Chapter 2 Clean Claim Instructions – Paper Billing Forms

Paper Billing Forms

TDI-DWC billing and reimbursement rules, included in Chapter 133, General Medical Provisions, address the paper medical billing and reimbursement process. The purpose of this chapter is to identify the paper medical billing forms prescribed by the TDI-DWC and to provide instructions for completing these forms.

The paper medical billing forms, and associated forms, referenced in this chapter are identified below.

Form	Purpose	Services
CMS-1500 (08-05 version)	Paper billing form for professional services.	Services such as physician, therapy, or durable medical equipment for example.
UB-04	Paper billing form from institutional services.	Services such as inpatient and outpatient hospital services, and home health care agency services.
DWC-066	Statement of Pharmacy Services	Services such as prescriptions provided by pharmacies.
ADA J515	Paper billing form for dental services.	Services such as tooth repair.
DWC-62	Explanation of Benefits (EOB).	All

Usage

Usage designators identify when an element is Required (R), Situational (S), and Optional (O). Required (R) indicates that an element must be submitted on the paper billing form for the bill to be considered complete. Situational (S) indicates that when defined criteria are met, the element must be submitted on the paper billing form. Optional (O) indicates the submission of the data is at the discretion of the health care provider.

CMS-1500

The Centers for Medicare and Medicaid Services (CMS) professional paper billing form, the CMS-1500 (08-05) is required for health claims (bills) submitted on or after July 1, 2007.

These instructions should be used in conjunction with the instructions published by the National Uniform Claim Committee (NUCC) for the completion of the CMS-1500 (08-05) form. While these instructions align with the NUCC instructions to the extent possible, some differences may be found in the following fields:

- Field 1a, Insured ID Number;
- Field 17, Referring Provider (includes state license number);
- Field 22, Original Reference Number;
- Field 24c, Emergency Indicator;
- Field 24j, Rendering Provider (includes state license number); and
- Field 33; Billing Provider (includes state license number, when applicable).

The instructions for completing the CMS-1500 (08-05) are in the table below.

Paper Form Field	CMS-1500 (08-05) Field Description	Usage	Comments
Carrier Block	The carrier block is located in the upper right margin of the form.	R	Enter the name and address of the Payer to whom this bill is being sent.
1	MEDICARE, MEDICAID, TRICARE CHAMPUS, PHAMPVA, GROUP HEALTH PLAN, FECA BLKLUNG,OTHER	R	Enter an “X” in OTHER box.
1a	Insured's ID Number	R	Enter the injured employee’s social security number (SSN). If the SSN is not available, use the driver’s license number & jurisdiction; green card number + ZY, visa number & “TA”, or passport number & “ZZ”.
2	Patient's Name (Last Name, First Name, and Middle Initial)	R	
3	Patient's Birth Date & Patient's Gender	R	
4	Insured Name (last name, first name, Middle Initial)	R	Enter name of the Employer.
5	Patient's Address	R	
6	Patient's Relationship to the Insured	R	Enter an "X" in the box "Other”.
7	Insured's Address	R	Enter the employer’s address.
8	Patient Status	O	
9	Other Insured’s Name	O	
9a	Other Insured’s Policy or Group Number	O	
9b	Other Insured’s Date of Birth	O	
9c	Employer’s Name or School	O	
9d	Insurance Plan Name or Program	O	

Paper Form Field	CMS-1500 (08-05) Field Description	Usage	Comments
10a – 10c	Is the Patient's Condition Related to:	R	Mark "yes" or "no" as appropriate. In workers' compensation, the employment field is marked "yes".
10d	Reserved for Local Use	O	Condition codes. The health care provider may include condition codes when submitting a bill that is a duplicate or an appeal. These codes assist the payer in identifying the reason for the resubmission. The following condition codes are available for this purpose: W2 – Duplicate of Original W3 -- 1st Level appeal (request for reconsideration or appeal with insurance carrier) W4 - 2nd Level appeal (resubmitted after receipt of TDI decision) W5 - 3rd Level appeal (resubmitted after receipt of hearing or judicial decision) Do not use condition codes when submitting a revised or corrected bill.
11	Insured's Policy Group or FECA Number	S	Workers' Compensation Claim Number assigned by the insurance carrier. Required when known by the health care provider.
11a	Insured Date of Birth, Sex	O	
11b	Employer Name or School Name	O	
11c	Insurance Plan Name or Program Name	S	Employer Department Name/Division. Required when different than the name contained in field 4.
11d	Is There Another Health Benefit Plan	O	
12	Patient's or Authorized Person's Signature on File	O	
13	Insured's or Authorized Person's Signature	O	
14	Date of Current Illness, Injury or Pregnancy	R	Enter the date of Accident/Illness.
15	Date of Similar Illness	O	
16	Dates Patient Unable to Work	O	
17	Name of Referring Physician or Other Source	S	Required when the referral source is a health care provider and the referring provider is different than the rendering provider. Also required if the bill is for ASC facility services (operating physician name). Enter the name and credentials of the professional who referred, ordered, or supervised the service(s) or supply (supplies) on the claim.

Paper Form Field	CMS-1500 (08-05) Field Description	Usage	Comments
17a	Other ID Qualifier and Identification Number	S	Required when field 17 contains the name of a licensed health care provider. Enter the '0B' State License Number qualifier and the license type, number and jurisdiction as described in Chapter 3.
17b	NPI Number of the Referring Provider or Ordering Provider	S	Required when field 17 contains the name of a health care provider eligible to receive an NPI Number.
18	Hospitalization Dates Related to Current Services	S	
19	Reserved for Local Use	O	Box 19 may be used to communicate the Attachment Information Control Number, if applicable. If providing attachment information, enter the three digit ID qualifier PWK, the appropriate two-digit Report Type Code, and the unique Attachment Control Identification Number. Do not enter spaces between the qualifiers and the data. *For example: PWKRRFX1234567*
20	Outside Lab/ Charges	S	
21.1	Diagnosis or Nature of Illness or Injury	R	
21.2		S	
21.3		S	
21.4		S	
22	Medicaid Resubmission Code/Original Reference Number	S	Payer's Unique Bill Identification Number. Required when condition codes W3, W4 or W5 are contained in field 10d AND the health care provider has received a unique bill identification or reference number from the payer. If providing the Original Reference Number, enter '7' Replacement of prior claim or, '8' Void/Cancel of prior claim, followed by the original reference number left justified in the left-hand side of the field.
23	Prior Authorization Number	S	Required when preauthorization, concurrent review or voluntary certification approval received. Enter the number assigned by the payer for the billed service(s).
24	Supplemental Information	S	Required when additional information is necessary to adjudicate payment for the related service line. Required when the billing entity is requesting separate reimbursement for surgically implanted devices. Supplemental information is to be entered in the shaded section of 24D through 24H as

Paper Form Field	CMS-1500 (08-05) Field Description	Usage	Comments
			defined by each Item Number.
24A	Dates of Service	R	
24B	Place of Service	R	
24C	EMG	O	Emergency indicator. May be used when services were provided in an emergency situation.
24D	Procedures, Services or Supplies and Modifiers	R	Enter valid code(s) and applicable modifier(s) for each service entered. Refer to TDI-DWC fee guidelines for Texas specific codes/modifiers.
24E	Diagnosis Pointers	R	
24F	Charges	R	
24G	Days or Units	R	
24H	Family Plan	O	
24I_1 (Grey)	ID Qualifier	S	Required when field 24J_1 is populated. Enter 'OB' as the ID Qualifier for the State License Number.
24J_1 (Grey)	Rendering Provider Other ID	S	State License Number. Required when different than the data listed in field 33a. Enter license type, number and jurisdiction as described in Chapter 3. State license number of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor.
24J_2	Rendering Provider NPI	S	NPI Number. Required when different than the data listed in field 33b. Enter the NPI number in the non-shaded area of the field. NPI of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor.
25	Federal Tax ID or Social Security Number and Type	R	
26	Patient's Account Number	R	
27	Accept Assignment	O	
28	Total Charge	R	
29	Patient Amount Paid	O	
30	Balance Due	O	

Paper Form Field	CMS-1500 (08-05) Field Description	Usage	Comments
31	Signature of Physician or Supplier Including Degrees or Credentials and Date	R	
32	Service Facility Location Information	S	Required when services are delivered at a location other than the patient's home or the health care provider's office. Enter name and address of facility where services were rendered.
32a	Service Facility Location NPI Number	S	Required when facility populated in field 32 is a licensed health care facility eligible for a NPI number.
32b	Other ID	O	
33	Billing Provider Info & Ph #	R	
33a	NPI Number of Billing Provider	S	Required when the billing provider is a health care provider eligible for an NPI number.
33b	Other ID	S	State License Number. Required when health care provider populated in field 33 is a licensed health care provider. Enter '0B' followed by the license type, number and jurisdiction as described in Chapter 3.

UB-04

The Centers for Medicare and Medicaid Services (CMS) institutional paper billing form, the UB-04 is required for health claims (bills) submitted on or after May 23, 2007.

These instructions should be used in conjunction with the instructions published by the National Uniform Billing Committee (NUBC) for the completion of the UB-04 form. While these instructions align with the NUBC instructions to the extent possible, some differences may be found in the following fields:

- Field 18-28, Condition Codes;
- Field 31-34, Occurrence Codes and Dates;
- Field 43, Revenue Description;
- Field 57a, Other Provider Identifier;
- Field 60a, Insured's Unique ID;
- Field 64, Document Control Number; and
- Field 71, Prospective Payment System Code.

The instructions for completing the UB-04 are in the table below.

Paper Form Field	UB-04 Field Description	Usage	Comments
1	Provider Name, Address, and Telephone Number	R	
2	Pay-To Name and Address	S	
3a	Patient Control Number	R	
3b	Medical/Health Record Number	S	
4	Type of Bill	R	Enter the National Uniform Billing Committee (NUBC) code for Type of Bill. The fourth digit defines the frequency of the bill ('1' indicates original claim or duplicate of original claim and '7' is for a replacement claim, such as for corrected bills). When submitting a bill as a duplicate or appeal on and after January 1, 2009, enter the appropriate NUBC condition code in field 18-28 to indicate bill resubmission type.
5	Federal Tax Number	R	
6	Statement Covers Period "From" and "Through"	R	
7	Reserved	O	
8a	Patient Identifier	R	Enter the injured employee's social security number (SSN). If the SSN is not available, use the driver's license number & jurisdiction; green card number + ZY, visa number & "TA", or passport number & "ZZ".
8b	Patient Name	R	

Paper Form Field	UB-04 Field Description	Usage	Comments
9	Patient Address	R	
9e	Patient County Code	S	Required when patient lives outside of the United States.
10	Patient Birth Date	R	
11	Patient Sex	R	
12	Admission/Start of Care Date	R	The start date for this episode of care. Enter date admitted for inpatient care, first date of outpatient service or start of care. If this bill is for Home Health Care or Physical Therapy the "First Date" would be the first day in billing cycle.
13	Admission Hour	S	
14	Priority (Type) of Visit	S	Required for all inpatient admissions.
15	Point of Origin for Admission or Visit	S	Required for all inpatient admissions.
16	Discharge Hour	S	Required on all final inpatient claims.
17	Patient Status (Discharge Status)	S	Required for all inpatient admissions.
18 – 28	Condition Codes	S	Required when condition information applies to the bill. Enter a valid condition code if applicable. The health care provider may include condition codes when submitting a bill that is a duplicate or an appeal. These codes assist the payer in identifying the reason for the resubmission. The following condition codes are available for this purpose: W2 – Duplicate of Original W3 -- 1st Level appeal (request for reconsideration or appeal with insurance carrier) W4 - 2nd Level appeal (resubmitted after receipt of TDI decision) W5 - 3rd Level appeal (resubmitted after receipt of hearing or judicial decision) Do not use these particular condition codes when submitting a revised or corrected bill.
29	Accident State Field	O	
30	Reserved	O	
31-34	Occurrence Codes and Dates	S	Required when there is an Occurrence Code that applies to this bill. At least one Occurrence Code must be entered with value of "O4" – Accident/Employment related. The Occurrence Date must be the date of the occupational injury or illness.

Paper Form Field	UB-04 Field Description	Usage	Comments
35 -36	Occurrence Span Codes and Dates	S	
37	Reserved	O	
38	Responsible Party Name and Address	R	Enter the workers' compensation payer responsible for payment of the bill, including name, address, city, state, and zip code.
39-41	Value Code and Amount	S	
42	Revenue Code	R	
43	Revenue Description	S	Enter narrative description of the related revenue categories included on this bill. When REV Code is RX, the description requires NDC Number/DAW Code/Units.
44	HCPCS/Rates/HIPPS Rate Codes	S	
45	Service Date	S	Required on outpatient bills.
46	Service Units	R	
47	Total Charges (by revenue code category)	R	
48	Non Covered Charges	O	
49	Reserved	O	
50a	Payer Identification (Name)	R	
51a	Health Plan ID	O	
52a	Release of Information Certification Indicator	R	
53a	Assignment of Beneficiary Certification Indicator	R	Enter a value of 'Y' – Yes.
54a	Prior Payments -- Payer	S	
55a	Estimated Amount Due (Payer)	O	
56	Provider NPI Number (Billing Provider)	S	Required if the billing provider is a health care provider eligible for an NPI. Enter billing provider NPI number
57a	Other Provider Identifier (Billing Provider Other ID)	S	State License Number. Required when the billing provider is a licensed health care provider. Enter '0B' followed by the license type (when applicable), number and jurisdiction as described in Chapter 3.
58a	Insured's Name	R	Enter the name of the Employer
59a	Patient's Relationship to Insured	R	Enter code '20' = Employee.
60a	Insured's Unique ID	R	Enter the injured employee's social security number (SSN). If the SSN is not available, use the driver's license number & jurisdiction; green card number & jurisdiction, visa number & "TA", or passport number & "ZZ".
61a	(Insured) Group Name	O	

Paper Form Field	UB-04 Field Description	Usage	Comments
62a	Insurance Group Number	S	Workers' Compensation Claim Number assigned by the insurance carrier. . Required when known by the health care provider.
63a	Treatment Authorization Code	S	Required when services were approved through preauthorization, concurrent review, or voluntary certification processes.
64	Document Control Number	S	Payer's Unique Bill Identification Number. Required when condition codes W3, W4 or W5 are used (fields 18-28) AND the health care provider has received a unique bill identification or reference number from the payer.
65a	Employer Name	S	Required when different than the insured's name contained in field 58a.
65b-c	Employer Address	O	
66	Diagnosis and Procedure Code Qualifier	R	
67	Principal Diagnosis Code	R	
67a-q	Other Diagnosis Code(s)	S	
68	Reserved	O	
69	Admitting Diagnosis Code	S	
70	Patient's Reason for Visit Code	S	
71	Prospective Payment System PPS Code	O	Hospitals should include the appropriate PPS code when reimbursement is based on the PPS code. For example, acute care hospitals seeking reimbursement under the hospital fee guidelines should enter the applicable DRG code (Note: DRG codes do not apply to every inpatient admission).
72	External Cause of Injury Code (E code)	O	
73	Reserved	O	
74	Principle Procedure Code and Date	S	
74a,e	Other Procedure Codes and Dates	S	
75	Reserved	O	
76a	Attending Physician NPI Number	S	Required when claim includes any services other than nonscheduled transportation services. For home health claims, this will be the NPI of the referring physician.
b	2nd Provider ID Qualifier Code	S	Required when an Attending Physician is associated with the bill. Enter the two digit

Paper Form Field	UB-04 Field Description	Usage	Comments
			qualifier '0B'.
c	2nd Provider ID- Number	S	State License Number. Required when an Attending Physician is associated with the bill. Enter the license type, number and jurisdiction as described in Chapter 3.
d	Attending Physician Last Name and First Name	S	
77a	Operating Physician NPI Number	S	Required when a surgical procedure code is listed on this bill. Enter NPI Number for operating physician
b	2nd Provider ID Qualifier Code	S	0B (State License Number). Required when a surgical procedure code is listed on this bill. Enter the two digit qualifier "0B".
c	2nd Provider ID Number	S	Required when a surgical procedure code is listed on this bill. Enter the license type, number and jurisdiction as described in Chapter 3.
d	Operating Physician Last Name and First Name	S	
78-79	Other Provider Name and Identifiers	S	Required when billing provider needs to identify other providers associated with the bill.
80	Remarks	S	Required when billing entity (or entities) are seeking separate reimbursement for surgically implanted devices.
81	Code - Code Field	S	Billing Provider Taxonomy Code. Required when adjudication is known to be impacted by the provider taxonomy code. Enter 'B3' followed by the taxonomy code. Note: This field may also be used to report the Attachment Information Control Number if documents are associated with the medical bill. Enter 'AC' in the code field followed by the Report Type Code, Transmission Type Code, and the unique Attachment Control Identification Number. Example: ACRRFX1234567.

DWC-066

The TDI-DWC Statement of Pharmacy Services (DWC-066) form or a mutually agreed upon form is required for health claims (bills) submitted by pharmacists and pharmacy processing agents. If a mutually agreed upon form is used, all the required data elements contained in these instructions must be present on the alternate form. The dispensing pharmacy and the prescribing physician National Provider Identification (NPI) number is required on bills submitted on and after May 23, 2008.

The instructions for completing the DWC-066 are in the table below.

Paper Form Field	DWC-066 Field Description	Usage	Comments
1	Pharmacy's name, address, city, state, ZIP code, and phone number.	R	
2	Date of Billing	R	Enter the date the bill was sent to the insurance carrier.
3	Pharmacy's NPI Number	R	
4	Remit Payment To	S	Required when the payment will be made to someone other than the dispensing pharmacy. Include name and address.
5	Invoice Number	R	Unique bill identification number assigned by the pharmacy or pharmacy processing agent.
6	Payee's FEIN (Federal Tax Identification Number)	R	FEIN of the party receiving payment.
7	Carrier's Name and Address	R	Workers' Compensation insurance carrier's name, address, city, state, and ZIP code.
8	Employer's Name, Address, and Phone Number	R	Employer's name, address, city, state, and ZIP code (include phone number, if known).
9	Injured Employee's Name, Address, and Phone Number	R	
10	Injured Employee's Identification	R	Provide the identification number, jurisdiction, and the type of identification.
11	Date of Injury	R	
12	Injured Employee's Date of Birth	R	
13	DWC Claim Number	O	Enter the DWC claim number, if known.
14	Carrier Claim Number	O	Enter the carrier's claim number, if known.
15	Prescribing Doctor's Name, Address, and Phone Number	R	Enter the prescribing doctor's name, address, city, state, and ZIP code (include phone number, if known).
16	Prescribing Doctor's NPI Number	R	
17	Generic or Brand Name Indicator	R	Indicate if the drug dispensed was a generic or name brand drug.
18	Generic Available Indicator	S	Required when brand name drug dispensed.

Paper Form Field	DWC-066 Field Description	Usage	Comments
19	Dispensed as Written Code	R	
20	Date filled	R	Date the prescription was filled.
21	Generic NDC Code	S	Required when: • a generic drug was dispensed, or • DAW 2 (patient selected the brand product) is reported in field 19.
22	Name Brand NDC Code	S	Required when name brand drug dispensed.
23	Quantity	R	
24	Days Supply	R	Provide the number of days the prescription drug should last based on the prescription.
25	Refills Remaining	S	Required when the DWC-66 is used. If an alternate form is used, similar types of data may be substituted to convey this type of information (such as fill number).
26	Paid by Employee	S	Provide the amount paid by the injured employee when the employee chooses to pay the difference between the generic and the name brand drug.
27	Drug Name and Strength	R	
28	Rx Number	R	Provide the prescription number.
29	Amount Billed	R	Provide the amount billed for the prescription.

ADA J515

The American Dental Association (ADA) dental paper billing form ADA-J515 is the current paper billing form for dental services. Dentists that provide and bill for professional medical services (non-ADA codes) must use the CMS-1500 to bill for the professional medical services rendered.

These instructions should be used in conjunction with the instructions published by the ADA for the completion of the ADA J515 form.

The instructions for completing the ADA-J515 are in the table below.

Paper Form Field	ADA J515 Field Description	Usage	Comments
1	Type of Transaction	O	
2	Predetermination/Preauthorization Number.	S	Required when preauthorization, concurrent review or voluntary certification received.
3	Primary Payer Information (name and address)	R	Enter the workers' compensation insurance carrier name and address.
4-11	Other Coverage	O	
12	Primary Insured Information (name and address)	R	Employer's name and current business address, city, state, zip code.
13	Primary Insured Information (date of birth)	O	Leave blank.
14	Primary Insured Information (gender)	O	Leave blank.
15	Subscriber Identifier	S	Workers' compensation insurance carrier claim number. Required when known.
16	Plan/Group Number	O	
17	Employer Name	O	
18	Patient Relationship to Primary Subscriber	O	Mark "Other" for workers' compensation
19	Student Status	O	
20	Patient Information (name and address)	R	
21	Patient Information (date of birth)	R	
22	Patient Information (gender)	R	
23	Patient Information (Patient ID/Account #)	R	Enter the injured employee's social security number (SSN). If the SSN is not available, use the driver's license number & jurisdiction; green card number & jurisdiction, visa number & "TA", or passport number & "ZZ". *Note: Do not use dental record or account number.*
24	Procedure Date	R	Date of Service
25	Area of Oral Cavity	S	Required when applicable.
26	Tooth System	S	Required when applicable.
27	Tooth Number(s) or Letter(s)	S	Required when applicable.
28	Tooth Surface	S	Required when applicable.

Paper Form Field	ADA J515 Field Description	Usage	Comments
29	Procedure Code	R	Use the appropriate dental procedure code from the current version of the Code on Dental Procedures and Nomenclature.
30	Description	R	
31	Fee	R	
32	Other Fee(s)	O	
33	Total Fee	R	
34	Missing Teeth Information	S	Required when applicable.
35	Remarks	O	Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36-37	Authorizations	O	
38	Place of Treatment	R	
39	Number of Enclosures	S	Required when applicable.
40	Is Treatment for Orthodontics?	R	Mark “Yes” or “No”.
41	Date Appliance Placed	S	Required when field 40 is marked “Yes”.
42	Months of Treatment Remaining	S	Required when field 40 is marked “Yes”.
43	Replacement of Prosthesis?	R	Mark “Yes” or “No”.
44	Date Prior Placement	S	Required when field 43 is marked “Yes”.
45	Treatment Resulting From	R	
46	Date of Accident	R	List the date of injury
47	Auto Accident State.	O	
48	Billing Dentist or Dental Entity (name and address)	R	
49	Billing Dentist or Dental Entity (NPI)	S	Required when billing entity is a licensed health care provider eligible for a NPI.
50	Billing Dentist or Dental Entity (License Number)	S	Required when billing entity is a licensed health care provider. Enter license type, number and jurisdiction as described in Chapter 5.
51	Billing Dentist or Dental Entity (SSN or TIN)	R	
52	Phone Number	R	
53	Treating Dentist Signature	R	
54	Treating Dentist NPI Number	S	Required when different than field 49
55	Treating Dentist (License Number)	S	Required when different than field 50. Enter license type, number and jurisdiction as described in Chapter 5.
56	Treating Dentist Address	R	Enter full address, including City, State, and Zip Code.
56A	Provider Specialty Code	O	
57	Treating Provider Phone number	S	Required when different than the entity listed in field 52.

Paper Form Field	ADA J515 Field Description	Usage	Comments
58	Additional Provider ID	O	

DWC-62

The DWC-62 is the paper Explanation of Benefits (EOB) form used by Insurance Carriers to communicate reimbursement to a Health Care Provider when a payment or denial is made or to acknowledge receipt of a refund from a Health Care Provider.

Paper Form Field	DWC-62 Form Description	Usage	Comments
Top Right	Claim #	S	DWC Claim Number, if known.
Top Right	Carrier Claim #	R	
1	Injured Employee's Name (Last, First, M.I.)	R	
2	Injured Employee's Social Security Number	R	
3	Date of Injury	R	
4	Injured Employee's Mailing Address (Street or P.O. Box)	R	
5	Employer's Name and Address	R	
6	Health Care Provider's Name and Address	R	
7	Insurance Carrier Name and Address	R	
8	Health Care Provider's Federal Tax ID Number	R	
9	Name and Address of the Company Performing the Audit.	R	
10	Date of the Audit	R	
11	Date of Final Action	R	Date the carrier paid, denied, or acknowledged receipt of a refund.
12	Name and telephone number of the person who can be contacted about the bill reduction.	R	
13	Patient Account Number/Bill Identification Number	S	Returned when populated on paper billing form.
14	Payment Identification Number	S	Check number or Electronic Funds Transfer (EFT) transaction identification number required when payment is associated with DWC-62/Explanation of Benefits.
Line Item			
15a	Date of Service	R	

15b	Procedure Code	R	HCPCS Code required on professional bills, Revenue (and HCPCS Code when required on billing) required on hospital bills, Dental Codes required on dental bills, and NDC or jurisdiction compound code required on pharmacy bills.
15c	Type of Service	S	Required only when needed to provide additional description of the line level service that is paid, denied, or reduced.
15d	ICD-9 Diagnosis Code	S	Required for professional and hospital bills.
15e	Units	R	
15f	Charges	R	Total dollar amount charged per line.
15g	Amount Paid	R	Total dollar amount paid per line.
15h	Reason Code	S	Reason code (ANSI or jurisdiction) explaining the payment, denial, request for recoupment, or acknowledgment of a refund is required when the amount paid does not equal the amount charged.
15i	Text to Explain Reason for Reduction/Denial	S	Text explaining the Reason Code value(s) in box 15h.