Hospital Inpatient UB-04

Claim form billing instructions for the Department of Human Services

DHS
Oregon 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 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. All inpatient charges must be billed on one 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

3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a

b

9 PATIENT ADDRESS a

b c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	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
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

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
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC			
a			
b			
c			
d			

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

3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a
b
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a b c d

Red = Required

Yellow = Optional

Box 1 - Optional

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

Billing Provider Information

- Enter the name and address of the Hospital 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

4 TYPE OF BILL
111

Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
  - 111 - Inpatient (including patients with Medicare Part A only)
  - 121 - Inpatient (including patients with Medicare Part B only)

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.
- The from date is the date of admission.
- The through date is the date of discharge, transfer or expiration.

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 date of admission, even if the recipient was not eligible on the date admitted.

Box 13 - Required

13 HR

10

Admission Hour

- Enter the hour of admission in military time.
- Example:

  01 - 1:00 a.m.

  10 - 10:00 a.m.

  14 - 2:00 p.m.

  23 - 11:00 p.m.

Box 14 - Required

14 TYPE

1

Admission Type

- Enter the type of admission.
- Example:

1 - Emergent

2 - Urgent

3 - Elective

4 - Newborn

Box 16 - Required

16 DHR
15

Discharge Hour

- Enter the discharge hour in military time.
- Example:

01 - 1:00 a.m.

10 - 10:00 a.m.

14 - 2:00 p.m.

23 - 11:00 p.m.

Box 17 - Required

17 STAT
01

Discharge Status

- Enter the recipient discharge status.
- Example:

01 - To home or self care
02 - To another acute care hospital
03 - To skilled nursing facility
04 - To intermediate care facility
05 - To another type of institution
06 - To home under care of Home Health
07 - Left against medical advice
08 - To home under care of Home Enteral/Parenteral
20 - Expired

Box 31 - Optional

31 OCCURRENCE CODE	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
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

Red = Required

Box 42 - Required

	42 REV. CD.
1	120
2	
3	250
4	
5	260
6	
7	270
8	305
9	
10	312
11	636
12	
13	710
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	0001

Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Use an accommodation day revenue center code if the recipient was admitted, discharged, transferred or expired on the same day.
- Do not use the same revenue center code twice.
- Refer to your Hospital supplemental for a complete list of revenue center codes.

Box 46 - Required

46 SERV. UNITS
6
29
1
8
2
1
7
8

Service Units

- Enter the number of days or units for each related revenue center code listed.
- One visit equals one unit of service.
- One supply item equals one unit of service.
- When billing with an accommodation day, never count the discharge date as a unit.

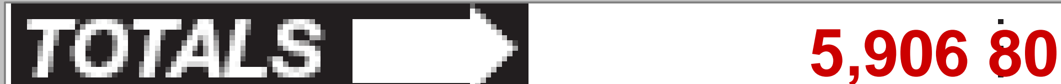
Box 47 - Required

47 TOTAL CHARGES	
4,200	00
533	95
38	35
260	68
26	00
80	00
167	82
600	00

Total Charges

- Enter the total usual and customary charge for each related revenue center code listed.
- Do not list credits.
- Do not use dashes.

Total - Required



Total Charges

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- 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 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P. REL
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
67 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
LAST FIRST
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
77 OPERATING NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
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 Hospital billing for services rendered.

Box 57 - Required

57 OTHER PRV ID	# # # # # #

Provider Number

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

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 63 - Optional

	63 TREATMENT AUTHORIZATION CODES
A	
B	#########
C	

Treatment Authorization

- If the service you provided requires prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.
- Correspond the placement as outlined in box 50 instructions.

Box 66 - Required

66 DX	7993

Diagnosis Code

- Enter the recipient’s diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for causing this hospitalization.
- 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 74 - Optional

74 PRINCIPAL PROCEDURE CODE	DATE

Principal Procedure

- This box is required if a procedure was performed.
- Enter the ICD-9-CM procedure code which best identifies the procedure completed.
- The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

Box 78 - Optional

78 OTHER		NPI ###########	QUAL		#######

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 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 (MVAF) 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)

COMPLETED

EXAMPLE

UB-04 CMS-1450

Field	Value
1	Hospital PO Box ### Anytown, OR 97###
3a PAT. CNTL #	X123400
4 TYPE OF BILL	111
6 STATEMENT COVERS PERIOD FROM	040107
6 STATEMENT COVERS PERIOD THROUGH	040707
8 PATIENT NAME	Patient, Your
12 ADMISSION DATE	040107
13 HR	10
14 TYPE	1
16 DHR	15
17 STAT	01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120				6	4,200 00		
250				29	533 95		
260				1	38 35		
270				8	260 68		
305				2	26 00		
312				1	80 00		
636				7	167 82		
710				8	600 00		
0001	PAGE ____ OF ____	CREATION DATE		TOTALS	5,906 80		

Field	Value
50 PAYER NAME	Medicaid
56 NPI	##########
57 OTHER PRV ID	######
60 INSURED'S UNIQUE ID	XX###X#X
66 DX	7993
78 OTHER NPI	##########
78 OTHER QUAL	######
80 REMARKS	NC

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!