Completing a CMS 1500 Form

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

FIELD#	Field Description	Instruction or Comments	Required or Conditional

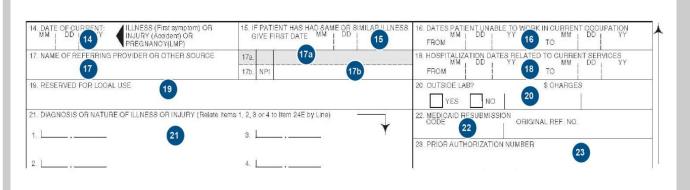| FIELD#	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	R
1a	INSURED I.D. NUMBER	The 10-digit Medicaid identification number on the member's KENTUCKY SPIRIT HEALTHPLAN I.D. card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's KENTUCKY SPIRIT HEALTHPLAN I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM|DD|YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's KENTUCKY SPIRIT HEALTHPLAN I.D. card.	Not Required
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	Not Required

FIELD#	Field Description	Instruction or Comments	Required or Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	PATIENT STATUS		Not Required

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FIELD#	Field Description	Instruction or Comments	Required or Conditional
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE / SEX	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9.	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	C
10d	Reserved for Local use		Not Required

FIELD#	Field Description	Instruction or Comments	Required or Conditional
11	Insured's policy group or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C
11b	Employer's Name or School Name	REQUIRED if Employment is marked Yes in box 10a.	C
11c	Insurance Plan Name or Program Name	Enter name of the insurance Health Plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	C
12	Patient's or Authorized Person's Signature	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Not Required
13	Patient's or Authorized Person's Signature		Not Required.

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FIELD#	Field Description	Instruction or Comments	Required or Conditional

14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the:
		    Present illness
		    Injury
		    LMP (last menstrual period) if pregnant
		
		Enter the appropriate date, if you marked "Yes" in the fields 10A-10C.
			C

15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		Not Required
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		Not Required
17	Name of Referring Physician or other source	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	Not Required

FIELD#	Field Description	Instruction or Comments	Required or Conditional
17a	ID number of referring physician	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	Not Required
17b	NPI number of referring physician	Enter the KenPAC or Lockin provider's NPI number. **Note: Contact the assigned KenPAC or Lockin provider for the appropriate NPI to be used when submitting the claim.**	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		Not Required
19	Reserved for Local Use		Not Required
20	Outside Lab / Charges		Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9-CM Volume 1 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes are NOT acceptable as a primary diagnosis. Note: Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission. Note: Re-submissions may NOT currently be submitted via EDI.	C
23	Prior authorization number	Enter the KENTUCKY SPIRIT HEALTHPLAN authorization or referral number. Refer to the KENTUCKY SPIRIT HEALTHPLAN Provider Manual for information on services requiring referral and/or prior authorization.	R

24A-J General Information	Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid Number qualifier, and Provider Medicaid Number. Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24A Un-shaded	DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM|DD|YY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24B Un-shaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf	R
24C Un-shaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency. Isn't this where they are supposed to enter the THSteps condition code?	Not Required
24D Un-shaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national modifiers are recognized as modifiers that will impact the pricing of your claim. **NOTE:** *Modifier "26" also identifies administration of vaccine for Vaccines for Children as well as appropriate by CMS guidelines *DME is required to be billed with a "NU" or "RR" modifier *Modifier U1 should be used when identifying services performed by a physician's assistant and where rendered by a physician's assistant when billed under a physician *Modifier "GP" identifies Physical Therapy, Modifier "GN" identifies Speech Therapy and modifier "GO" identifies Occupational Therapy and is required when billed by the therapist *Modifier "SN" and "SM" identifies second and third surgical opinions and will not apply to co-pay reduction <table><tr><td>26</td><td>50</td><td>80</td><td>81</td><td>82</td></tr><tr><td>AS</td><td>GN</td><td>GO</td><td>GP</td><td>NU</td></tr><tr><td>RR</td><td>SM</td><td>SN</td><td>TC</td><td>U1</td></tr></table>	R
24D Shaded Area	Enter the appropriate disposition code to define the EPSDT service or referral. Enter the appropriate EPSDT referral code, if applicable, from appendix.	**Category** **R = Referred T = Treated** / **Disposition Code** Vision — VR, VT Hearing — HR, HT Dental — DR, DT Mental Health — MR, MT Lead — LR, LT Sickle Cell — SR, ST Family Planning/Pregnancy — FR, FT Growth, Endocrine, Nutrition — GR, GT Cardiac — CR, CT Orthopedic — OR, OT Genito-Urinary — UR, UT ENT/Respiratory — ER, ET Neurology — NR, NT Hemoglobin — BR, BT Other — TR, TT Immunizations — DPT — ID Polio — IP MMR — IM HIB — IB Other — IO	
24E Un-shaded	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes for the date of service or the claim will be rejected/denied.	R

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24F Un-shaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24G Un-shaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R
24H Shaded	EPSDT (CHCUP) Family Planning	Leave Blank	Not Required
24H Un-shaded	EPSDT (CHCUP) Family Planning	Enter the appropriate qualifier for EPSDT visit	Not Required
24I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for Medicaid ID, if an Atypical Provider	C
24J Shaded	Non-NPI PROVIDER ID#	Enter as designated below the Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. Atypical Providers: Enter the 6-digit Medicaid Provider ID number.	R
24J Un-shaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, Independent Lab, Home Health, RHC/FQHC general Medical Exam, etc.)	R

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FIELD#	Field Description	Instruction or Comments	Required or Conditional
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	Patient's Account no.	Enter the provider's billing account number.	R
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	Not Required
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing KENTUCKY SPIRIT HEALTHPLAN. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
30	Balance due	REQUIRED when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature. Note: Does not exist in the electronic 837P.	Required
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical Providers Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (no spaces).	C
33	BILLING PROVIDER INFO & PH #	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	C
33b	GROUP BILLING OTHER ID	Enter as designated below the Billing Group Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier. Atypical Providers: Enter the 6-digit Medicaid Provider ID number.	C

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claims (to include hospital based ASCs and technical services) charges for reimbursement by Kentucky Spirit.
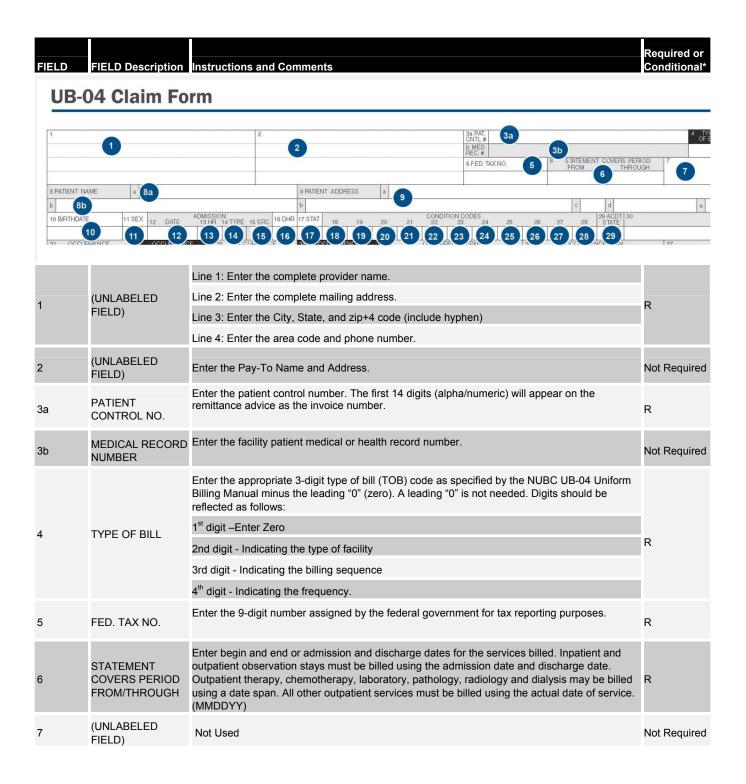
Incomplete or inaccurate information will result in the claim/encounter being rejected (RTP) for corrections.

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UB-04 Claim Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*

1	(UNLABELED FIELD)	Line 1: Enter the complete provider name.	R
		Line 2: Enter the complete mailing address.	
		Line 3: Enter the City, State, and zip+4 code (include hyphen)	
		Line 4: Enter the area code and phone number.	
2	(UNLABELED FIELD)	Enter the Pay-To Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	R
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	Not Required
4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows:	R
		1st digit –Enter Zero	
		2nd digit - Indicating the type of facility	
		3rd digit - Indicating the billing sequence	
		4th digit - Indicating the frequency.	
5	FED. TAX NO.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MMDDYY)	R
7	(UNLABELED FIELD)	Not Used	Not Required

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
8 a-b	PATIENT NAME	8a – Enter the patient's 10-digit Medicaid identification number on the member's KENTUCKY SPIRIT HEALTHPLAN I.D. card.	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the KENTUCKY SPIRIT HEALTHPLAN ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name e.g. McKendrick. H Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
9 a-e	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
14	ADMISSION TYPE	Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referal (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available	

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
		For type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	
16	DISCHARGE HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
17	PATIENT STATUS	REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicareapproved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 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 (CAH)	C
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
29	ACCIDENT STATE		Not Required
30	(UNLABELED FIELD)	Not Used	Not Required

UB-04 Claim Form

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	REQUIRED for re-submissions or adjustments. Enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission. Note: Re-submissions may NOT currently be submitted via EDI.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

UB-04 Claim Form

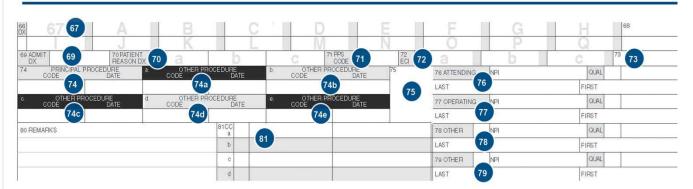| 42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
42	43	44	45	46	47	48	

General Information Fields 42-47	Service Line Detail	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate 4 digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1").	R
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s) Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract with Kentucky Spirit Health Plan or to the Kentucky Medicaid Provider Procedures Manual	C
45 Line 1-22	SERVICE DATE	Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	R

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
45 Line 23	CREATION DATE	Enter the invoice date or invoice creation date. (MMDDYY)	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

UB-04 Claim Form

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
50 A-C	PAYER	Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	REL. INFO	Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	Not Required
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	Not Required
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid/ KENTUCKY SPIRIT HEALTHPLAN is listed as secondary or tertiary.	C
55	PRIOR ALLOWED	Enter the amount allowed from the primary payer on the appropriate line when Medicaid/ KENTUCKY SPIRIT HEALTHPLAN is listed as secondary or tertiary.	Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter provider's 10-character NPI ID.	R
57	OTHER PROVIDER ID	Enter the TPI number (non NPI number) of the billing provider	C

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES		Not Required
64	DOCUMENT CONTROL NUMBER	Enter the 12-character Document Control Number (DCN) of the paid HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting KENTUCKY SPIRIT HEALTHPLAN from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to appeals/corrected claims section	C
65	EMPLOYER NAME		Not Required
~~66~~	~~DX~~		~~Not Required~~

UB-04 Claim Form

| 67 | PRINCIPAL DIAGNOSIS CODE | Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis code submitted must be a valid ICD-9 code for the date of service and carried out to its highest level of specificity– 4th or "5" digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied. Effective dates of service July 1, 2010 and after, DRG facilities must indicate whether each diagnosis was present at the time of admission. Refer to the Present on Admission (POA) Indicators in the table below. The POA Indicator should follow the diagnosis code (in the shaded area in each field). | R |

POA	Description

FIELD	FIELD Description	Instructions and Comments		Required or Conditional*
		Y (Yes)	Present at the time of inpatient admission.	
		N (NO)	Not present at the time of inpatient admission.	
		U (Unknown)	The documentation is insufficient to determine if the condition was present at the time of inpatient admission.	
		W (Clinically Undetermined	The provider is unable to clinically determine whether the condition was present at the time of admission.	
		1 (one) (for unreported/not used)	Diagnosis is exempt from POA reporting. **Note: The International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-9-CM) Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting. Use POA indicator 1 only for codes on the list.**	
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied. Note: refer to instructions for field 67 for a table of Present on Admission (POA) indicators.		C
68	(UNLABELED)	Not Used		Not Required
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.		R
70 a,b,c	PATIENT REASON CODE	Enter the ICD-9-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or "5". "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied		R
71	PPS / DRG CODE			Not Required
72 a,b,c	EXTERNAL CAUSE CODE			Not Required
73	(UNLABELED)			Not Required
74	PRINCIPAL PROCEDURE CODE / DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY). REQUIRED for EDI Submissions.		C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).		C
75	(UNLABELED)			Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and Name of the physician in charge of the patient care: NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code		R

FIELD	FIELD Description	Instructions and Comments	Required or Conditional*
		QUAL: ___ Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed: NPI: Enter the operating physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: ___ Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code LAST: Enter the operating physician's last name FIRST: Enter the operating physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and Name of the physician in charge of the patient care: (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: ___ Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # LAST: Enter the other physician's last name. FIRST: Enter the other physician's first name.	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use ZZ qualifier	Not Required

Key Information: A clean claim is a claim submitted on an approved or identified claim format (CMS or UB) that contains all data fields required by Kentucky Spirit Health Plan and the state, for final adjudication of the claim. The required data fields must be complete and accurate. A clean claim must also include health plan published requirements for adjudication, such as, Medicaid number, TIN number, NPI and taxonomy or medical records, as appropriate.

Helpful Hints for Successful Claims Filing

- **Imaging-**
  - Use red and white images
  - Use Black Ink only
  - Do not use glue, staples, white out or correction tape
  - Do not send attachments smaller than the accompanying claim form
- **Common Reasons for Return to Provider Letter (RTP)**
  - Incorrect/Missing Provider ID
  - Incorrect/Missing Member ID

- o   Incorrect Missing Member D.O.B.
- o   Missing Service line data
- o   Unreadable Image
- **Initial Claim Timely Filing-** 365 days from the date of service.
- **Reconsideration for Provider Error Timely Filing-** 365 days from the date of service.
- **Reconsideration for Incorrect Processing Timely Filing-** 24 months from the date of EOP
- **Claims Dispute Timely Filing-** 24 months from the date of EOP.
- **Commercial Insurance Coverage-** When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.
- **Unlisted Procedure Codes-** All unlisted procedure codes will require review of medical records. Please submit appropriate records with your claim submission.
- **Audiology-Hearing Aids-** Paper claim and invoice required
- **Durable Medical Equipment (DME)-** DME services that requiring an invoice should be submitted as a paper claim.
- **Optometrists & Ophthalmologists-** All claims rendered by an optometrist or ophthalmologist should be submitted to Opticare for payment consideration.
- **Behavioral Health-** All behavioral health services should be submitted to Cenpatico Behavioral Health.
- **Dental-** Dental claims should be submitted to MCNA
- **Deleted Codes-** Codes deleted from the previous editions of the CPT Manual or ICD-9 Manual are not reimbursable and should not be submitted.
- **COB Claims-** COB (Coordination of Benefits) claims can be submitted electronically.
- **EPSDT Special Services-** Providers who are contracted to perform regular services and EPSDT Special Services are required to bill the appropriate taxonomy code on all claims submitted to ensure correct provider selection and to avoid erroneous denials.
- **NDC Requirements-** National Drug Code should be listed in box 24a   of the CMS 1500 for all HCPCS contained on the Kentucky Spirit Physician Injectable Drug Listing (PIDL). NDC will require N4 qualifier.
- **Biopharmacy-** National Drug Code should be listed in box 24a of the CMS 1500 for all HCPCS. NDC will require N4 qualifier. Refer to Kentucky Spirit web site for authorization requirements.