UB-04 (CMS 1450) FORM COMPLETION INSTRUCTIONS

INTRODUCTION

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04.

☑ Revenue codes are used to bill line-item services provided in a facility.

☑ Revenue codes must be valid for the service provided.

☑ Revenue codes also must be valid for the bill type on the claim.

☑ For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 with a bill type 81X-82X (Special Facility Hospice).

☑ If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.

☑ ICD-9 diagnosis codes are required.

☑ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

☑ ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-04.

☑ CPT/HCPCS and modifiers must be used to identify other services rendered.

COMPLETING THE UB-04 CLAIM FORM

The following instructions explain how to complete the UB-04 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the AHA Uniform Billing Manual for the UB-04.

NOTE: This chapter applies to paper UB-04 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.azahcccs.gov. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.
Form Locator Fields:

1. Provider Data

Enter the name, address, and phone number of the provider rendering service.

<table>
<thead>
<tr>
<th>1. Arizona Hospital</th>
<th>2.</th>
<th>3. Patient Control No.</th>
<th>4. Bill Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Main Street</td>
<td>2</td>
<td>B MED. REC. #</td>
<td>PROVIDER UNIQUE CLAIM IDENTIFIER</td>
</tr>
<tr>
<td>Scottsdale, AZ 85342</td>
<td></td>
<td>5 FED. TAX.ID</td>
<td>STATEMENT COVERS PERIOD FROM THROUGH</td>
</tr>
</tbody>
</table>

2. Unassigned

Not required

3. Patient Control No.

Required if applicable

This is a number that the facility assigns to uniquely identify a claim in the facility’s records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility’s accounting or tracking system.

<table>
<thead>
<tr>
<th>1. Arizona Hospital</th>
<th>2</th>
<th>3. PAT. CNTL #</th>
<th>PROUDIER UNIQUE CLAIM IDENTIFIER</th>
<th>4 TYPE OF BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Main Street</td>
<td></td>
<td>B MED. REC. #</td>
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<td></td>
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<tr>
<td>Scottsdale, AZ 85342</td>
<td></td>
<td>5 FED. TAX.ID</td>
<td>STATEMENT COVERS PERIOD FROM THROUGH</td>
<td>7</td>
</tr>
</tbody>
</table>

4. Bill Type

Required

This is a 4 digit number based on Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See UB-92 Manual for codes.

Enter the four digit code that identifies the specific type of bill and frequency of submission. *The first digit is a leading zero.*

2nd Digit - Submitting Facility
1 = Hospital
2 = Skilled Nursing
3 = Home Health
4 = Christian Science (Hospital)
5 = Christian Science (Extended Care)
6 = Intermediate Care  
7 = Clinic (Use "2nd Digit - Clinics Only" below)  
8 = Special Facility (Use "2nd Digit - Special Facilities Only" below)  

2nd Digit - Bill Classification (Except Clinics and Special Facilities)  
1 = Inpatient (Including Medicare Part A)  
2 = Inpatient (Medicare Part B Only)  
3 = Outpatient  
4 = Other  
5 = Intermediate Care - Level I  
6 = Intermediate Care - Level II  
7 = Intermediate Care - Level III  
8 = Swing Beds  

2nd Digit - Clinics Only  
1 = Rural Health  
2 = Hospital Based or Independent Renal Dialysis Center  
3 = Free Standing  
4 = Outpatient Rehabilitation Facility (ORF)  
5 = Comprehensive Outpatient Rehabilitation Facility (CORF)  
9 = Other  

2nd Digit - Special Facilities Only  
1 = Hospice (Non-Hospital Based)  
2 = Hospice (Hospital Based)  
3 = Ambulatory Surgery Center  
4 = Free Standing Birthing Center  
9 = Other  

3rd Digit - Frequency  
0 = Non-Payment/Zero Claim  
1 = Admit Through Discharge Date (one claim covers entire stay)  
2 = First Interim Claim  
3 = Continuing Interim Claim  
4 = Last Interim Claim  
7 = Replacement of Prior Claim  
8 = Void/Cancel of Prior Claim
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Arizona Hospital</strong></td>
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<tr>
<td>Scottsdale, AZ 85342</td>
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<tr>
<td><strong>2.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3a PAT. CNTL #</strong></td>
<td>PROVIDER UNIQUE CLAIM IDENTIFIER</td>
</tr>
<tr>
<td><strong>B MED. REC. #</strong></td>
<td>111</td>
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<tr>
<td><strong>5 FED. TAX.ID</strong></td>
<td>6 STATEMENT COVERS PERIOD FROM THROUGH</td>
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<td><strong>STATEMENT COVERS PERIOD</strong></td>
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<tr>
<td>FROM</td>
<td>THROUGH</td>
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<td>01/01/14</td>
<td>01/03/14</td>
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<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td><strong>5 FED. TAX.ID</strong></td>
<td>861234567</td>
</tr>
</tbody>
</table>

**5. Fed Tax No.**
Required
Enter the facility’s federal tax identification number.

<table>
<thead>
<tr>
<th>Field</th>
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</tr>
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<tbody>
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<tr>
<td>FROM</td>
<td>THROUGH</td>
</tr>
<tr>
<td>01/01/2014</td>
<td>01/03/2014</td>
</tr>
</tbody>
</table>

**6. Statement Covers Period**
Required
Enter the beginning and ending dates of the billing period.

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<td><strong>1. Arizona Hospital</strong></td>
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<tr>
<td>FROM</td>
<td>THROUGH</td>
</tr>
<tr>
<td>01/01/2014</td>
<td>01/03/2014</td>
</tr>
</tbody>
</table>

**7. Future Use**
Not Required

**8. Patient Name/Identifier**
Required
Enter the recipient’s last name, first name, and middle initial as they appear on the AHCCCS ID card.
9. Patient Address  
Required

10. Patient Birth Date  
Required

11. Patient Sex  
Required

12. Admission/Start of care date  
Required

| 8 PATIENT NAME | a | John Smith |
| 9 PATIENT ADDRESS | a | 111 0 Ave, Phoenix, AZ 11111 |

<table>
<thead>
<tr>
<th>10 BIRTHDATE</th>
<th>11 SEX</th>
<th>12 DATE</th>
<th>13 HR</th>
<th>14 TYPE</th>
<th>15 SRC</th>
<th>16 DHR</th>
<th>17 STAT</th>
<th>18</th>
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<table>
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<th>39 CODE</th>
<th>VALUE CODE AMOUNT</th>
<th>40 CODE</th>
<th>VALUE CODE AMOUNT</th>
<th>41 CODE</th>
<th>VALUE CODE AMOUNT</th>
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</thead>
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<td>b</td>
<td></td>
<td>c</td>
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<td>d</td>
<td></td>
</tr>
</tbody>
</table>

13. Admission hour  
Required if applicable

Enter the hour (using a two-digit code below) that the patient entered the facility.

1:00 a.m. - 01  
2:00 a.m. - 02
3:00 a.m. - 03  
4:00 a.m. - 04
5:00 a.m. - 05  
6:00 a.m. - 06
7:00 a.m. - 07  
8:00 a.m. - 08
9:00 a.m. - 09  
10:00 a.m. - 10
11:00 a.m. - 11 
12:00 noon - 12
1:00 p.m. – 13  
2:00 p.m. - 14
3:00 p.m. - 15  
4:00 p.m. - 16
5:00 p.m. - 17  
6:00 p.m. - 18
7:00 p.m. - 19  
8:00 p.m. - 20
9:00 p.m. - 21  
10:00 p.m. - 22
11:00 p.m. - 23  
12:00 a.m. - 24/00
14. Priority (type) of Admission/Visit  Required
This field is required for all claims. Enter the code that best describes the recipient’s status for this billing period.

1 = Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
2 = Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
3 = Elective: Patient’s condition permits time to schedule services.
4 = Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.
5 = 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.

15. Point of Origin for Admission or Visit  Required
Enter one of the following source of admission codes:
1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from Hospital
5 = Transfer from SNF
6 = Transfer From Another Health Care Facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available
In the Case of Newborn
1 = Normal Delivery
2 = Premature Delivery
3 = Sick Baby
4 = Extramural Birth
16. Discharge Hour
Required if applicable
Enter the code which best indicates the recipient's time of discharge. This field is required for inpatient claims when the recipient has been discharged. See Field 13 Admission Hour for coder structure.

17. Patient discharge status
Required
Field is required for all claims. Enter the code that best describes the recipient's status for this billing period:
01 Discharged to home or self-care (routine discharge)
02 Discharged/Transferred to a short-term general hospital for inpatient care
03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care
04 Discharge/Transferred to a facility that provides custodial or supportive care
05 Discharge/Transferred to a designated cancer center or children's hospital
06 Discharge/Transferred to home under care an organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
09 Admitted as an inpatient to this hospital
20 Expired
21 Discharged/Transferred to Court/Law Enforcement
30 Still a patient
40 Expired at home
41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice
42 Expired, place unknown (hospice only)
43 Discharged/Transferred to a federal health care facility
50 Discharged to Hospice -home
51 Discharged to Hospice -medical facility (certified) providing hospice level of care
61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital
66 Discharges/Transfers to a Critical Access Hospital
70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18-28 Condition Codes  Required if applicable
Enter the appropriate condition codes that apply to this bill. See UB-04Manual for codes.
In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field.
To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).
To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.

29. Accident State  Required if applicable

31-34 Occurrence Codes and Dates  Required if applicable
35-36. Occurrence Span codes and dates
38. Responsible Party Name and Address

39-41. Value Codes and Amounts

42. Revenue Code

Enter the appropriate revenue code(s) that describe the service(s) provided. See UB-04 Manual for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

<table>
<thead>
<tr>
<th>42 REV.CODE</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/RATE/HIPPS CODE</th>
<th>45 SERV.DATE</th>
<th>46 SERV UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NONCOVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>0132</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0251</td>
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<tr>
<td>0258</td>
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</tr>
</tbody>
</table>

43. Revenue Code Description/NDC code (effective 7/1/12)

Enter the description of the revenue code billed in Field 42. See UB-04 Manual for description of revenue codes.

<table>
<thead>
<tr>
<th>42 REV.CODE</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/RATE/HIPPS CODE</th>
<th>45 SERV.DATE</th>
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<th>47 TOTAL CHARGES</th>
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<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>0132</td>
<td>OB/3&amp;4 BED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0251</td>
<td>DRUGS/Generic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0258</td>
<td>IV SOLUTION</td>
<td></td>
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</tr>
</tbody>
</table>

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):
- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.
The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

### 44. HCPCS/Rates
Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

<table>
<thead>
<tr>
<th>REV CODE</th>
<th>DESCRIPTION</th>
<th>HCPCS/RATE/HIPPS CODE</th>
<th>DATE</th>
<th>UNITS</th>
<th>TOTAL CHARGES</th>
<th>NONCOVERED CHARGES</th>
</tr>
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<tbody>
<tr>
<td>0132</td>
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<td></td>
<td></td>
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<td>0251</td>
<td>DRUGS/Generic</td>
<td>85595</td>
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<td></td>
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<tr>
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<td>IV SOLUTION</td>
<td>98900</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Form Locator 44 (HCPCS/Rate/HIPPS code):** Enter the corresponding HCPCS code associated with the NDC.

<table>
<thead>
<tr>
<th>REV CODE</th>
<th>DESCRIPTION</th>
<th>HCPCS/RATE/HIPPS CODE</th>
<th>DATE</th>
<th>UNITS</th>
<th>TOTAL CHARGES</th>
<th>NONCOVERED CHARGES</th>
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<tr>
<td>0250</td>
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<td>J1642</td>
<td>2.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 45. Service Date
The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

<table>
<thead>
<tr>
<th>REV CODE</th>
<th>DESCRIPTION</th>
<th>HCPCS/RATE/HIPPS CODE</th>
<th>DATE</th>
<th>UNITS</th>
<th>TOTAL CHARGES</th>
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</thead>
<tbody>
<tr>
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<td>1088.00</td>
<td>01/01/14</td>
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<td>98900</td>
<td>01/01/14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
46. Service Units
Number of units for ALL services must be indicated.
If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.

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<tr>
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<td>OB/3&amp;4 BED</td>
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<td>30.00</td>
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Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

<table>
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<tr>
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<td>01/01/14</td>
<td>2.00</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

47. Total Charges
Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

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<th>44 HCPCS/RATE/HIPPS CODE</th>
<th>45 SERV.DATE</th>
<th>46 SERV UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NONCOVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>0132</td>
<td>OB/3&amp;4 BED</td>
<td>1088.00</td>
<td>01/01/14</td>
<td>2.00</td>
<td>1276</td>
<td>00</td>
<td></td>
</tr>
<tr>
<td>0251</td>
<td>DRUGS/GENERIC</td>
<td>85595</td>
<td>01/01/14</td>
<td>3.00</td>
<td>104</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>0258</td>
<td>IV SOLUTION</td>
<td>98900</td>
<td>01/01/14</td>
<td>30.00</td>
<td>529</td>
<td>92</td>
<td></td>
</tr>
</tbody>
</table>
48. Non-covered Charges
Required if applicable
Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

49. Unlabeled Field
Not Required

50. (A–C) Payer
Required
Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

51. (A–C) Healthplan Identification No.
Required
Enter the facility’s ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility’s six-digit AHCCCS service provider ID number should be listed last. Behavioral health providers must not enter their BHS provider ID number.

52. (A–C) Release of Information
Not required

53. (A–C) Assignment of Benefits
Not required

54. (A–C) Prior Payments
Required if applicable
Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer other than AHCCCS, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter “Ø.” The “Ø” indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.
55. (A–C) Amount due
   Not required

56. National Provider Identifier-Billing Provider
   Required
<table>
<thead>
<tr>
<th>50 PAYER NAME</th>
<th>51 HEALTHPLAN ID</th>
<th>52 REL INFO</th>
<th>53 ASG. BEN.</th>
<th>54 PRIOR PAYMENTS</th>
<th>55 EST. AMOUNT DUE</th>
<th>56 NPI</th>
</tr>
</thead>
</table>
   A          | AHCCCS         | 654321     |             |                |                   | 1234567890       |
   B          |                |            |            |                |                   |                  |
   C          |                |            |            |                |                   |                  |

57. Other (Billing) Provider Identifier
   Required if applicable

58. (A–C) Insured's Name
   Not Required
   Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field 50.
<table>
<thead>
<tr>
<th>58 INSURED'S NAME</th>
<th>59 P REL</th>
<th>60 INSURED'S UNIQUE ID</th>
<th>61 GROUP NAME</th>
<th>62 INSURANCE GROUP NO.</th>
</tr>
</thead>
</table>
   A        | Holliday, John H.  |       |                        |               |                        |
   B        |                     |       |                        |               |                        |
   C        |                     |       |                        |               |                        |

59. (A–C) Patient's Relationship to Insured
   Not required

60. (A–C) Patient CERT. - SSN – HIC – ID NO.
   Not required
   Enter the recipient's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client’s AHCCCS ID number, not the client’s BHS number.
<table>
<thead>
<tr>
<th>58 INSURED'S NAME</th>
<th>59 P REL</th>
<th>60 INSURED'S UNIQUE ID</th>
<th>61 GROUP NAME</th>
<th>62 INSURANCE GROUP NO.</th>
</tr>
</thead>
</table>
   A        | Holliday, John H.  |       | A12345678               |               |                        |
   B        |                     |       |                        |               |                        |
   C        |                     |       |                        |               |                        |

61. (A–C) Group Name
   Not required
   Enter "FFS" for AHCCCS IHS and ESP recipients.
### 62. (A–C) Insurance Group Number
- Not required

### 63. (A–C) Treatment Authorization
- Not required

The Mercy Care claims system automatically searches for the appropriate authorization for services that require authorization.

### 64. Document Control Number
- Not required

### 65. (A–C) Employer Name
- Not required

### 66. Diagnosis and Procedure Code Qualifier
- Required

### 67. Principal Diagnosis Code
- Required

Enter the principal ICD-9 diagnosis code. Behavioral health providers must not use DSM-4 diagnosis codes.

<table>
<thead>
<tr>
<th>A</th>
<th>585.0</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
<th>P</th>
<th>Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 DX</td>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

### 69. Admitting Diagnosis
- Required

Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

<table>
<thead>
<tr>
<th>A</th>
<th>585.0</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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</tbody>
</table>

### 70. Patient’s Reason for Visit
- Not required

#### 72 E-Codes
- Required if applicable

Enter trauma diagnosis code, if applicable.

### 74. Principal Procedure Code and Dates
- Required if applicable
Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

76. Attending Provider Name and identifiers  
Required if applicable

77. Operating Physician Name and Identifiers  
Required if applicable

78-79. Other Physician  
Not required

80. Remarks  
Required if applicable
Required on resubmissions, adjustments, and voids. Enter the CRN of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write “Resubmission” in this field.

81. Other Procedure Codes  
Required if applicable
Enter other procedure codes in descending order of importance.