDS Section O therapy days and minutes is accurate	MDS and therapy logs
	25. MDS Item O00402 therapy calendar days reflects daily skilled services and therapy RUG grouper	MDS and therapy logs
	26. Diagnoses for skilled services accurate and matches between the MDS, UB-04 and therapy logs Field 66/69	MDS, UB-04, therapy logs
	27. Diagnoses are appropriately coded Field 66/69	MDS and UB-04
	28.Rehab medical and treatment DX are present and Correct Field 66	UB04
	29. A signed order is present to "admit to skilled care"	Physician Orders
	30. Physician certification / recert is timely, accurate and filled out to meet all specifications for coverage	Progress notes / Cert-Recert form
	31. Physician cert / recert signature is Legible and Dated; if physician signature is not legible – is on a signature form In the facility	Progress notes / Cert-Recert form

	32. Rehab Orders / Plan of Care / Updated plan of care are signed and dated by the physician	Medical record- rehab
	33. Physician signature is Legible and dated on rehab POC	Medical record – rehab
	34. Denial notices completed timely and accurately	Financial folder

I certify that the accompanying information accurately reflects resident assessment and tracking information for this resident and that I collected and/or coordinated collection of this information in accordance with applicable Medicare/Medicaid requirements. I understand that this information is used as a basis for insuring that residents receive appropriate and quality care and as a basis for federal funds and such conditions is based on the accuracy and truthfulness of this information, that I maybe personally subject to or subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.

_____	**Administrator**	_____Date
_____	**DON**	_____Date
_____	**BOM**	_____Date
_____	**MDS Coordinator**	_____Date
_____	**Rehab**	_____Date