UB-92 – Institutional Providers
Data Element Requirements for Non-electronic Clean Claims

For any conflicts between the following reference materials and the rules, the rules prevail.

Field #	Data Element	HB 610 required as indicated (unless otherwise agreed to by contract)	SB 418 Emergency Rules required as indicated (Cannot be changed by contract)	SB 418 Final Rules required as indicated (Cannot be changed by contract)
1	Provider's name, address and telephone number	R	R	R
3	Patient control number	R	R	R
4	Type of bill code	R	R - shall include a "7" in the 3rd position if claim is a duplicate	R - shall include a "7" in the 3rd position if claim is a corrected claim
5	Provider's federal tax ID number	R	R	R
6	Statement period (beginning and ending date of claim period)	R	R	R
7	Covered days	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor
8	Noncovered days	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor
9	Coinsurance days	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor
10	Lifetime reserve days	R – if Medicare is a primary or secondary payor and patient was an inpatient	R – if Medicare is a primary or secondary payor and patient was an inpatient	R – if Medicare is a primary or secondary payor and patient was an inpatient
12	Patient's name	R	R	R
13	Patient's address	R	R	R
14	Patient's date of birth	R	R	R
15	Patient's gender	R	R	R
16	Patient's marital status	R	R	R
17	Date of admission	R	R - for inpatient admissions, observation stays, and emergency room care	R - for admissions, observation stays, and emergency room care
18	Admission hour	R	R - for inpatient admissions, observation stays, and emergency room care	R - for admissions, observation stays, and emergency room care

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19	Type of admission (e.g. emergency, urgent, elective, newborn)	R	R - for inpatient admissions	R - for admissions
20	Source of admission code	R	R – for inpatient admissions	R
21	Discharge hour	R – if patient was an inpatient or admitted for outpatient observation	R – for inpatient admissions, outpatient surgeries or observation stays	R – for admissions, outpatient surgeries or observation stays
22	Patient status-at-discharge code	R	R - for inpatient admissions, observation stays, and emergency room care	R - for admissions, observation stays, and emergency room care
24-30	Condition codes	R – if the CMS UB-92 manual contains a condition code appropriate to patient's condition	R – if the CMS UB-92 manual contains a condition code appropriate to patient's condition	R – if the CMS UB-92 manual contains a condition code appropriate to patient's condition
32-35	Occurrence codes and dates	R – if the CMS UB-92 manual contains an occurrence code appropriate to patient's condition	R – if the CMS UB-92 manual contains an occurrence code appropriate to patient's condition	R – if the CMS UB-92 manual contains an occurrence code appropriate to patient's condition
36	Occurrence span code, from and through dates	R – if the CMS UB-92 manual contains an occurrence span code appropriate to patient's condition	R – if the CMS UB-92 manual contains an occurrence span code appropriate to patient's condition	R – if the CMS UB-92 manual contains an occurrence span code appropriate to patient's condition
39-41	Value code and amounts	R	R – for inpatient admissions. If no value codes are applicable to admission, provider can enter value code 01	R – for inpatient admissions. If no value codes are applicable to admission, provider can enter value code 01
42	Revenue code	R	R	R
43	Revenue description	R	R	R
44	HCPCS/Rates	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor	R – if Medicare is a primary or secondary payor

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45	Service date	Not required	R – if claim is for outpatient services	R – if claim is for outpatient services
46	Units of Service	R	R	R
47	Total Charge	R	R	R
50	HMO or preferred provider carrier name	R	R	R
51	Provider number	Not required	R - if carrier required provider numbers and gave notice of the requirement to physician/provider prior to 6-17-2003.	R - if carrier required provider numbers and gave notice of the requirement to physician/provider prior to 6-17-2003.
54	Prior payments - payor and patient	R – if payments have been made to provider by or on behalf of patient or scriber or by a primary plan	R – if payments have been made to provider by or on behalf of patient or subscriber or by a primary plan	R – if payments have been made to provider by or on behalf of patient or subscriber or by a primary plan
58	Subscriber's name	R	R – if shown on patient's ID card	R – if shown on patient's ID card
59	Patient's relationship to subscriber	R	R	R
60	Patient's/subscriber's certificate number, health claim number, ID number	R	R	R – if shown on the patient's ID card
62	Insurance group number	Not required	R – if a group number is shown on the patient's ID card	R – if a group number is shown on the patient's ID card
63	Verification codes	Not required	R- if services have been verified per §19.1724 (Verification). Otherwise, treatment authorization codes are required when authorization is required	R- if services have been verified per §19.1724 (Verification). Otherwise, treatment authorization codes are required when authorization is required and granted
67	Principal diagnosis code	R	R	R

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68-75	Diagnoses codes other than principal diagnosis code	R – if there are diagnoses other than the principal diagnosis	R – if there are diagnoses other than the principal diagnosis	R – if there are diagnoses other than the principal diagnosis
76	Admitting diagnosis code	Not required	R	R
79	Procedure coding methods used -	R - if the CMS UB-92 manual indicates a procedural coding method appropriate to patient's condition	R - if the CMS UB-92 manual indicates a procedural coding method appropriate to patient's condition	R - if the CMS UB-92 manual indicates a procedural coding method appropriate to patient's condition
80	Principal procedure code	R – if patient has undergone an inpatient or outpatient surgical procedure	R – if patient has undergone an inpatient or outpatient surgical procedure	R – if patient has undergone an inpatient or outpatient surgical procedure
81	Other procedure code	R – as an extension of Field 80 if additional surgical procedures were performed	R – as an extension of Field 80 if additional surgical procedures were performed	R – as an extension of Field 80 if additional surgical procedures were performed
82	Attending physician ID	R	R	R
85	Signature of provider representative or notation that the signature is on file with the HMO or PPO carrier	R	R – signature of provider representative. Electronic signature, or notation that signature is on file with carrier.	R – signature of provider representative. Electronic signature, or notation that signature is on file with carrier.
86	Date bill submitted	R	R	R