UB-04 Claim Form

This document explains the UB-04 claim form, which is used for submitting claims for reimbursement for specially designated facilities. The instructions included in this section are excerpts from Medicare instructions (Rev. 3709, 02-03-17) along with commentary by Find-A-Code. This document is to be used only by those who have purchased a current edition of a specialty specific *Reimbursement Guide* by Find-A-Code. Book references refer to the *Reimbursement Guide*. Please note that this document only contains basic instructions or information that should be paid close attention to when submitting claims. It is not a comprehensive *UB-04* coding manual.

Book: See Chapter 1.3 — Claims Processing for general claim completion tips and other information regarding claims submission.

Book: See "1500 Claim Form Tips" in Chapter 1.3 — Claims Processing for information about submitting claims for professional services.

UB-04 Claim Form Instructions

The following rules for the *UB-04* are excerpts from Medicare instructions, but they are generally universal for billing specially designated facilities. Consult with your specific insurance payer for their adaptations. However, these instructions apply to claims submitted on paper or electronically and must be used when filing claims with Medicare. Please note that payment rules can change frequently for any payer.

The National Uniform Billing Committee (NUBC) maintains the lists of approved codes for the form. To obtain complete code information, visit FindACode.com or visit their website.

Resource: See Resource 410 to review the complete *Medicare Claims Processing Manual* for institutional claims.

Resource: See Resource 188 for code lists as found on FindACode.com.

Instruction Conventions

Medicare instructions are in regular text. Please note that in the instructions, FL stands for Form Locator and is used to describe the different fields on the claim form. Many fields not in use by Medicare are not included.

Tip — Combined Claims: Typically, the *UB-04* is only used for institutional claims. However, Critical Access Hospitals, Federally Qualified Health Centers, and Rural Health Clinics that bill Medicare are required to submit a "combined claim." This is a claim that includes both facility and professional components.

Resource: See Resource 411 to review the complete *Medicare Manual Claims Processing Manual for Rural Health Clinics and Federally Qualified Health Centers*.

Field Locator Numbers and Titles are in bold text and style like this.

Medicare instructions are in regular text.

Commentary by Find-A-Code is in a box and type style like this.

FL 1 – Billing Provider Name, Address, and Telephone Number

Required. The minimum entry is the provider name, city, State, and nine-digit ZIP Code. Phone and/or Fax numbers are desirable.

Find-A-Code: To avoid payment delays, enter the name exactly as it appears on your credentialing records with each payer.

FL 2 – Billing Provider's Designated Pay-to Name, address, and Secondary Identification Fields

Not Required. If submitted, the data will be ignored.

FL 3a – Patient Control Number

Required. The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

Find-A-Code: Although this is required for Medicare, some payers consider this field optional so be aware of payer differences.

FL 3b – Medical/Health Record Number

Situational. The number assigned to the patient's medical/health record by the provider (not FL3a).

FL 4 – Type of Bill

Required. This four-digit alphanumeric code gives three specific pieces of information after a leading zero. **CMS will ignore the leading zero**. **CMS will continue to process three specific pieces of information.** The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Code Structure

2nd Digit-Type of Facility (CMS will process this as the 1st digit)

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)

4th Digit-Frequency – Definition (CMS will process this as the 3rd digit)

Find-A-Code: Be aware of individual payer differences. For example, some payers require the type of bill to begin with a zero while others do not want a leading zero submitted on the claim. Also, Medicare prefers to have an X at the end of the code (e.g., 011X, 021X) to make it a four character code (as shown above). Other payers do not.

The following are some commonly used (non-Medicare) TOB codes:

011	Hospital – Inpatient (Including Medicare Part A)
012	Hospital – Inpatient (Medicare Part B only)
018	Hospital – Swing Beds
021	Skilled Nursing Facility – Inpatient (Including Medicare Part A)
022	Skilled Nursing – Inpatient (Medicare Part B only)
028	Skilled Nursing – Swing Beds
065	Intermediate Care – Level I
066	Intermediate Care – Level II
086	Special Facility – Residential Facility

Resource: See Resource 188 for the complete list of Type of Bill codes (available by subscription only).

Note: One payer has made this a 4 digit code requirement where the final digit (instead of the X) includes additional claim information. For example, 1 (e.g., 0121) indicates that the claim includes "all" dates of services including discharge date and 2 (e.g., 0122) indicates that this is the first claim and subsequent claims will follow.

FL 5 – Federal Tax Number

Required. The format is NN-NNNNNNN.

FL 6 – Statement Covers Period (From-Through)

Required. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).

FL 7

Not used.

FL 8 – Patient's Name and Identifier

Required. The provider enters the patient's last name, first name, and, if any, middle initial, along with patient identifier (if different than the subscriber/insured's identifier).

FL 9 – Patient's Address

Required. The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP Code.

FL 10 – Patient's Birth Date

Required. The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

Find-A-Code: Some payers may want this formatted as MM/DD/CCYY. Check with the payer to ensure that it is entered properly.

FL 11 – Patient's Sex

Required. The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

FL 12 – Admission/Start of Care Date

Required For Inpatient and Home Health. The hospital enters the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.

FL 13 – Admission Hour

Not Required. If submitted, the data will be ignored.

FL 14 – Priority (Type) of Admission or Visit

Required. Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: These are some commonly used codes. Payer policies may vary.

1	Emergency – The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent – The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	Elective – The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.

Resource: See Resource 188 for the complete list of FL 14 codes (available by subscription only.)

FL 15 – Point of Origin for Admission or Visit

Required except for Bill Type 014X. The provider enters the code indicating the source of the referral for this admission or visit.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: These are some sample codes. Payer policies may vary.

1	Non-Health Care Facility Point of Origin (Physician Referral). Usage note: Includes patients coming from home, a physician's office, or workplace.
2	Clinic or Physician's Office
4	Transfer from a Hospital (Different Facility). Usage Note: Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).
5	Transfer from a SNF or Intermediate Care Facility (ICF) or Assisted Living Facility
6	Transfer from Another Health Care Facility
8	Court/Law Enforcement. Usage Note: Includes transfers from incarceration facilities.
D	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer

Resource: See Resource 188 for the complete list of FL 15 codes (available by subscription only.)

FL 16 – Discharge Hour

Not Required.

Find-A-Code: Even though Medicare does not require this field, other payers may, particularly for hospital claims. For example, the following are instructions from one Medicaid payer:

Enter the discharge hour as follows:

- Eliminate the minutes
- Convert the hour of discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

If the patient has not been discharged, leave this box blank.

FL 17 – Patient Discharge Status

Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's discharge status as of the "Through" date of the billing period (FL 6).

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: These are some commonly used codes. Payer policies may vary.

01	Discharged to home or self-care (routine discharge)
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to a SNF with Medicare Certification in Anticipation of Covered Skilled Care
04	Discharged/Transferred to a Facility That Provides Custodial or Supportive Care

06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
09	Admitted as an Inpatient to This Hospital
43	Discharged/Transferred to a Federal Health Care Facility
61	Discharged/Transferred within this institution to a hospital based Medicare approved swing bed
62	Discharged/Transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/Transferred to long term care hospital (LTCH)
65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
70	Discharged/Transferred to another type of health care institution not defined elsewhere in the code list.

Resource: See Resource 188 for the complete list of FL 17 codes (available by subscription only).

FLs 18 - 28 – Condition Codes

Situational. The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: These are some commonly used codes. Payer policies may vary.

A5	Disability
A6	Vaccines/Medicare 100% Payment
29	Disabled Beneficiary and/or Secondary to Medicare
31	Patient is a Student (Full-Time - Day)
31	Patient is a Student (Part Time)
39	Private Room Medically Necessary
41	Partial Hospitalization

Resource: See Resource 188 for the complete list of Condition Codes (available by subscription only.)

FL 29 – Accident State

Not used. Data entered will be ignored.

FL 30 – (Untitled)

Not used. Data entered will be ignored.

FLs 31, 32, 33, and 34 – Occurrence Codes and Dates

Situational. Required when there is a condition code that applies to this claim.

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the "b" fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved. Occurrence and occurrence span codes are mutually exclusive. When FLs 36 A and B are fully used with occurrence span codes, FLs 34a and 34b and 35a and 35b may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field. Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: This field defines a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.) These are some sample codes. Contact individual payers to determine their requirements.

11	Onset of Symptoms/Illness
16	Date of Last Therapy
40	Scheduled Date of Admissions

FLs 35 and 36 – Occurrence Span Code and Dates

Required For Inpatient. The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Special Billing Procedures When more than Ten Occurrence Span Codes (OSCs) Apply to a Single Stay

The Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) Prospective Payment Systems (PPSs) requires a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

When a provider paid under the LTCH, IPF or IRF PPSs encounters a situation in which ten or more OSCs are to be billed on the claim, the provider must bill for the entire stay up to the Through date of the 10th OSC for the stay (the Through date for the Statement Covers Period equals the Through date of the tenth OSC). As the stay continues, the provider must only bill the 11th through the 20th OSC for the stay, if applicable. Once the twentieth OSC is applied to the claim, the provider must only bill the 21st through the 30th OSC for the stay, if applicable. The Shared System Maintainers (SSMs) retain the history of all OSCs billed for the stay to ensure proper processing (i.e., as if no OSC limitation exists on the claim).

For a detailed billing example that outlines possible billing scenarios, please go to http://www.cms.hhs.gov/Transmittals/01_Overview.asp and refer to CR 6777 located on the 2010 Transmittals page.

Find-A-Code: These are some sample codes. Contact individual payers to determine their requirements.

71	Hospital Prior Stay Dates
72	First/Last Visit Dates
74	Non-covered Level of Care/Leave of Absence Dates
76	Patient Liability
77	Provider Liability Period
M1	Provider Liability - No Utilization Code
M4	Residential Level of Care

FL 37 – (Untitled)

Not used. Data entered will be ignored.

FL 38 – Responsible Party Name and Address

Not Required. For claims that involve payers of higher priority than Medicare.

FLs 39, 40, and 41 – Value Codes and Amounts

Required. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: Although this is required for Medicare, other payers consider this field optional. Be aware of individual payer policies.

These are some sample codes. Contact individual payers to determine their requirements.

01	Most Common Semi-Private Room Rate
09	Coinsurance Amount in the First Calendar Year
21	Catastrophic
24	Medicaid Rate Code
31	Patient Liability Amount
50	Physical Therapy Visits
56	Skilled Nurse - Home Visit Hours (HHA only)
80	Covered Days
81	Non-Covered Day
D3	Patient Estimated Responsibility

Resource: See Resource 188 for the complete list of codes (available by subscription only).

FL 42 – Revenue Code

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: Use this field to report the appropriate HIPAA-compliant code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/or ancillary service

These are some commonly used codes for Medicare claims. Payer policies may vary.

011X Room and board (private)
012X Room and board (semiprivate room, two beds)
013X Room and board (semiprivate room, three and four beds)
015X Room and board (ward)
018X Leave of absence (noncovered day)
025X Pharmacy
027X Medical supplies
030X Laboratory
032X Radiology (diagnostic)
041X Respiratory services
042X Physical therapy
043X Occupational therapy
054X Ambulance services

Resource: See Resource 188 for the complete list of Revenue Codes (available by subscription only.)

FL 43 – Revenue Description/IDE Number/Medicaid Drug Rebate

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of durable medical equipment (DME) or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in Healthcare Common Procedure Coding System (HCPCS) coding.

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11 digit National Drug Code (NDC) in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on Form CMS-1450 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	

FL 44 – HCPCS/Rates/HIPPS Rate Codes

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.

HCPCS used for Medicare claims are available from Medicare contractors.

Find-A-Code: This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system

Additional guidelines and information regarding the payment system(s) for this field type are found in the *Medicare Claims Processing Manual*.

Find-A-Code: HCPCS codes are available in Find-A-Code's specialty-specific *Reimbursement Guides* and at FindACode.com.

Resource: See Resource 410 to review the complete Medicare manual.

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case mix group and assigns the correct RUG code. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Rate Codes used for Medicare claims are available from Medicare contractors.

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference

date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HIPPS Modifiers/Assessment Type Indicators used for Medicare claims are available from Medicare contractors.

HCPCS Modifiers (Level I and Level II)

Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx= to current year) Current Procedural Terminology Appendix A – HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

HCPCS modifiers used for Medicare claims are available from Medicare contractors.

Find-A-Code: HCPCS modifiers are available in Find-A-Code's *Reimbursement Guides* and at FindACode.com.

FL 45 – Service Date

Required Outpatient. CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X (effective April 1, 2010), 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

Find-A-Code: This is an eight digit date entered as MMDDCCYY or MM/DD/CCYY depending on payer requirements.

FL 46 – Units of Service

Required. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

FL 47 – Total Charges – Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The A/B MAC (A or HHH) determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, the A/B MAC (A or HHH) adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the carrier to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

Find-A-Code: Use this field to report to total charges related to the current billing period. This includes both covered and non-covered charges and (depending on the payer) could also include both inpatient and outpatient services.

Medicare will make their payment based on the allowable amount and then the non-covered charges may be submitted to any secondary/tertiary insurance.

FL 48 – Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

Find-A-Code: This field is used to report policy specific noncovered charges. For example, home drugs if noncovered in the patient's policy indicate that amount here.

FL 49 – (Untitled)

Not used. Data entered will be ignored.

Note: the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A (Required), B (Situational), and C (Situational) – Payer Identification

If Medicare is the primary payer, the provider must enter "Medicare" on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.

Find-A-Code: If more than one payer is responsible for this claim, enter the name(s) of primary, secondary, and tertiary payers, as applicable. Multiple payers should be listed in priority sequence according to the priority the provider expects to receive payment from these payers.

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

FLs 52A, B, and C – Release of Information Certification Indicator

Required. 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. 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. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

NOTE: The back of Form CMS-1450 contains a certification that all necessary release statements are on file.

FL 53A, B, and C – Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C – Prior Payments

Situational. Required when the indicated payer has paid an amount to the provider towards this bill.

FL 55A, B, and C – Estimated Amount Due From Patient

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required on or after May 23, 2008.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Not used. Data entered will be ignored.

FLs 58A, B, and C – Insured's Name

Required. The name of the individual under whose name the insurance benefit is carried.

Find-A-Code: Be sure to list the name EXACTLY as it appears on the insured's ID card.

FL 59A, B, and C – Patient's Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: These are some sample codes. Contact individual payers to determine their requirements.

01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
53	Life Partner
G8	Other Relationship

FLs 60A (Required), B (Situational), and C (Situational) – Insured's Unique ID (Certificate/Social Security Number/HI Claim/ Identification Number (HICN))

The unique number assigned by the health plan to the insured.

FL 61A, B, and C – Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a Worker's Compensation (WC) or an Employer Group

Health Plan (EGHP) is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C – Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 – Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever Quality Improvement Organization (QIO) review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 – Employer Name (of the Insured)

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)

Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision.

FL 67 – Principal Diagnosis Code

Required. The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable for ICD-9 or all seven digits for ICD-10. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes where ICD-9-CM is applicable. Where the proper code has fewer than five digits (ICD-9-CM) or seven digits (ICD-10-CM), the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a Diagnosis Related Group (DRG) and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported. If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis. When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations.

Find-A-Code: The principle diagnosis code is the main reason for the patient encounter.

Book: See Chapter 5.1 — Diagnosis Coding Essentials for more information.

FLs 67A-67Q – Other Diagnosis Codes

Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.

Find-A-Code: This field is for reporting all relevant diagnosis codes, other than the principal diagnosis, that coexist, develop after admission, or impact the treatment of the patient or the length of stay.

The ICD-10-CM code, completed to its fullest character (highest level of specificity) must be used. The present on admission (POA) indicator applies to diagnosis codes (e.g., principal, secondary) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting.

FL 68 – Reserved

Not used. Data entered will be ignored.

FL 69 – Admitting Diagnosis

Required. For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70A – 70C – Patient's Reason for Visit

Situational. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are

reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.

If the Patient's Reason for Visit is not required, it may be reported on other 013x and 085x bill types that fail to meet the criteria in a) or b) above at the sender's discretion when this information substantiates the medical necessity of services.

FL71 – Prospective Payment System (PPS) Code

Not used. Data entered will be ignored.

FL72 – External Cause of Injury (ECI) Codes

Not used. Data entered will be ignored.

FL 73 – Reserved

Not used. Data entered will be ignored.

FL 74 – Principal Procedure Code and Date

Situational. Required on inpatient claims when a procedure was performed. Not used on outpatient claims.

FL 74A - 74E – Other Procedure Codes and Dates

Situational. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.

FL 75 – Reserved

Not used. Data entered will be ignored.

FL 76 – Attending Provider Name and Identifiers (including NPI)

Situational. Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.

Secondary Identifier Qualifiers:

0B – State License Number

1G – Provider UPIN Number

G2 – Provider Commercial Number

FL 77 – Operating Provider Name and Identifiers (including NPI)

Situational. Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Secondary Identifier Qualifiers:

0B – State License Number

1G – Provider UPIN Number

G2 – Provider Commercial Number

FLs 78 and 79 – Other Provider Name and Identifiers (including NPI)

Situational. The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

DN – Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.

ZZ – Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.

82 – Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Secondary Identifier Qualifiers:

0B – State License Number

1G – Provider UPIN Number

G2 – Provider Commercial Number

FL 80 – Remarks

Situational. For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's A/B MAC (A or HHH) may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)

FL 81 – Code-Code Field

Situational. To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Find-A-Code: Up to four separate values/codes (a - d) may be reported. Be sure to preface the information with the appropriate qualifier. For example, to indicate the provider's taxonomy code is being reported, use B3 followed by the taxonomy code.

Here are some other qualifiers for this field:

A1	National Uniform Billing Committee Condition Codes (FL 18-22)
A2	National Uniform Billing Committee Occurrence Codes (FL 31-34)
AC	Attachment Control Number
B7	Preferred Language Spoken

Resource: See Resource 188 for the complete list of Revenue Codes (available by subscription only.)