

UB-04 Facility Claim Form Instructions

This guide is designed to be used as a reference tool for our claim submitters to provide the expected content of each field on the UB-04, the standard paper claim form for facility claims. The UB-04 claim form must be completed for all facility claim submissions (including home health agency). All claims must be submitted within the required filing timeframe.

This guide is not intended to replace the Official UB-04 Data Specifications published by the National Uniform Billing Committee (NUBC) and the American Hospital Association. For more information on purchasing licenses for their complete specifications, please visit their website:

http://www.nubc.org/subscriber/index.dhtml.

1	2	3a PAT. CNTL # 4 TYPE OF BILL
		b. MED. REC. #
		5 FED. TAX NO. 6 STATEMENT COVERS PERIOD 7 FROM THROUGH 7
8 PATIENT NAME a	9 PATIENT ADDRESS a	
b	b	c d

FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
1	UNLABELED FIELD	1st Line: Enter the Billing Provider Organization Name 2nd Line: Enter the complete Billing Provider Street Address – Do not use punctuation or P.O. Boxes. 3nd Line: Enter City, State and 9-digit Zip code 4th Line: Enter the 10-digit Telephone Number XXXXXXXXXX (no formatting)	Required
2	UNLABELED FIELD	The Pay-to Name and Address if different than the information in Field 1. NOT USED BY CARECENTRIX	N/A
3a	PAT CNTL#	Enter the Provider's Patient Account/Control Number.	Required
3b	MED REC#	Enter the Patient's Medical or Health Record Number. NOT USED BY CARECENTRIX	N/A
4	TYPE OF BILL	Enter the specific type of bill (e.g. hospital inpatient, outpatient, replacements, voids, etc.). • The first digit is a leading zero, • The next 2 digits indicate the type of bill, • The fourth digit indicates the frequency of the bill. However, DO NOT enter a frequency code. Instead, to submit a replacement claim, mark 'CORRECTED' across the top of the claim without obstructing any claim elements.	Required
5	FED. TAX NO.	Enter the 10-character Billing Provider's Federal Tax ID Number (TIN) assigned by the federal government for tax reporting purposes, including the hyphen in the XX-XXXXXXX format. Must not be blank or all zeroes.	Required
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter two 6-digit dates (MMDDYY MMDDYY) of the beginning and ending service dates for the entire period invoiced on this claim.	Required
7	UNLABELED FIELD	NOT USED	N/A
8 a, b	PATIENT NAME	 8a Enter the Patient's health plan ID, as it appears on the subscribers ID card. 8b Enter Patient Last Name, First Name and Middle Name/Initial (in that specific order.) Use name as it appears on Health Plan ID card. Use a comma or space to separate last and first names. Do NOT use Titles (Mr., Mrs., Dr., etc.) No spaces should be used in hyphenated or prefixed names. e.g. McKendrick, MacBeth, Smith-Jones A Suffix (such as Jr. or III) should follow the last name. e.g. Johnson III, Richard Paul 	Required
9 a-e	PATIENT ADDRESS	 9a Enter the Patient's mailing Street Address or P.O. Box 9b Enter the Patient's City 9c Enter the Patient's State 9d Enter the Patient's Zip code 9e Do NOT use unless the Patient's address is outside of the US. This is for the Country Code for non-US addresses. 	Required

	10 BIRTHDATE	11 SEX	12	DATE	ADMISSIO 13 HR	N 14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDIT	TON COD	ES 24	25	26	27	28	29 ACDT STATE	30
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FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
10	BIRTHDATE	Enter the Patient's Date of Birth. MMDDYYYY, e.g. 09211965	Required
11	SEX	Enter the Patient's Gender. M, F, and U (Unknown) are acceptable.	Required
12	ADMISSION DATE	Required for Inpatient, Home Health and Hospice claims. For Home Health, this is the Start of Care Date. MMDDYY	Conditional
13	ADMISSION HR	Required for inpatient claims only, except Bill Type 021x. Enter the Admission Hour in military time (00-23).	Conditional
14	ADMISSION TYPE	Enter the Admission Type Code: 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma 9=Information Not Available	Required
15	ADMISSION SRC	Enter the Source of Admission Code: 1=Non-HealthCare Facility Point of Origin 2=Clinic or Physician's Office 4=Transfer from a Hospital (different facility) 5=Transfer From a SNF or ICF or ALF 6=Transfer from Another Health Care Facility not defined elsewhere in this list 8=Court/Law Enforcement, Incarceration Facility 9=Information Not Available B=Transfer from Another Home Health Agency D=Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer E=Transfer from Ambulatory Surgery Center F=Transfer from Hospice For Newborns Only (indicated by Admission Type 4): 5=Born inside of this Hospital 6=Born outside of this Hospital	Required
16	DHR	Enter the Discharge Hour in military time (00-23). Required on all final inpatient claims.	Conditional
17	STAT	Enter the Patient's 2-digit Status at the end of the period covered by this bill through discharge (Always include both digits.) See Appendix A for a partial list of the Patient's Discharge Status Codes and more information on the complete list.	Required
18-28	CONDITION CODES 18-28	Enter Condition Codes if they are applicable. If more than one condition code applies, list in numerical order. See Appendix B for a partial list of Condition Codes and more information on the complete list.	Conditional
29	ACDT STAT	Required when the services reported on this claim are related to an auto accident. Enter the 2-character state or province code where the accident occurred.	Conditional
30	UNLABELED FIELD	NOT USED	N/A

31 C0	ODE ODE	32 C CODE	OCCURRENCE DATE	33 C CODE	34 C CODE	35 CODE		OCCURRENCE FROM	SPAN THROUGH	36 CODE	OCCURRENCE FROM		'HROUGH	37	
а															
b															
38							39 COE	VALUE (E AMO		40 CODE	VALUE CODES AMOUNT		41 \ CODE	ALUE CODES AMOUNT	
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						d						1			1

FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
31-34 a,b	OCCURRENCE CODE & DATE	 Required when there is an Occurrence Code that applies to this claim. Occurrence CODES and Occurrence SPANS are mutually exclusive. Occurrence Codes are 01-69 and A0-LZ. Occurrence codes happen on a single day and the associated date should be in MMDDYY format. Enter each code and corresponding date. List in alphanumeric order (numbers before letters), and use row A before moving to Row B. 	Conditional
35-36 a,b	OCCURRENCE SPAN CODE & FROM/THROUGH	 Required when there is an Occurrence Span that applies to this claim. Occurrence CODES and Occurrence SPANS are mutually exclusive. Occurrence Codes are 70-99 and M0-ZZ. Occurrence Spans happen over a period of time and have an associated from and through date. Enter each code and corresponding date range. List in alphanumeric order (numbers before letters), and use row A before moving to Row B. 	Conditional
37	UNLABELED FIELD	NOT USED.	N/A
38	UNLABELED FIELD	Name and Address of Claim Addressee - NOT USED BY CARECENTRIX.	N/A
39-41	VALUE CODE & AMOUNT	Enter any Value Codes and Amounts. If more than one value code applies, list in alphanumeric order.	Conditional

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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3	PAGE OF	CREATION DATE	F	TOTALS	>	<u> </u>	

FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
42	REV CD	The 4-digit revenue code that applies to this service line. See Appendix C for examples. Note: Must be 0022 (SNF HIPPS), 0023 (HHA HIPPS), or 0024 (IRF HIPPS) if this Service Line contains a HIPPS code.	Required
43	DESCRIPTION	Required ONLY when the service is a Miscellaneous HCPC or a Drug. Otherwise, leave blank. For a drug, enter the NDC and associated information as follows with no spaces or delimiters: N4 followed by the 11-digit NDC(no hyphens) followed by the Unit of Measure (F2, GR, ML, UN or ME) followed by the quantity, using a decimal to represent any fractional units with no more than 3 digits to the right of the decimal	Conditional
44	HCPCS/RATES/HIPPS CODE	Enter the applicable HCPCS code and up to 4 modifiers (as needed) or a HIPPS code with NO modifiers. The code submitted needs to be appropriate for the rev code entered in field 42. CareCentrix does not accept Q-codes. Note: Home Health claims for patients covered under Medicare Advantage plans are required to contain a HIPPS code. HIPPS codes must be submitted with the appropriate revenue codes. Must be 0022 (SNF HIPPS), 0023 (HHA HIPPS), or 0024 (IRF HIPPS.) For more information on HIPPS codes, refer to the CMS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicare-Fee-SvcPmtGen/HIPPSCodes.html	Required
45	SERV DATE	Lines 1-22: Enter the Date of Service on this line item in the MMDDYY format. Use a separate line item for different dates of service. The date should fall within the range entered in Field 6. Line 23: Enter the Date this form is completed/printed.	Required
46	SERV UNITS	Enter the quantity (number of units) for this service line. Note: For a HIPPS code line, this should always be 1.	Required
47	TOTAL CHARGES	Lines 1-22: Enter the billed amount for this service line. Note: For a HIPPS code line, this should always be a zero. Line 23: Enter the total of all charges billed (the sum of the detail lines) on line 23 of the final page of this claim only.	Required
48	NON-COVERED CHARGES	Lines 1-22: Required if there are non-covered charges for this line. Line 23: Enter the total of all non-covered charges (the sum of the detail lines) on line 23 of the <u>final</u> page of this claim only.	Conditional
49	UNLABELED FIELD	NOT USED	N/A

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASC BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
А							57	A
В					:	:	OTHER	В
С							PRV ID	c

FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
50	PAYER NAME	Enter the name of each Payer (or health plan) being invoiced. e.g. CARECENTRIX	Line A Required
		When the patient has other coverage, list the payers as indicated below: • Line A (Required)= Primary Payer • Line B = Secondary • Line C = Tertiary	Lines B and C Conditional
		Required for each Payer listed.	Line A Required
51	HEALTH PLAN ID	Enter the Health Plan ID Number.	Lines B and C
		For CARECENTRIX, this number is 113454103.	Conditional
		Required for each Payer listed.	
52	REL. INFO	Release of Information Certification Indicator. This field conveys whether or not the provider has a signed statement from the patient allowing the release of medical claim billing information to another organization	Line A Required Lines B and C Conditional
		It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y".	
		Required for each Payer listed.	
		Assignment of Denefits Contification Indicator. This field conveys that the	Line A Required
53	ASG. BEN.	Assignment of Benefits Certification Indicator. This field conveys that the provider has a signed form from the patient authorizing the payer to remit payment directly to the provider. Valid entries are Y (Yes) and N (No).	Lines B and C Conditional
54	PRIOR PAYMENTS	Required when the claim has already been adjudicated by the payer listed on this line. It is the amount that the health plan has paid towards this bill. 8 digits are allowed before the decimal point provided on the form and 2 after.	Conditional
55	EST. AMOUNT DUE	Amount provider estimates is due by the indicated provider (after prior payments are deducted) - NOT USED BY CARECENTRIX	N/A
56	NPI	The billing provider's 10-character National Provider ID number should be entered here.	Required
57	OTHER PRV ID	Health Plan Provider Identifier - NOT USED BY CARECENTRIX	N/A

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME		62 INSURANCE GROUP NO.	
Α.							A
В							В
С							c
Ī	63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAM	IE	
Α							7
В							В
С							c

FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
58	INSURED'S NAME	The name of the individual under whose name the insurance is carried for the payers listed in field 50. LAST, FIRST MIDDLE (In this exact order.) • Use a comma or space to separate last and first names. • Do NOT use Titles (Mr., Mrs., Dr., etc.) • No spaces should be used in hyphenated or prefixed names. • g. McKendrick, MacBeth, Smith-Jones • Name should be written as it appears on the Service Authorization Form (ie: SAF) or on the patients Subscriber Identification Card. A Suffix (such as Jr. or III) should follow the last name. e.g. Johnson III,	Line A Required Lines B and C Conditional
59	P REL	Enter the 2-digit code that represent the patient's relationship to the insured for each of the entries in 58: 01 = Spouse 18 = Self 19 = Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other	Line A Required Lines B and C Conditional
60	INSURED'S UNIQUE ID	Enter the patient's Health Plan ID for each of the entries in 58. Do not include the person code.	Line A Required Lines B and C Conditional
61	GROUP NAME	Enter the patient's Group NAME for each of the entries in 58 if no group NUMBER (in field 62) is available.	Conditional
62	INSURANCE GROUP NO.	Enter the patient's Group NUMBER (if on the ID card) for each of the entries in 58.	Conditional
63	TREATMENT AUTHORIZATION CODES	Line A: Enter the payer's authorization number if applicable Line B: Enter a referral number if applicable.	Conditional
64	DOCUMENT CONTROL NUMBER	Enter each payer's claim control number when submitting a replacement or void.	Conditional
65	EMPLOYER NAME	Employer Name of the insured - NOT USED BY CARECENTRIX	N/A



FIELD#	FIELD LABEL	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
66	DX	Enter the ICD Code Qualifier to indicate the code revision in use 9 = ICD-9 0 = ICD-10 (DO NOT USE UNTIL DIRECTED BY CARECENTRIX.)	Required
67	Principal DX Code	Enter the complete Principal Diagnosis Code. Include the 4th and 5th digits if applicable.	Required
67 A-Q	Other DX Code	Enter any OTHER Relevant Diagnosis Codes. Include the 4th and 5th digits if applicable.	Conditional
68	UNLABELED FIELD	NOT USED.	N/A
69	ADMIT DX	Required when the claim involves an inpatient admission. Enter the complete Admitting Diagnosis Code that represents the reason for visit at the time of admission. Include the 4th and 5th digits if applicable. For appropriate diagnosis selection, utilize the most current ICD-9-CM coding material.	Conditional
70 a, b, c	PATIENT REASON DX	Required for Outpatient Claims. Enter the Diagnosis Code that represents the patient's stated reason(s) for their outpatient visit at the time of registration.	Conditional
71	PPS CODE	Required when an inpatient hospital is under DRG contract with the payer. Enter the appropriate PPS code. NOT USED BY CARECENTRIX.	Conditional
72 a, b, c	ECI	Required when an External Cause of Injury Code is needed to describe an injury, poisoning or adverse effect. Enter the appropriate Diagnosis Code.	Conditional
73	UNLABELED FIELD	NOT USED.	N/A
74	PRINCIPAL PROCEDURE CODE & DATE	Represents Primary Procedure performed on inpatient claims - NOT USED BY CARECENTRIX.	N/A
74 a-e	OTHER PROCEDURE CODE & DATE	Represents Other Procedures performed on inpatient claims – NOT USED BY CARECENTRIX	N/A
75	UNLABELED	NOT USED.	N/A
76	ATTENDING	The ATTENDING Provider has the overall responsibility for the patient's medical care and treatment reported on a claim. Enter the Attending Provider's information in the NPI, LAST, and FIRST boxes beside (and below) the box labeled 76 ATTENDING.	Required
77	OPERATING	The OPERATING Physician information is only required when a surgical procedure code is listed on the claim. This is the individual with primary responsibility for performing the surgery. If it is relevant, enter the Operating Provider's information in the NPI, LAST, and FIRST boxes beside (and below) the box labeled 77 OPERATING.	Conditional
78-79	OTHER	If the REFERRING provider's information is different than the ATTENDING provider in Field 76, enter the REFERRING Provider's NPI, LAST, and FIRST in the boxes beside and below 78 OTHER (or 79 OTHER) with a qualifier in the first box (in front of the NPI box) of ' DN '. If the RENDERING provider's information is different than the ATTENDING provider in Field 76, enter the RENDERING Provider's NPI, LAST, and FIRST in the boxes beside and below 78 OTHER (or 79 OTHER) with a qualifier in the first box (in front of the NPI box) of '82.	Conditional
80	REMARKS	Providers may enter free-form narrative text in this field.	Not Required
81a	СС	Enter qualifying code 'B3' for Taxonomy code and the Billing Provider's 10-digit Taxonomy Code.	Conditional

Appendix A

FIELD 17 STAT - PATIENT DISCHARGE STATUS CODES

Below is a partial list of Patient Discharge Status Codes. The complete list is included in the Official UB-04 Data Specifications, published by the National Uniform Billing Committee (NUBC) and the American Hospital Association. For more information on purchasing licenses for their complete specifications, please visit their website:

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01=Discharged to home or self-care

02=Discharged/Transferred to another short term hospital for inpatient care

03=Discharged/Transferred to Skilled Nursing Facility (SNF)

04=Discharged/Transferred to a Facility that provides Custodial or Supportive Care, including Intermediate Care Facilities (ICF)

05=Discharged/Transferred to a designated Cancer Center or Children's hospital

06=Discharged/Transferred to home under care or organized Home Health service organization

07=Left against medical advice or discontinued care

09=Admitted as an inpatient to this hospital (for use only on Medicare outpatient claims)

20=Expired (or did not recover)

21=Discharged/Transferred to Court/Law Enforcement

30=Still patient

40=Expired at home (Hospice claims only)

41=Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)

42=Expired - place unknown (Hospice claims only)

43=Discharged/transferred to a federal health care facility

50=Discharged/transferred to Hospice - home

51=Discharged/transferred to Hospice - medical facility

61=Discharged/transferred to a hospital based Medicare approved swing bed.

62=Discharged/transferred to an inpatient rehabilitation facility (IRF) including Rehab distinct part units of a hospital.

63=Discharged/transferred to long term care hospitals.

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).

Appendix B

FIELD 18-28 - CONDITION CODES

Below is a partial list of Condition Codes. The complete list is included in the Official UB-04 Data Specifications, published by the National Uniform Billing Committee (NUBC) and the American Hospital Association. For more information on purchasing licenses for their complete specifications, please visit their website:

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01	Military Service Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report or a bill for a beneficiary who is enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 18 Months of Entitlement Covered By Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 18 months of end stage renal disease entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care but the provider is not treating the patient for the terminal condition and is therefore requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	The beneficiary would not provide information concerning other insurance coverage.

Appendix C

FIELD 42 - REVENUE CODES

Below are some examples of Revenue Codes. The complete list is included in the Official UB-04 Data Specifications, published by the National Uniform Billing Committee (NUBC) and the American Hospital Association. For more information on purchasing licenses for their complete specifications, please visit their website:

http://www.nubc.org/subscriber/index.dhtml

042X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

SubcategoryStandard Abbreviations0 - General ClassificationPHYSICAL THERP1 - Visit ChargePHYS THERP/VISIT2 - Hourly ChargePHYS THERP/HOUR3 - Group RatePHYS THERP/GROUP4 - Evaluation or Re-PHYS THERP/EVAL

evaluation

9 - Other Physical Therapy OTHER PHYS THERP

057X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory
0 - General Classification
1 - Visit Charge
2 - Hourly Charge
9 - Other Home Health Aide
Standard Abbreviations
AIDE/HOME HEALTH
AIDE/HOME HLTH/VISIT
AIDE/HOME HLTH/HOUR
AIDE/HOME HLTH/OTHER

058X Other Visits (Home Health)

Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified. Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviations	
0 - General Classification	VISIT/HOME HEALTH	
1 - Visit Charge	VISIT/HOME HLTH/VISIT	
2 - Hourly Charge	VISIT/HOME HLTH/HOUR	
3 - Assessment	VISIT/HOME HLTH/ASSES	
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER	