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Provider Toolkit

1500 Health Insurance Claim Form & UB-04 Form

Provider Toolkit: MCP; MCA; MHG
Mercy Care Training
Rev 3/2008

1500 Health Insurance Claim Form

Field 1

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(Member ID#)	(SSN or ID)	(SSN)	(ID)

- For this field, select the type of insurance plan for the patient.
- The selection from this field will determine the ID number you will use for Field 1a.
- Under each insurance type listed the type of ID number required is listed in ().
    - **Example:** If you select the Medicaid for the patient, you will use the **Medicaid #** or if Tricare CHAMPUS is selected, you will use the **Sponsor's SSN**.

Field 1a

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

- For this field, enter the correct ID for the selected insurance plan.

Fields 2 through 13

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM | DD | YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY | STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY | STATE
ZIP CODE | TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE | TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

- These fields are basic demographic information for the patient.
- For the Signatures in Fields 12 and 13 can be listed as: **SIGNATURE ON FILE** along with the current date

Fields 14 and 15

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

- For Field 14:
  - Enter the date for the current illness (when the symptoms began), injury/accident (when the injury/accident happened), or pregnancy (give date of Last Menstrual Period)
- For Field 15
  - Enter the first date of any illness that the patient previously had that is the same or similar to the current illness
  - Leave blank **for Medicare** submission. This field is NOT required when submitting to Medicare.

Field 16

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

- **If the patient is employed** and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work.
  - An entry in this field may indicate employment related insurance coverage.

Fields 17, 17a, and 17b

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		
	17b.	NPI	

- **For Field 17**:
  - Enter **the name of the referring or ordering physician** if the service or item was ordered or referred by a physician.
- See Fields 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:
  - Medicare covered services and items that are the result of a physician's order or referral
  - Parenteral and enteral nutrition
  - Immunosuppressive drug claims
  - Hepatitis B claims
  - Diagnostic laboratory services
  - Diagnostic radiology services
  - Portable x-ray services
  - Consultative services
  - Durable medical equipment
  - When the ordering physician is also the performing physician
    - As often is the case with in-office clinical laboratory tests
  - When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in Field 17
  - When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

- **Field 17a:**
  - Enter the CMS assigned UPIN of the referring/ordering physician listed in Field 17.
    - The UPIN may be reported on the Form CMS-1500 **until May 22, 2007**, and
    - MUST be reported if an NPI is not available.
- Field 17a and/or 17b is required when a service was ordered or referred by a physician.
- **Effective May 23, 2007**, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.
- When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.
- All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007.
  - After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a
- UPIN shall contact the Medicare carrier.
  - Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.
- **Field 17b:**
  - Enter the NPI of the referring/ordering physician listed in Field 17 as soon as it is available.
  - The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
- Field17a and/or 17b is required when a service was ordered or referred by a physician.
  - **Effective May 23, 2007, and later**, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Field 18

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	MM	DD	YY		MM	DD	YY
FROM				TO			

- Enter any hospitalization dates related to the current illness, injury/accident, or pregnancy.

Field 19

19. RESERVED FOR LOCAL USE

- Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician.
  - When an **independent physical or occupational therapist** submits claims or a physician providing routine foot care submits claims.
  - For **physical or occupational therapists**, entering this information certifies that the required physician certification (or recertification) is being kept on file.
- Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for **chiropractor services** (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation).
  - By entering an x-ray date and the initiation date for course of chiropractic treatment in Field 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02,
  - Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.
- Enter **the drug's name and dosage** when submitting a claim for Not Otherwise Classified (NOC) drugs.
- Enter a concise description of an **"unlisted procedure code" or an NOC code** if one can be given within the confines of this box.
  - Otherwise an attachment shall be submitted with the claim.
- Enter **all applicable modifiers** when modifier -99 (multiple modifiers) is entered in Field 24d.

- If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows:
  - **1=(mod)**, where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

- Enter the statement **"Homebound"** when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.
- Enter the statement, **"Patient refuses to assign benefits"** when the beneficiary absolutely refuses to assign benefits to a participating provider.
  - In this case, no payment may be made on the claim.
- Enter the statement, **"Testing for hearing aid"** when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.
- When **dental examinations** are billed, enter the specific surgery for which the exam is being performed.
- Enter the specific name and dosage amount when **low osmolar contrast material** is billed, but **only if** HCPCS codes do not cover them.
- Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for **a global surgery claim** when providers share post-operative care.
- Enter demonstration ID number "30" for **all national emphysema treatment trial claims**.
- Enter the pin (or NPI when effective) of **the physician who is performing a purchased interpretation of a diagnostic test**.
- **Method II suppliers** shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis.

Field 20

20. OUTSIDE LAB?	$ CHARGES	
☐ YES ☐ NO		

- Complete this Field when billing for diagnostic tests subject to purchase price limitations.
  - Enter the purchase price under charges if the "yes" block is checked.
  - A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test.
  - A "no" check indicates "no purchased tests are included on the claim."
  - When **"yes"** is annotated, **Field 32 shall be completed**.
- When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500.
  - Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.
- This is a **required field** when billing for diagnostic tests subject to purchase price limitations.

Field 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

- Enter the patient's diagnosis/condition.
  - With the **exception of claims submitted by ambulance suppliers** (specialty type 59), **all physician** and **non-physician specialties** (i.e., PA, NP, CNS, CRNA):
    - Use an **ICD-9-CM code** number and code to the highest level of specificity for the date of service.
- Enter up to four diagnoses in priority order.
  - **All narrative diagnoses for non-physician specialties** shall be submitted on an attachment.

Field 22

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.

- **Leave blank**. Not required by Medicare.

Field 23

23. PRIOR AUTHORIZATION NUMBER

- Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.
- Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.
- Post Market Approval number should also be placed here when applicable.
- For physicians performing care plan oversight services, enter the 6-digit Medicare provider number or NPI when effective, of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.
- Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.
- When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician shall enter the Medicare facility provider number of the SNF in Field 23.
- **NOTE:** Field 23 can contain **only one condition**.
    - Any additional conditions should be reported on a separate Form CMS-1500.

Field 24

- The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.
- The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.
- At this time, the shaded area is not used by Medicare.
- Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1															NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

Fields 24A thru E

24. A. DATE(S) OF SERVICE From			To			B. PLACE OF	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER

- **Field 24A**
  - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply.
    - When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.
    - Return as not processable if a date of service extends more than 1 day and a valid "to" date is not present.
- **Field 24B**
  - Enter the appropriate place of service code(s) from the list provided in Section 10.5.
  - Identify the location, using a place of service code, for each item used or service performed.
  - This is a **required field**.
  - NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.
- **Field 24C**
  - **Medicare providers** are not required to complete this Field.
  - This field was previously titled "Type of Service"
- **Field 24D**
  - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code.
  - When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.
  - Enter the specific procedure code without a narrative description.

- **Field 24D *(cont.)***
    - However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in Field 19 if a coherent description can be given within the confines of that box.
    - Otherwise, an attachment shall be submitted with the claim.
  - **This is a required field**.
  - Return as not processable if an "unlisted procedure code" or an (NOC) code is indicated in Field 24d, but an accompanying narrative is not present in Field 19 or on an attachment.

Fields 24E thru J

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #

- **Field 24E**
  - Enter the diagnosis code reference number as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis.
  - Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4.
  - **This is a required field.**
  - If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in Field 21.
- **Field 24F**
  - Enter the charge for each listed service.

- **Field 24G**
  - Enter the number of days or units.
  - This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume.
  - If only one service is performed, the numeral 1 must be entered.
  - Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures).
  - When multiple services are provided, enter the actual number provided.
  - For anesthesia, show the elapsed time (minutes) in Field 24g.
    - Convert hours into minutes and enter the total minutes required for this procedure.
  - For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.
  - **NOTE:** This field should contain at least 1 day or unit.
    - The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as not processable.
- **Field 24H**
  - **Leave blank**. Not required by Medicare.
- **Field 24I**
  - In the previous version of this form this field was labeled as EMG and was left blank.
  - In the new form effective May 23, 2007:
    - Enter **the ID qualifier 1C** in the shaded portion.
    - The field is now labeled as **ID. QUAL**.

- **Field 24J**
  - In the previous version of this form this field was labeled as COB and was left blank.
  - In the new form effective May 23, 2007 and later:
    - Now labeled Rendering Provider ID. #
    - Do not use the shaded portion
    - Beginning no earlier than October 1, 2006, enter the **rendering provider's NPI** number in the lower portion.
    - In the case of a **service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising**, enter the NPI of the supervisor in the lower portion.

Field 25

25. FEDERAL TAX I.D. NUMBER SSN EIN

Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number.

The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

Field 26

26. PATIENT'S ACCOUNT NO.

- Enter the patient's account number assigned by the provider's of service or supplier's accounting system.
- This field is **optional** to assist the provider in patient identification.
- As a service, any account numbers entered here will be returned to the provider.

Field 27

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
☐ YES ☐ NO

- Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.
    - If Medigap is indicated in field 9 and Medigap payment authorization is given in field 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.
- The following providers of service/suppliers and claims can only be paid on an assignment basis:
    - Clinical diagnostic laboratory services;
    - Physician services to individuals dually entitled to Medicare and Medicaid
    - Participating physician/supplier services
    - Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers
    - Ambulatory surgical center services for covered ASC procedures
    - Home dialysis supplies and equipment paid under Method II
    - Ambulance services
    - Drugs and biologicals
    - Simplified Billing Roster for pneumococcal and influenza virus vaccines

Fields 28, 29, and 30

28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
$	$	$

- **Field 28 -** Enter total charges for the services (i.e., total of all charges in Field 24f).
- **Field 29 -** Enter the total amount the patient paid on the covered services only.
- **Field 30 - Leave blank**. Not required by Medicare.

Fields 31

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

- Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.
- In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in Field 31.
- When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in Field 31.
- **NOTE:** This is a **required field**, however the claim can be processed if the following is true:
  - If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Fields 32, 32a, and 32b

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

- **Field 32**
  - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.
  - Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.
  - Only one name, address and zip code may be entered in the block.
    - **If additional entries are needed**, separate claim forms shall be submitted.
  - Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests.
  - When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
  - **For foreign claims**, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code.
    - When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim.
    - If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim.
    - The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as not processable due to the lack of a ZIP code.
  - **For durable medical, orthotic, and prosthetic claims**, the name and address of the location where the order was accepted must be entered (DMERC only).

  - **This field is required**.
  - When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier. This field is completed whether the supplier's personnel performs the work at the physician's office or at another location.
  - **If a modifier is billed**, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.
  - Complete this field **for all laboratory work performed outside a physician's office**.
    - If an independent laboratory is billing, enter the place where the test was performed.

- **Field 32a**
  - Enter the NPI of the service facility as soon as it is available.
  - The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
  - When this form is in printed format, the NPI in this field may not be easily seen.
- **Field 32b**
  - Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported.
  - Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.
  - **If the supplier is a certified mammography screening center**, enter the 6-digit FDA approved certification number.
  - For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in Field 32 (DMERC only).

Fields 33, 33a, and 33b

33. BILLING PROVIDER INFO & PH # ( )	
a. NPI	b.

- **Field 33**
  - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number.
  - **This is a required field.**
- **Field 33a**
  - Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500.
  - **This is a required field.**
  - When this form is in printed format, the NPI in this field may not be easily seen.
- **Field 33b**
  - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group.
  - Effective May 23, 2007, and later, 33b **is not to be reported**.
  - Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.
  - Enter the PIN **for the performing provider of service/supplier** who is **not** a member of a group practice.
  - Enter the group PIN **for the performing provider of service/supplier who is a member of a group practice**.
  - Enter the group UPIN, including the 2-digit location identifier, **for the performing practitioner/supplier** who is a member of a group practice.
  - The title of this field was changed from “GRP# to “b” to accommodate the reporting other ID numbers.

UB04 Form

Fields 1 and 2

1	2

- **Field 1**
  - Provider Name, Address, and Telephone Number **Required**.
    - The minimum entry is the provider name, city, State, and ZIP code.
    - The post office box number or street name and number may be included.
    - The State may be abbreviated using standard post office abbreviations.
    - Five or nine-digit ZIP codes are acceptable.
    - This information is used in connection with the Medicare provider number to verify provider identity. Phone and/or Fax numbers are desirable.
- **Field 2**
  - Include the Pay-to Name, address, and Secondary Identification.
  - Field is not required but used based on the situation
    - **Required when** the pay-to name and address information is different than the Billing Provider information in Field1.
    - **If used**, the minimum entry is the provider name, address, city, State, and ZIP code.

Fields 3a and 3b

3a PAT. CNTL #	
b. MED. REC. #	

- **Field 3a**
  - Patient Control Number **Required**.
  - The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.
- **Field 3b:**
  - Medical/Health Record Number **Situational**.
    - The number assigned to the patient's medical/health record by the provider (not in Field 3a).

Field 4

4 TYPE OF BILL

- This field is **Required**.
- This four-digit alphanumeric code gives three specific pieces of information after a leading zero.
  - CMS will ignore the leading zero.
  - The second digit identifies the type of facility.
  - The third classifies the type of care.
  - The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Field 5

5 FED. TAX NO.

- The Federal Tax ID number is **required.**
  - The format is NN-NNNNNNN

Field 6

6 STATEMENT COVERS PERIOD FROM	THROUGH

- This field is **required**.
- The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).
- Days before the patient's entitlement are not shown.
- With the exception of home health PPS claims, the period may not span two accounting years.
- The field uses the "From" date to determine timely filing.

Field 7

7

- This field is **NOT** used.

Field 8

8 PATIENT NAME	a	
b		

- **This field is required**.
- The provider enters the patient's last name, first name, and, if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).

Field 9

9 PATIENT ADDRESS	a							
b		c		d		e		

- **This field is required**.
- The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

Fields 10 thru 17

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT

- **Field 10**
  - **This field is required**.
  - The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.
- **Field 11**
  - **This field is required.**
  - The provider enters an "M" (male) or an "F" (female).
  - The patient's sex is recorded at admission, outpatient service, or start of care.
- **Field 12**
  - **Admission date required** for inpatient and home health**.**
  - The hospital enters the date the patient was admitted for inpatient care (MMDDYY).
  - The HHA enters the same date of admission that was submitted on the RAP for the episode.
- **Field 13**
  - Admission hour **NOT required.**
  - If submitted, the data will be ignored.
- **Field 14**
  - Type of admission/visit **required** on inpatient bills **only.**
  - This is the code indicating priority of this admission.
    - Code Structure:

- **Emergency** - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- **Urgent** - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
- **Elective** - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
- **Newborn** - Use of this code necessitates the use of a Special Source of Admission codes.
- **Trauma Center** - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving trauma activation.
- **Reserved for National Assignment**
- **Information Not Available** – Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

- **Field 15**
  - **This field is required.**
  - The provider enters the code indicating the source of the referral for this admission or visit.
    - Code Structure:
      - Physician Referral
        - **Inpatient**: The patient was admitted to this facility upon the recommendation of their personal physician.
        - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).
      - Clinic Referral **Inpatient**:
        - The patient was admitted to this facility upon the recommendation of this facility's clinic physician.
        - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

- Managed Care Plan Referral
  - **Inpatient**: The patient was admitted to this facility upon the recommendation of a Managed Care Plan physician.
  - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a Managed Care Plan physician.
- Transfer from a Hospital (different facility *)
  - **Inpatient**: The patient was admitted to this facility as a transfer from a different cute care facility where they were an inpatient
  - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility.
  - For transfers from hospital inpatient in the same facility, see code D.
- Transfer from a SNF
  - **Inpatient**: The patient was admitted to this facility as a transfer from a SNF where he or she was an inpatient.
  - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she was an inpatient.
- Transfer from Another Health Care Facility
  - **Inpatient**: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a nonskilled level of care.
  - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where they are an inpatient.
- Emergency Room
  - **Inpatient**: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
  - **Outpatient**: The patient received services in this facility's emergency department.
- Court/Law Enforcement
  - **Inpatient**: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
  - **Outpatient**: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
- Information Not Available

        - **Inpatient**: The means by which the patient was admitted to this facility is not known.
        - **Outpatient**: For Medicare outpatient bills, this is not a valid code.
    - A Transfer from a Critical Access Hospital (CAH)
        - **Inpatient**: The patient was admitted to this facility as a transfer from a CAH where he or she was an inpatient.
        - **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient was an inpatient.
    - B Transfer From Another Home Health Agency
        - The patient was admitted to this home health agency as a transfer from another home health agency
    - C Readmission to Same Home Health Agency
        - The patient was readmitted to this home health agency within the same home health episode period.
        - D Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer. The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
    - E-Z Reserved for national assignment.

- **Field 16**
    - **Discharge hour not required.**
- **Field 17**
    - **This field is required.**
    - For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.
    - This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Fields 18 thru 30

CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

- **Fields 18 thru 28:** These fields are required based on the situation.
  - Enter a code identifying to identify conditions relating to this claim that may affect payer processing.
  - Refer to the UB-04 Billing Manual for more information.
- **Field 29:** This field is not required.
- **Field 30:** This field is not required.

Fields 31 thru 34

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE
a								
b								

- These fields are required when there is a condition code that applies to this claim.

Fields 35 thru 37

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
						a
						b

- **Fields 35 and 36**
  - These fields are required for inpatient services.
  - The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period.
  - Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.
- **Field 37**
  - This field is **not required**.
  - Information entered here will be ignored during submission.

Field 38

38

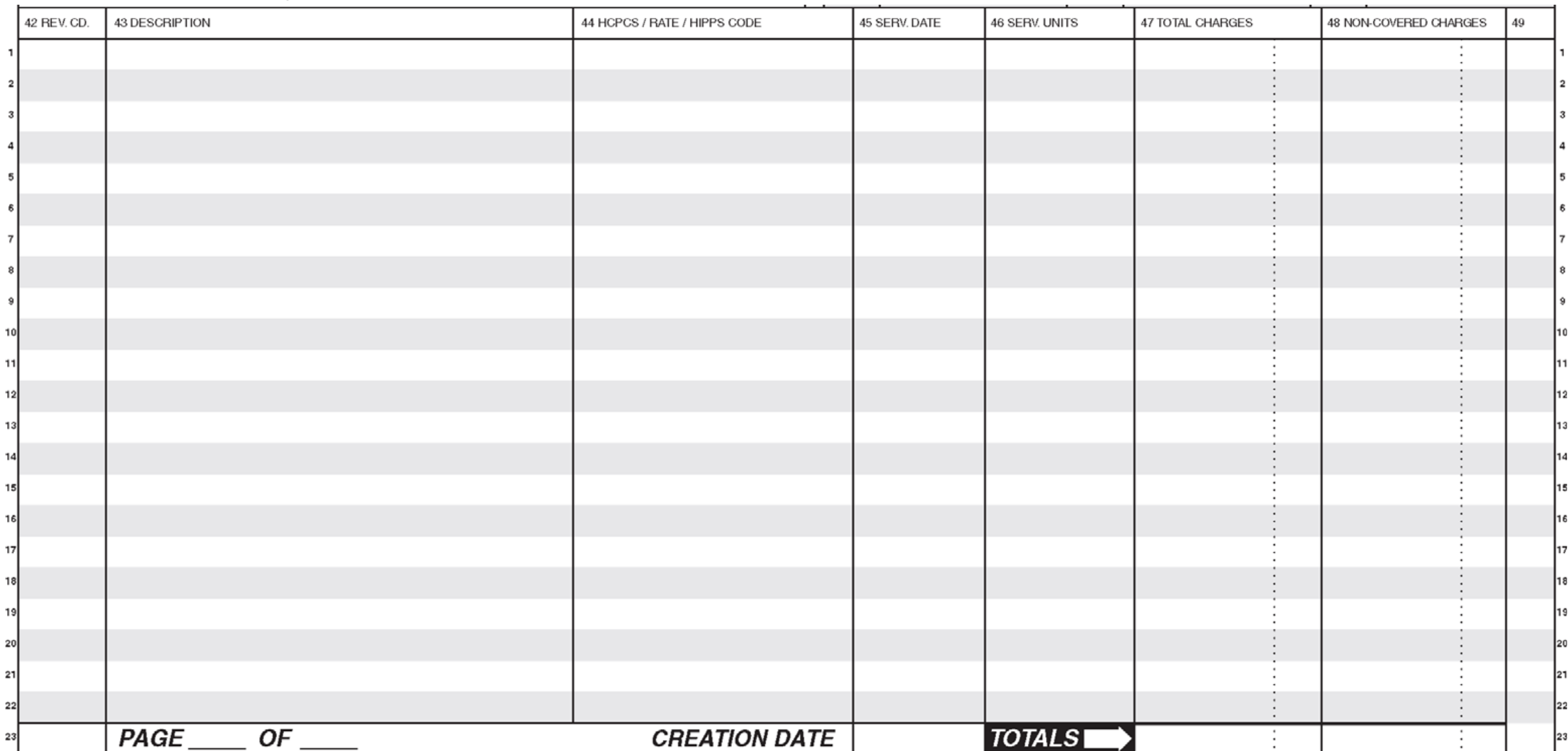
- This field is **not required**.
  - Used for claims that involve payers of higher priority than Medicare

Fields 39 thru 41

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

- The Value Codes and Amounts fields are **required**.
- Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.
- The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so the provider must refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.
- There are four lines of data, line “a” through line “d.”
- The provider uses Fields 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Fields 42 thru 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									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

- **Field 42:** This Revenue Code is **required**.
  - The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges.
  - It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in Field 47.

  - Additionally, there is no fixed "Total" line in the charge area.
  - The provider must enter revenue code 0001 instead in Field 42.
  - The adjacent charges entry in Field 47 is the sum of charges billed.
  - This is the same line on which non-covered charges, in Field 48, if any, are summed.
  - To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible.
  - To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.
- **Field 43:** The Revenue Description is **not required.**
  - The provider enters a narrative description or standard abbreviation for each revenue code shown in Field 42 on the adjacent line in Field 43.
  - The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.
  - The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624.
  - The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces). HHAs identify the specific piece of DME or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code.
  - This description must be shown in HCPCS coding. (Also see FL 80, Remarks.)
- **Field 44:** The HCPCS/Rates/HIPPS Rate Codes are **required.**
  - When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.
  - The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper.
  - SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year.
  - The Grouper translates the data in the Long Term Care Resident Instrument into a case mix group and assigns the correct RUG code.
  - The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below).

  - The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates.
  - The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.
- **Field 45:** The Service Date field for Outpatients is **required**.
  - Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes.
  - This includes claims where the "from" and "through" dates are equal.
  - This change is due to a HIPAA requirement.
  - Inpatient claims for skilled nursing facilities and swing bed providers enter the assessment reference date (ARD) here where applicable.
  - There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x).
  - If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.
  - Assessment Date – used for billing SNF PPS (Bill Type 021X).
- **Field 46:** The Units of Service field is **required**.
  - Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood.
  - However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.
  - Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following:
    - Accommodations - 0100s - 0150s, 0200s, 0210s (days)
    - Blood pints - 0380s (pints)
    - DME - 0290s (rental months)
    - Emergency room - 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)
    - Clinic - 0510s and 0520s (HCPCS code definition for visit or procedure)

        - Dialysis treatments - 0800s (sessions or days)
        - Orthotic/prosthetic devices - 0274 (items)
        - Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (Units are equal to the number of times the procedure/service being reported was performed.)
        - Outpatient clinical diagnostic laboratory tests - 030X-031X (tests)
        - Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)
        - Oxygen - 0600s (rental months, feet, or pounds)
        - Drugs and Biologicals- 0636 (including hemophilia clotting factors)
    - The provider enters up to seven numeric digits.
    - It shows charges for non-covered services as non-covered, or omits them.
    - **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.
    - For RHCs or FQHCs, a “visit” is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals.
    - Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single “visit,” except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
- **Field 47:** The Total Charges - Not Applicable for Electronic Billers field is r**equired**.
    - This is the field in which the provider sums the total charges for the billing period for each revenue code (Field 42)
    - If the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code.
- **Field 48:** The Non-covered Charges field is **required**.
    - The total non-covered charges pertaining to the related revenue code in Field 42 are entered here.
- **Field 49:** This field is **not used.**
    - Data entered will be ignored.
- **Note:** the “PAGE ____ OF ____” and CREATION DATE on line 23 should be reported on all pages of the UB-04.

Field 50A, B and C

	50 PAYER NAME
A	
B	
C	

- The Payer Identification is **required**.
- If Medicare is the primary payer, the provider must enter “Medicare” on line A.
- Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer.
- All additional entries across line A (Fields 51-55) supply information needed by the payer named in Field 50A.
- If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.
- Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on a Home Health Agency Request for Anticipated Payment (RAP).
- A = Primary Payer, B = Secondary Payer, and C = Tertiary Payer.
    - For example: If “Medicare” is entered in Form Locator 50A, this indicates that the provider has determined based on the responses from the patient or the patient’s representative or from the insurance enrollment card information that Medicare is the primary payer.

- In the UB-04, there are a number of value codes to indicate various reasons and amounts associated with insurance or other payers that are primary to Medicare (e.g., Form Locators 39-41, Codes 12, 13, 14, 15, 16, 41, 42, and 43).
- These value codes are analogous to "Payer Codes" (A, B, D, E, F, H, I, and G respectively).
- When applicable, use these value codes so they are consistent with the associated payer codes (both are required).

Fields 51A, B, and C

51 HEALTH PLAN ID

- The Health Plan ID fields:
  - Field A is required
  - Field B and C are both situational.
  - For example: If "Medicare" is entered in Form Locator 50A, this indicates that the provider has determined based on the responses from the patient or the patient's representative or from the insurance enrollment card information that Medicare is the primary payer.
- Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

Fields 52 and 53 A, B and C

52 REL. INFO		53 ASG. BEN.

- **Fields 52A, B, and C:** The Release of Information Certification Indicator fields are **required**.
  - A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim.
  - Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected.
  - An "I" code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.
  - Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.
- **Fields 53A, B, and C:** The Assignment of Benefits Certification Indicator are **not used**.
  - Data entered in these fields will be ignored.

Fields 54A, B, and C

54 PRIOR PAYMENTS

- The Prior Payments is required based on the situation.
  - For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient toward deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column.
  - In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as non-covered by Medicare.
  - If total inpatient hospital charges were $350.00 including $50.00 for a deductible pint of blood, the hospital would apportion $300.00 to the Part A deductible and $50.00 to the blood deductible.
  - Blood is treated the same way in both Part A and Part B.
  - Part A home health DME cost sharing amounts collected from the patient are reported in this item.

Fields 55A, B, and C

55 EST. AMOUNT DUE

- The Estimated Amount Due field is **not used**.

Fields 56 and 57A, B and C

56 NPI		
57		A
OTHER		B
PRV ID		C

- **Field 56:** The National Provider ID (NPI) field is **required, effective May 23, 2007.**
- **Field 57A, B and C:** The Other Provider ID (primary, secondary, and/or tertiary) fields are required **situationally.**
    - Use these fields to report other provider identifiers as assigned by a health plan (as indicated in Field 50 lines 1-3).

Field 58A, B and C

	58 INSURED'S NAME
A	
B	
C	

- The Insured's Name fields are **required**. On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in Fields 50-54, the provider must enter the patient's name as shown on the HI card or other Medicare notice. All additional entries across line A (FLs 59-66) pertain to the person named in Item 58A.
- The instructions that follow explain when to complete these items.
- The provider must enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and it is requesting payment because:
  - Another payer paid some of the charges and Medicare is secondarily liable for the remainder
  - Another payer denied the claim
  - The provider is requesting conditional payment. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:
    - EGHPs for employed beneficiaries and spouses age 65 or over
    - EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to l2 months
    - LGHPs for disabled beneficiaries
    - An auto-medical, no-fault, or liability insurer
    - WC including BL

Fields 59A, B, and C

59 P. REL

- The fields for Patient's Relationship to Insured **are required**.
- If the provider is claiming payment under any of the circumstances described under Fields 58A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.
- Use the following codes:
    - 01 Spouse
    - 18 Self
    - 19 Child
    - 20 Employee
    - 21 Unknown
    - 39 Organ Donor
    - 40 Cadaver Donor
    - 53 Life Partner
    - G8 Other Relationship

Fields 60A, B, and C

60 INSURED'S UNIQUE ID

- The fields for Insured's Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN)) are **required**.
- On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in Fields 50-54, the provider enters the patient's HICN, i.e., if Medicare is the primary payer, it enters this information in Field 60A.
- It shows the number as it appears on the patient's HI Card, Certificate of Award, Medicare Summary Notice, or as reported by the Social Security Office.
- If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP for the patient or the patient's spouse or during the first year of ESRD entitlement), it shows the involved claim number for that coverage on the appropriate line.

Fields 61A, B, and C

61 GROUP NAME

- The fields for Insurance Group Name Situational are **required if known**.
- Where the provider is claiming payment under the circumstances described in Fields 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.

Fields 62A, B, and C

62 INSURANCE GROUP NO.

- The fields for the Insurance Group Number are **required if known**.
- Where the provider is claiming payment under the circumstances described in Fields 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

Fields 63A, B, and C

63 TREATMENT AUTHORIZATION CODES
A
B
C

- The fields for Treatment Authorization Code **are required when** an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved.
- Whenever QIO review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

Field 64

64 DOCUMENT CONTROL NUMBER

- The Document Control Number (DCN) is **used based on the situation.**
- The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

Field 65

65 EMPLOYER NAME	
	A
	B
	C

- The Employer Name field **is only required where** the provider is claiming payment under the circumstances described in the second paragraph of Fields 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in Field 58.

Field 66

66 DX

- The Diagnosis and Procedure code Qualifier (ICD Version Indicator) field is **required.**
- The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
- The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision.
- **Medicare does not accept ICD-10 codes.**
- **Medicare only processes ICD-9 codes.**

Fields 67A thru Q

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

- Field 67 for the Principal Diagnosis Code is **required**.
- The hospital enters the ICD code for the principal diagnosis.
- The code **must** be the full ICD diagnosis code, including all five digits where applicable.
- The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.
- The principal diagnosis code will include the use of "V" codes. Where the proper code has fewer than five digits, the hospital may not fill with zeros.
- The principal diagnosis is the condition established after study to be chiefly responsible for this admission.
- Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis.
- Entering any other diagnosis may result in incorrect assignment of a DRG and cause the hospital to be incorrectly paid under PPS.
- The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty.
- For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (7862).
- If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis (4660).
- When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).
- Examples include:

  - Routine general medical examination (V700);
  - General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V709); and
  - Examination of ears and hearing (V721).
  - **NOTE:** Diagnosis codes are not required on non-patient claims for laboratory services where the hospital functions as an independent laboratory.
- **Fields 67A-67Q:** The fields for Other Diagnosis Codes **Inpatien**t **are required**.
  - The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.
  - It may **not** duplicate the principal diagnosis listed in Fields 67 as an additional or secondary diagnosis.
  - If the principal diagnosis is duplicated, the field will remove the duplicate diagnosis before the record is processed by GROUPER for IPPS claims.
  - The MCE identifies situations where the principal diagnosis is duplicated for IPPS claims.
  - Out Patient fields are also **required**.
  - The hospital enters the full ICD codes in Fields 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.
- **NOTE:** Medicare will ignore data submitted in 67I – 67Q.

Field 68

68

- This field is **not used**.

Field 69

69 ADMIT DX	

- The Admitting Diagnosis field is **required**.
- For inpatient hospital claims subject to QIO review, the admitting diagnosis is required.
- Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.
- This definition is not the same as that for SNF admissions.

Fields 70A, B, and C

70 PATIENT REASON DX	a	b	c

- The Patient's Reason for Visit field is **required only if the situation warrants it.**
- Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.

Field 71

71 PPS CODE	

- This field is **not used**.

Field 72

72 ECI	a	b	c

- This field is **not used**.

Field 73

73

- This field is **not used**.

Fields 74, 74A, B, C, D, and E

74 PRINCIPAL PROCEDURE		a. OTHER PROCEDURE		b. OTHER PROCEDURE	
CODE	DATE	CODE	DATE	CODE	DATE
c. OTHER PROCEDURE		d. OTHER PROCEDURE		e. OTHER PROCEDURE	
CODE	DATE	CODE	DATE	CODE	DATE

- **Field 74:**
  - The Principal Procedure Code and Date is required on inpatient claims when a procedure was performed.
  - Not used on outpatient claims.
- **Fields 74A – 74E:**
  - The fields for Other Procedure Codes and Dates are **r**equired on inpatient claims when additional procedures must be reported.
  - Not used on outpatient claims.

Field 75

75

- This field is **not used**.

Field 76

76 ATTENDING	NPI	QUAL		
LAST		FIRST		

- The Attending Provider Name and Identifiers (including NPI) fields **are required when** claim/encounter contains any services other than nonscheduled transportation services.
- If not required, do not send.
- The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.

Fields 77 thru 79

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

- **Field 77:**
  - The Operating Provider Name and Identifiers (including NPI) field **is required** when a surgical procedure code is listed on this claim.
  - If not required, do not send.
  - The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).
- **Fields 78 and 79**
  - The Other Provider Name and Identifiers (including NPI) fields are used to provide the name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.
  - Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN - Referring Provider. The provider who sends the patient to another provider for services.
  - Required on an outpatient claim when the Referring Provider is different than the Attending Physician.
  - If not required, do not send.

Field 80

80 REMARKS

- The Remarks field is used for DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's Field may determine whether to approve the rental or purchase of the equipment.
- Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations.
- In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.
- For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP.

Field 81

81CC a			
b			
c			
d			

- The Code-Code Field is used to report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.