UB-04 CMS-1450 – 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	Clean Claims Rules effective July 11, 2007 Applicable to plans with contracts issued or renewed on or after August 16, 2003 for claims filed or re-filed on or after July 18, 2007. (SB418) Rules as indicated (cannot be changed by contract)
1	Provider's name, address and telephone number	R
3	Patient control number	R
4	Type of bill code	R - shall include a "7" in the 4th position if claim is a corrected claim
5	Provider's federal tax ID number	R
6	Statement period (beginning and ending date of claim period)	R
7	Covered days	Not required
8	Noncovered days	Not required
8a	Patient's name	R
9a – 9e	Patient's address	R
10	Patient's date of birth	R
11	Patient's gender	R
12	Date of admission	R- for admissions, observation stays, and emergency room care
13	Admission hour	R - for admissions, observation stays, and emergency room care
14	Type of admission (e,g,, emergency, urgent, elective, newborn)	R – for admissions
15	Source of admission code	R
16	Discharge hour	R – for admissions, outpatient surgeries or observation stays
17	Patient status-at-discharge code	R - for admissions, observation stays, and emergency room care
18-28	Condition codes	R – if the CMS UB-04 manual contains a condition code appropriate to patient's condition
31-34	Occurrence codes and dates	R – if the CMS UB-04 manual contains an occurrence code appropriate to patient's condition
35 & 36	Occurrence span code, from and through dates	R – if the CMS UB-04 manual contains an occurrence span code appropriate to patient's condition
39-41	Value code and amounts	R – for inpatient admissions. If no value codes are applicable to admission, provider can enter value code 01
42	Revenue code	R
43	Revenue description	R
44	HCPCS/Rates	R – if Medicare is a primary or secondary payor

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45	Service date	R – if claim is for outpatient services
45, line 23	Date bill submitted	R
46	Units of Service	R
47	Total Charge	R
50	HMO or preferred provider carrier name	R
54	Prior payments - payor	R – if payments have been made to the physician or provider by a primary plan
56	NPI number of billing provider	R – for claims filed or re-filed on or after May 23, 2008 if the billing provider is eligible for an NPI number
57	Other provider number	R – if carrier required provider numbers and gave notice of the requirement to physician/provider prior to June 17, 2003.
58	Subscriber's name	R – if shown on patient's ID card
59	Patient's relationship to subscriber	R
60	Patient's/subscriber's certificate number, health claim number, ID number	R – if shown on the patient's ID card
62	Insurance group number	R – if a group number is shown on the patient's ID card
63	Verification number	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
67A – 67Q	Diagnoses codes other than principal diagnosis code	R – if there are diagnoses other than the principal diagnosis
69	Admitting diagnosis code	R
74	Principal procedure code	R – if patient has undergone an inpatient or outpatient surgical procedure
74 – 74e	Other procedure code	R – as an extension of Field 74 if additional surgical procedures were performed
76	Attending physician NPI number	R – on or after May 23, 2008, if attending physician is eligible for an NPI number and attending physician is required.
76, qualifier portion	Attending physician ID	R