

Hospice UB-04

Claim form billing instructions for the
Department of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use commercially available “red form” versions of the UB-04.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible.
- If possible, submit no more than twenty-two lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
 - Local business forms suppliers
 - Standard Register Company, Forms Division (800-755-6405)

Services billed on the UB-04

Institutional Providers

- Free Standing Kidney Dialysis
- Home Health
- Hospice
- Hospital

Services billed on the UB-04

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
 - Toll free: 800-336-6016
 - E-mail: DMAP.providerservices@state.or.us

Introducing the UB-04

1	2	33 PAT CNTL #	4 TYPE OF BILL
		b. MED REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH 7
8 PATIENT NAME a		9 PATIENT ADDRESS a	
b	c	d	e
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION UP 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
			18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE
35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE DATE	38 OCCURRENCE DATE
39 OCCURRENCE DATE	40 OCCURRENCE DATE	41 OCCURRENCE DATE	42 OCCURRENCE DATE
39 CODE	40 CODE	41 CODE	42 CODE
a	b	c	d
43 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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841			

UB-04

- Not sure if you are using the correct form?

The bottom left corner will look like this.

UB-04 CMS-1450



Top section

1										2										3a PAT. CNTL #					4 TYPE OF BILL							
8 PATIENT NAME										9 PATIENT ADDRESS										5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM THROUGH							
10 BIRTHDATE										11 SEX		12 DATE		13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		CONDITION CODES					29 ACDT STATE		30	
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Red = Required

Yellow = Optional

Box 1 - Optional

1	Hospice		
	PO Box ###		
	Anytown, OR 97###		

Billing Provider Information

- Enter the name and address of the Hospice that is requesting to be paid for the services rendered.

Box 3a - Optional

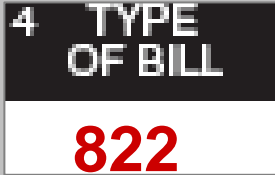
3a PAT.
CNTL #

X123400

Patient Account Number

- Enter your recipient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

Box 4 - Required



Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
 - First-digit: Always use an 8 for Hospice
 - Second-digit: Use 1 for non-hospital based
Use 2 for hospital based
 - Third-digit: Use 1 for admit through discharge date
Use 2 for first claim
Use 3 for interim-continuing claim
Use 4 for interim-last claim

Box 6 - Required

6	STATEMENT COVERS PERIOD FROM	THROUGH
	040107	040707

Statement Covers Period

- Enter the beginning and ending dates of services covered by this claim.
- This box must list numeric dates of service.

Box 8b - Required

8 PATIENT NAME	a
b	Patient, Your

Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use the recipient's last name first.
- Do not use nicknames.

Box 12 - Required

12	DATE
	040107

Admission Date

- Enter the actual admission date, even if the recipient was not eligible on that date.

Box 31 - Optional

31 CODE	OCCURRENCE DATE

Accident Occurrence

- If this claim is a result of an accident, enter one of the following codes and the date of the occurrence.

01 - Auto accident

04 - Employment related accident

- Pursue all prior resources first.
- DMAP is the payer of last resort.

Middle section

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
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	PAGE ____ OF ____	CREATION DATE		TOTALS			23

Red = Required

Box 42 - Required

42 REV. CD.	
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Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Refer to your Hospice supplemental for a complete list of revenue center codes or on the following page.

Revenue Center Codes

651	Routine Home Care
652	Continuous Home Care (bill in hours)
655	Inpatient Respite Care
656	General Inpatient Care
659	In-Home Respite Care
0001	For total claim

Total - Required

TOTALS  **985:15**

Total

- Enter the total charge amount for all services listed in column 47.
- Each claim form is a separate document, and is to be totaled as such.

Bottom section

50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASS BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	57 OTHER PRV ID	
58 INSURED'S NAME		59 R.RE	60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.			
63 TREATMENT AUTHORIZATION CODES					64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			
66 DX	A B C D E F G H I J K L M N O P Q										68	
69 ADMIT DX	70 PATIENT REASON DX		a	b	c	71 PPS CODE	72 ECI	a	b	c	73	
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75		76 ATTENDING NPI		QUAL		
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c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE				77 OPERATING NPI		QUAL		
								LAST		FIRST		
80 REMARKS		81 CC a						78 OTHER NPI		QUAL		
		b						LAST		FIRST		
		c						79 OTHER NPI		QUAL		
		d						LAST		FIRST		

Red = Required

Yellow = Optional

Box 50 - Optional

50 PAYER NAME	
A	Primary payer
B	Secondary payer
C	Tertiary payer

Payer Name

- Enter the names of up to three payer organizations in order.

Example:

If Medicaid is primary, enter on line A.

If Medicaid is secondary, enter on line B.

If Medicaid is tertiary payer, enter on line C.

Box 54 - Optional

54 PRIOR PAYMENTS	

Prior Payments

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

Box 56 - Required

56 NPI

#####

National Provider Identifier (NPI)

- Enter the ten-digit NPI of the Hospice billing for services rendered.

Box 57 - Required

57	
OTHER	#####
PRV ID	

Provider Number

- Enter the six-digit (DHS issued) provider number of the Hospice billing for services rendered.
- Correspond the placement number as outlined in box 50 instructions.
- Do not list other payer provider numbers.

Box 60 - Required

60 INSURED'S UNIQUE ID
X X # # # X # X

Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

Box 66 - Required

66 00	7993	67
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Diagnosis Code

- Enter the recipient's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
- You may enter up to five codes if necessary by listing them in box 67 - 67D.
- The diagnosis codes must be carried out to its highest degree of specificity.
- Do not use the decimal point.

Box 78 - Optional

78 OTHER		NPI #####	QUAL		#####
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Referring Provider ID

- This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).
- Enter the ten-digit NPI of the referring PCM or PCO.
- Enter the six-digit (DHS issued) provider number of the referring PCM or PCO.
- If the recipient is not referred by the PCM or PCO, leave this box blank. Rendering provider numbers or six-nines are no longer required.

Box 80 - Optional

80 REMARKS
NC

Third Party Resource

- If the recipient has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.
- TPR codes can be found in your specific provider rulebook supplemental, or on the following slides.

Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes continued on next slide

Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAFF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

Multiple carrier TPR codes

SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes continued on next slide

Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

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1 Hospice PO Box ### Anytown, OR 97###	2	33 PAT CNTL # b. MEDI REC. #		X123400	4 TYPE OF BILL 822															
9 PATIENT NAME a Patient, Your			9 PATIENT ADDRESS a																	
10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDD STATE	30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE DATE	37	38	39	40	41	42	43	44	45	46	47	48	49		
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49													
1 651		T###		7	144 19															
2 652		T###		24	840 96															
23 0001	PAGE ____ OF ____	CREATION DATE	TOTALS	958 15																
50 PAYER NAME Medicaid	51 HEALTH PLAN ID	52 REL INFO	53 ASSO BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI #####	57 OTHER #####	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID XX###X#X	61 GROUP NAME	62 INSURANCE GROUP NO.								
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66 DX 7993	67	68	69	70	71	72	73	74	75	76	77	78	79	80			
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87		
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80	81	82	83	84	85	86	87	88	89	90	91	92		
80 REMARKS NC	81CC a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r		

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Resources

Where to mail your claim

- Mail your UB-04 claim form to:

DMAP

PO Box 14956

Salem, OR 97309-4957

Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your UB-04 claim form.
- They can be reached at:
 - Toll free: 800-336-6016
 - E-mail: DMAP.providerservices@state.or.us



Thank You!