General Guidelines – Facility or Institutional Claims Submitted on UB-04

NOTE: Only one date of service may be billed per claim for outpatient facility services. If submitting on paper, providers must use UB-04 claim forms.

Show the billing NPI in box 56 and the attending NPI in box 76.   The attending physician's NPI must be included on all UB-04 claims.

Completing the UB-04 Claim Form:

The following information shows field by field description of required data elements in addition to the NPI requirements listed above and required rendering/attending provider information.

1 Provider Name, Address, Telephone Number, and Country Code: **Required:** Enter the complete Service address (the address where the services are being performed/rendered) and the telephone and/or fax number.

2 Pay-to Name and Address: **Required**: Enter the address to which payment should be sent if different from the information in Field 1.

3a Patient Control Number: **Optional**: Enter the patient account number that allows for the retrieval of individual patient financial records.

3b Medical/Health Record Number: **Optional**: In this field, report the patient's medical record number as assigned by the provider.

4 Type of Bill: **Required**: The type of bill code indicates the facility type, whether the claim is inpatient or outpatient, and the bill frequency. See the references at the end of this section for acceptable Bill Type codes and Bill Frequency codes.

5 Federal Tax Number: **Required**: Enter the number assigned by the Federal Government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN).

6 Statement covers Period "From" and "Through": **Required**: Enter the beginning and end dates of service for the period reflected on the claim in MMDDYY format.

7   Reserved for Assignment by NUBC: **Not Required**: N/A

8a Patient Identifier: **Required**: Enter the patient's identification number.

8b Patient Name: **Required**: Enter the patient's last name, first name and middle initial.

9a Patient Address: **Required**: Enter the patient's street address.

9b   (unlabeled field): **Required**: Enter the patient's city.

9c   (unlabeled field): **Required**: Enter the patient's state code.

9d   (unlabeled field): **Required**: Enter the patient's ZIP code.

9e   (unlabeled field): **Required**: Enter the patient's Country code.

10   Patient Date of Birth: **Required**: Enter the patient's complete date of birth using the eight-digit format MMDDCCYY.

11   Sex: **Required**: Enter the sex of the patient.

12   Admission Date/State of Care Date: **Required**: Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.

13   Admission Hour: **Required**: Enter the hour in which the patient is admitted for inpatient or outpatient care. NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only.

14   Priority (Type) of Visit: **Required**: Enter the appropriate code for the priority of the admission or visit.

15   Source of Referral for Admission or Visit: **Required**: Enter the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.).

16   Discharge Hour: **Conditional**: Enter the hour the patient is discharged from inpatient care. NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only.

17   Patient Discharge Status: **Required**: Enter the status of the patient upon discharge.

18-28 Condition Codes: **Conditional**: Enter any conditions or events related to the bill that may affect the processing of it.

29   Accident State: **Conditional**: When appropriate, assign the two-digit abbreviation of the state in which an accident occurred.

30   Reserved for Assignment by NUBC: **Not Required**: N/A

31-34 Occurrence Codes and Dates: **Conditional**: Enter the occurrence code and the date fields associated with define a significant event associated with the bill that affects processing by the payer.

35-36 Occurrence Span Codes and Dates: **Conditional**: Enter the beginning and the end dates of the specific event related to the bill.

37   Reserved for Assignment by NUBC: **Not Required**: N/A

38   Responsible Party Name and Address: **Required**: Enter the name and address of the person responsible for the bill.

39-41 Value Codes and Amounts: **Required**: Enter the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers.

42 Revenue Code: **Required**: Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001.

43 Revenue Description: **Required if billing a drug code for outpatient and inpatient claims**: Enter the National Drug Code (NDC) – Medicaid Drug Rebate Reporting.

44 HCPCS/ Tate/ HIPPS Code: **Conditional**: Enter the appropriate HCPCS codes corresponding to the revenue codes.

45 Service Date: **Required**: Enter the date the outpatient service was provided and the date the bill was created using the six- digit format MMDDYY.

46 Service Units: **Required**: Enter the units such as pints of blood used, miles traveled and the number of inpatient days are reported.

47 Total Charges: **Required**: Enter the total charges--covered and non-covered-- related to the revenue code.

48 Non-Covered Charges: **Conditional**: Enter the charges that are non- covered charges by the payer as related to the revenue code.

49 Reserved for Assignment by NUBC: **Not Required**: N/A

50a, b, c Payer Name: **Optional:** Enter the name of the payer.

51a, b, c Health Plan Identification Number: **Not Required**: Enter the identification number of the health insurance plan that covers the patient and from which payment is expected.

52a, b, c Release of Information Certification Indicator: **Required**: Enter the appropriate code denoting whether the provider has on file a signed statement form the member to release information.

53a, b, c Assignment of Benefits Certification Indicator: **Required**: Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.

54a, b, c Prior Payments: **Conditional**: Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.

55a, b, c Estimated Amount Due: **Not Required**: Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.

56   National Provider Identifier-Billing Provider: **Required**: Enter the Facility's billing NPI.

57   Other Provider Identifier-Billing Provider: **Not Required**: Enter the unique provider identifier assigned by the health plan is reported in this field.

58a, b, c   Insured's Name (last, first name, middle initial): **Required**: Enter the name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial.

59a, b, c   Patient's Relationship to Insured: **Required**: Enter the applicable code that indicates the relationship of the patient to the insured.

60a, b, c   Insured's Unique Identification: **Required**: Enter the unique number the health plan assigns to the insured individual. The ID Number from the Member's Insurance Card should be entered.

61a, b, c   Group Name: **Required**: Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured.

62a, b, c   Insurance Group Number: **Conditional**: Enter the plan or group number for the primary, secondary, and tertiary payer through which the coverage is provided to the insured.

63a, b, c   Treatment Authorization Codes: **Optional**: Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has preauthorized.

64a, b, c   Document Control Number: **Not Required**: From the Provider, enter the number assigned by the health plan to the bill for their internal control.

65a, b, c   Employer Name (of the Insured): **Conditional**: Enter the name of the primary employer that provides the coverage for the insured indicated in Field 58.

66   Diagnosis and Procedure Code Qualifier ICD Version Indicator: **Required**: This qualifier is used to indicate the version of ICD-10-CM being used. A"0" is required in this field for the UB- 04.

67   Principal Diagnosis Code: **Required**: Enter the valid ICD-10-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered.

67 a-q   Other Diagnosis Codes/Present on Admission Indicator (POA): **Conditional**: Enter all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The present on admission (POA) indicator applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code.

68   Reserved for Assignment by NUBC: **Not Required**: N/A

69   Admitting Diagnosis: **Required**: Enter a valid ICD-10-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission.

70 a-c Patient's Reason for Visit: **Conditional**: Enter the ICD-10-CM codes that report the reason for the patient's outpatient visit.

71   Prospective Payment System (PPS) Code: **Not Required**: Enter the code identifies the DRG based on the grouper software.

72   External Cause of Injury (ECI) Code: **Not Required**: In the case of external causes of injuries, poisonings, or adverse effects, enter the appropriate ICD-10-CM diagnosis code this field.

73   Reserved for Assignment by NUBC: **Not Required**: N/A

74   Principal Procedure Code and Date**: Conditional**: Enter the principal ICD-10-CM procedure code covered by the bill and the related date.

74 a-e Other Procedure Codes and Dates: **Conditional**: Enter additional ICD-10-CM procedure code covered by the bill and the related date.

75   Reserved for Assignment by NUBC: **Not Required**: N/A

76   Attending Provider Names and Identifiers: **Required**: Enter the NPI of the attending provider is required.

77   Operating Physician Name and Identifiers: **Conditional**: Enter the name and identification number of the physician responsible for performing surgical procedure in this field.

78-79 Other Provider Names and Identifiers: **Conditional**: Enter the names and identification numbers of individuals that correspond to the provider type category.

80   Remarks Field: **Not Required**: Enter additional information necessary to process the claim.

81 a-d Code-Code Field: **Conditional**: Enter codes that overflow other fields and for externally maintained codes.