UNISYS

UB04
CLAIM FORM REVISION
PROVIDER TRAINING

Fall 2007

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Personal Care Services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES
Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT
If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES
Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical Equipment and Supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION
Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED, CALL 1-888-758-2220 FOR ASSISTANCE.

OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Support Coordination
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CSRAs

METROPOLITAN HUMAN SERVICES DISTRICT
Janise Monetta, CSRA
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CAPITAL AREA HUMAN SERVICES DISTRICT
Pamela Sund, CSRA
4615 Government St. – Bin#16 – 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Fee: 1-800-768-8824

REGION III
John Hall, CSRA
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
Celeste Larroque, CSRA
214 Jefferson Street – Suite 301
Lafayette, LA 70501
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
Connie Mead, CSRA
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
Nora H. Dorsey, CSRA
429 Murray Street – Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
Rebecca Thomas, CSRA
3018 Old Minden Road – Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
Deanne W. Groves, CSRA
122 St. John St. – Rm. 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Marie Gros, CSRA
21454 Koop Drive – Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
Stephanie Campo, CSRA
Donna Francis, Asst CSRA
3300 W. Esplanade Ave. –Suite 213
Metairie, LA 70002
Phone (504) 838-5357
FAX: (504) 838-5400

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2007 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana Medicaid website, www.lamedicaid.com.

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OVERVIEW

The UB04 claim form was first accepted by Louisiana Medicaid for all dates of submission beginning August 1, 2007, but will not be mandated for use until November 5, 2007.

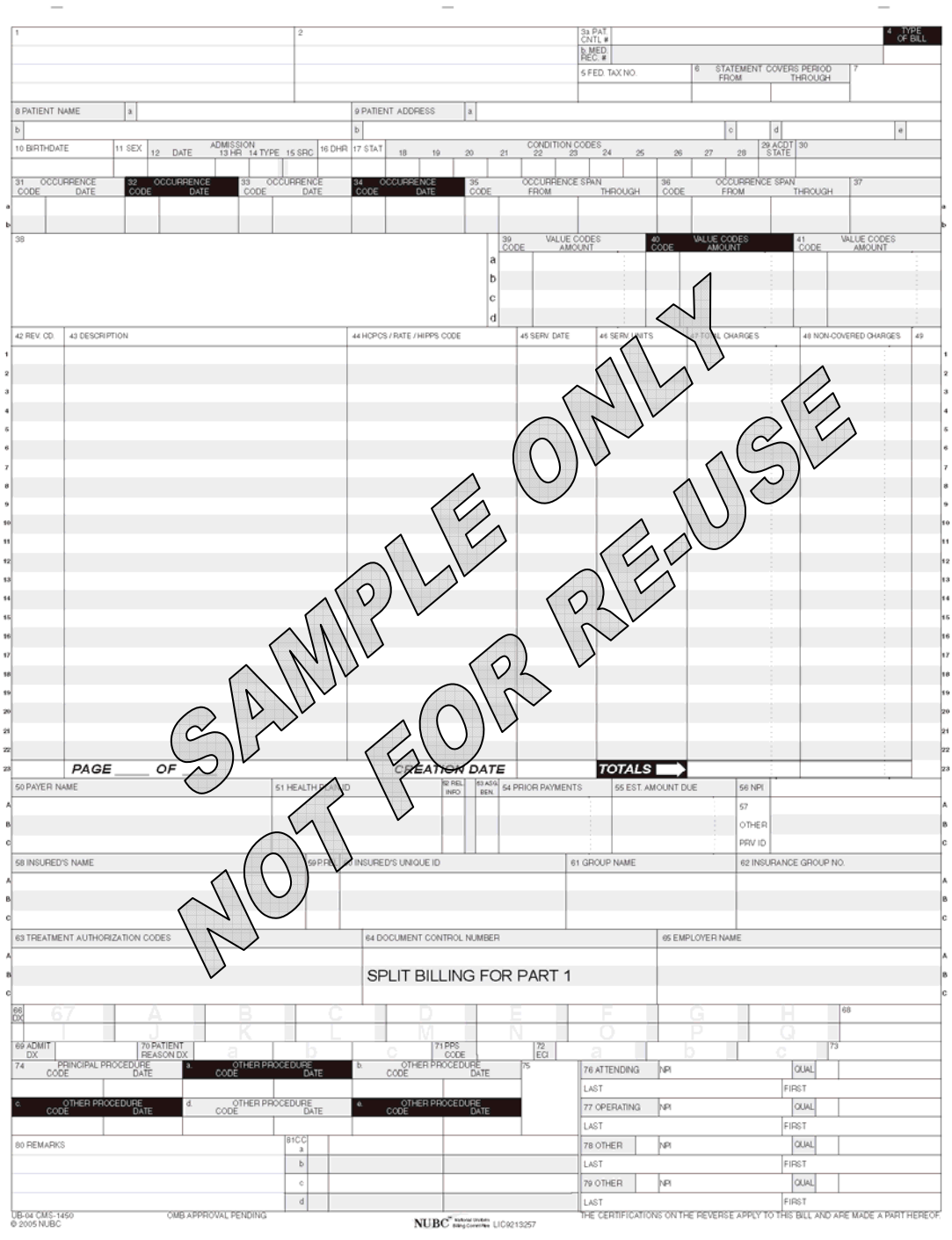
Providers are permitted to use either the current UB92 form or the new UB04 form beginning August 1, 2007 through November 4, 2007.

Effective November 5, 2007, the UB92 form will be discontinued and only the new UB04 form shall be used. This includes all rebilling of claims even though earlier submissions may have been on the UB92 form.

Failure to submit all hard copy claims on the revised form results in the rejection of those claims and delays payment.

The changes from the UB92 to the UB04 were significant. Among the more important changes are the facts that the UB04 accommodates the entry of NPIs for servicing and billing providers and the signature required is removed from the form. Other differences are highlighted in a special **Alert** column in the instructions that are provided below. The reporting of certain data fields and special instructions related to Louisiana Medicaid billing are indicated in this **Alert** column.

SAMPLE UB04


SAMPLE ONLY
NOT FOR RE-USE
SPLIT BILLING FOR PART 1
PAGE _____ OF
CREATION DATE
TOTALS
UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

GENERAL SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR GENERAL SERVICES

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each; see program-specific instructions for details.	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates	
7	Unlabeled	**Optional.** State Assigned.	**Covered days are now reported in the value code field (39-41) as value code 80.** **The CommunityCARE emergency indicator was formerly entered in UB-92 Form Locator 11.**

Locator #	Description	Instructions	Alerts
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 18.**
14	Type Admission	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 19.**
15	Source of Admission	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 20.**
16	Discharge Hour	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in Form Locator 21.**
17	Patient Status	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 22.**

Locator #	Description	Instructions	Alerts
18-28	Condition Codes	**Required for some programs.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 24-30.**
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Situational.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 32-35.**
35-36	Occurrence Spans (Code and Dates)	**Situational.** See the program-specific instructions for details.	**Formerly entered in UB-92 Form Locator 36.**
37	Unlabeled	**Leave Blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required**. See the program-specific instructions for details.	
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service. See program-specific instructions for details.	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	
44	HCPCS/Rates HIPPS Code HCPCS/CPT Code (Outpatient DX Lab)	**Required for some programs.** See program-specific instructions for details.	
45	Service Date	**Required for some programs.** See program-specific instructions for details.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required for some programs.** See program-specific instructions for details.	
47	Total Charges	**Required for some programs.** See program-specific instructions for details.	

Locator #	Description	Instructions	Alerts
48	Non-Covered Charges	**Situational.** See program-specific instructions for details.	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0 00’ in this field.	

Locator #	Description	Instructions	Alerts
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Spouse 04 = Grandfather or Grandmother 05 = Grandson or Granddaughter 07 = Nephew or Niece 10 = Foster child 15 = Ward (Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order) 17 = Stepson or Stepdaughter 18 = Self 19 = Child	

Locator #	Description	Instructions	Alerts
		20 = Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 32 = Mother 33 = Father 39 = Organ Donor 41 = Injured Plaintiff 43 = Child where insured has no financial responsibility	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Situational.** If the services on the claim require prior authorization or pre-certification, enter the prior authorization or pre-certification number in 63A.	

Locator #	Description	Instructions	Alerts
		If the services require a CommunityCARE PCP referral authorization number, enter the PCP 7-digit Medicaid referral authorization number or the unique electronic 9-digit referral authorization number (assigned through e-RA) in 63C, as appropriate.	**The CommunityCARE Referral Authorization Number was formerly entered in Form Locator 83A of the UB-92.**
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	

Locator #	Description	Instructions	Alerts
66	DX Version Qualifier	**Optional.** Enter the diagnosis/procedure code version qualifier of "9."	**The diagnosis/procedure code version qualifier was formerly entered in Form Locator 79 of the UB-92.**
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Situational.** If the claim is for inpatient services, enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Optional.** Enter the appropriate Diagnosis Code indicating the patient's presenting symptom.	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74	Principal Procedure Code / Date	**Required for inpatient services**. Enter a valid current ICD-9-CM procedure code.	

Locator #	Description	Instructions	Alerts
74 a - e	Other Procedure Code / Date	**Required for inpatient services.** Enter valid current ICD-9-CM procedure codes as appropriate.	
75	Unlabeled	**Leave blank.**	
76	Attending	**Required for some programs**. See program-specific instructions for details.	**Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.**
77	Operating	**Situational**. See program-specific instructions for details.	**Operating physician name and/or number is new to the UB-04.** **Operating physician name for sterilization procedures was formerly entered in Form Locator 82.**
78	Other	**Situational.** If applicable, enter the name and/or number of any other physician.	**CommunityCARE referral authorization number, formerly entered in 83A (Other Physician) of the UB-92, has been moved to Form Locator 63C of the UB-04.**
79	Other	**Situational**. If applicable, enter the name and/or number of any other physician.	

Locator #	Description	Instructions	Alerts
80	Remarks	**Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

HOSPITAL SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR HOSPITAL PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: a. First digit-type facility 1 = Hospital b. Second digit-classification 1 = Inpatient Medicaid and/or Medicare Part A or Parts A & B 2 = Inpatient Medicaid and Medicare Part B only 3 = Outpatient or Ambulatory Surgical Center c. Third digit-frequency 0 = Non-Payment claim 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	

Locator #	Description	Instructions	Alerts
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates	
7	Unlabeled	**Optional.** State Assigned. **Note: Hospitals billing for services associated with moderate to high level emergency physician care (99283, 99284, 99285) should place a '3' in Form Locater 7 on the UB-04.** **Hospitals billing for services associated with low level emergency physician care (99281, 99282) should place a '1" in Form Locator 7 on the UB-04.**	**The CommunityCARE emergency indicator was formerly entered in UB-92 Form Locator 11.** **If providers do not use the emergency indicator correctly, the claim will deny with a 104 error edit.** **Covered days are now reported in the value code field (39-41) as value code 80.**
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**

Locator #	Description	Instructions	Alerts
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required for Hospital Services.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Required for Hospital Services.** Enter the 2-digit code which corresponds to the hour the patient was admitted for care as: <u>Code Time</u> 00 = 12:00 - 12:59 midnight 01 = 01:00 - 01:59 A.M. 02 = 02:00 - 02:59 03 = 03:00 - 03:59 04 = 04:00 - 04:59 05 = 05:00 - 05:59 06 = 06:00 - 06:59 07 = 07:00 - 07:59 08 = 08:00 - 08:59 09 = 09:00 - 09:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 noon 13 = 01:00 - 01:59 P.M. 14 = 02:00 - 02:59 15 = 03:00 - 03:59 16 = 04:00 - 04:59 17 = 05:00 - 05:59 18 = 06:00 - 06:59 19 = 07:00 - 07:59 20 = 08:00 - 08:59 21 = 09:00 - 09:59 22 = 10:00 - 10:59 23 = 11:00 - 11:59	**Formerly entered in UB-92 Form Locator 18.**

Locator #	Description	Instructions	Alerts
14	Type Admission	**Required for Hospital Services.** Enter one of the appropriate codes indicating the priority of this admission. 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn	**Formerly entered in UB-92 Form Locator 19.**
15	Source of Admission	**Required for Hospital Services.** Enter the appropriate code from the list of "Code Structure for Adult and Pediatrics: shown below. * Newborn coding structure must be used when the type of admission code in Form Locator 14 is "4" <u>Valid codes if type of admission is 1, 2, or 3</u> 1 = Physician Referral 2 = Clinic Referral 3 = HMO Referral 4 = Transfer from a Hospital 5 = Transfer from a Skilled Nursing Facility 6 = Transfer from Another Health Care Facility 7 = Emergency Room <u>Valid codes if type of admission is 4</u> 1 = Normal Delivery 2 = Premature Delivery 3 = Sick Baby 4 = Extramural Birth	**Formerly entered in UB-92 Form Locator 20.**
16	Discharge Hour	**Required for Hospital Services.** Enter the two-digit code which corresponds to the hour the patient was discharged. See Form Locator 13.	**Formerly entered in Form Locator 21.**

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required for Hospital Services.** Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are: 01 = Discharged (routine) 02 = Discharged to another short-term general hospital 03 = Discharged to Skilled Nursing Facility 04 = Discharged to Intermediate Care Facility 05 = Discharged to another type of institution 06 = Discharged/transferred to home under care of home health service organization 07 = Left against medical advice 20 = Expired 30 = Still Patient	**Formerly entered in UB-92 Form Locator 22.** **Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**
18-28	Condition Codes	**Required for Hospital Services.** Enter C1 in Form Locator 18 for inpatient claims. <u>PRO Approval</u> C1 Approved as billed **Optional.** Must be a valid code if entered. Valid codes are listed as follows: <u>Insurance</u> 01 = Military service related 02 = Condition is employment related 03 = Patient is covered by insurance not reflected here 04 = Information only bill 05 = Lien has been filed 06 = End stage renal disease in first 30 months of entitlement covered by employer group insurance <u>Accommodations</u> 38 = Semi-private room not available 39 = Private room medically	**Formerly entered in UB-92 Form Locator 24-30.**

Locator #	Description	Instructions	Alerts
		necessary 40 = Same day transfer <u>Special Program Indicators</u> A1 = EPSDT/CHAP A2 = Physically Handicapped Children's Program A4 = Family Planning	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Situational.** Enter, if applicable. Each code must be two position numeric and have an associated date. Dates must be valid and in MMDDYY format. Valid codes are listed as follows: 01 = Accident/Medical Coverage 02 = Auto accident/no fault 03 = Accident/tort liability 04 = Accident/employment related 05 = Accident/No Medical Coverage 06 = Crime victim 24 = Date insurance denied 25 = Date benefits terminated by primary payer 27 = Date of Hospice certification or recertification 42 = Date of discharge when "Through" date in Form Locator 6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill. A3, B3, C3 = Benefits exhausted	**Formerly entered in UB-92 Form Locator 32-35.**

Locator #	Description	Instructions	Alerts
35-36	Occurrence Spans (Code and Dates)	**Situational.** Enter, if applicable, a code and related dates that identity an event that relates to the payment of the claim. Code and date must be valid. Date must be (MMDDYY) format. Valid codes are listed as follows: 72 = First/Last visit 74 = Non-covered Level of Care	**Formerly entered in UB-92 Form Locator 36.**
37	Unlabeled	**Leave Blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields. 02 = Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 = Medicare blood deductible 08 = Medicare lifetime reserve first CY 09 = Medicare coinsurance first CY 10 = Medicare lifetime reserve second year 11 = Coinsurance amount second year 12 = Working Aged Recipient/Spouse with employer group health plan 13 = ESRD (End Stage Renal Disease) Recipient in the 12-month coordination period with an employer's group health plan 14 = Automobile, no fault or any liability insurance 15 = Worker's Compensation	**Value Code 80 must be used to report covered days, which was formerly reported in Form Locator 7.** **For Medicare Crossover claims only:** **Value Code 81 must be used to report non-covered days, which was formerly reported in Form Locator 8.** **Value Code 82 must be used to report co-insurance days, which was formerly reported in Form Locator 9.** **Value Code 83 must be used to report lifetime reserve days, which was formerly reported in Form Locator 10.**

Locator #	Description	Instructions	Alerts
		including Black Lung 16 = VA, PHS, or other Federal Agency 30 = Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 = Pints blood furnished 38 = Blood not replaced - deductible is patient's responsibility 39 = Blood pints replaced *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) A1,B1,C1 = Deductible A2,B2,C2 = Co-insurance *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	**Please read the instructions carefully for entering the new number of days information in the Value Code fields.**
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service. Accommodation codes require a rate in Form Locator 44. Revenue Codes 300-319 and 490 for outpatient require a CPT/HCPCS procedure code in Form Locator 44. Specific revenue codes should be selected if at all possible (i.e. 258 = IV Solutions, 305 = Lab /	**Revenue Codes 89x (other donor bank) are now unassigned. Use Revenue Codes 81x instead.**

Locator #	Description	Instructions	Alerts
		Hematology, etc.) See Revenue Codes listing that follows these instructions. The amount charged must be present in Form Locator 47. Codes must be valid and entered in ascending order, except for the final entry for total charges. **Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.**	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42. Two page claims are accepted for inpatient hospital **ONLY**. Use "Page ___ of ___" on line 23 as needed for two-page claims. Enter "Page 1 of 2" or "Page 2 of 2" as appropriate.	**Instructions for two-page claims have been added.**
44	HCPCS/Rates HIPPS Code HCPCS/CPT Code (Outpatient DX Lab)	**Required for inpatient services.** Enter the accommodation rate for any accommodation Revenue Codes indicated in Form Locator 42. If present, the accommodation rate must be numeric. **Situational.** When Revenue Codes 300-319 (Lab) or 490 (Ambulatory Surgery) are indicated in Form Locator 42, entry of the appropriate CPT/HCPC Codes in Form Locator 44 is **required**.	

Locator #	Description	Instructions	Alerts
45	Service Date	**Required for outpatient services.** Enter the appropriate service date (MMDDYY) on each line indicating a Revenue Code. **Required.** Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter the appropriate unit(s) of service by Revenue Code.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes.	
48	Non-Covered Charges	**Situational.** Indicate charges included in Form Locator 47 which are not payable under the Medicaid Program.	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	

Locator #	Description	Instructions	Alerts
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field. If the patient has Medicare Part B only, enter the amount **billed** to Medicare Part B.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**

Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Spouse 04 = Grandfather or Grandmother 05 = Grandson or Granddaughter 07 = Nephew or Niece 10 = Foster child 15 = Ward (Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order) 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 32 = Mother 33 = Father 39 = Organ Donor 41 = Injured Plaintiff 43 = Child where insured has no financial responsibility	

Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Situational.** If the services on the claim require prior authorization or pre-certification, enter the prior authorization or pre-certification number in 63A. If the services require a CommunityCARE PCP referral authorization number, enter the PCP 7-digit Medicaid referral authorization number or the unique electronic 9-digit referral authorization number (assigned through e-RA) in 63C, as appropriate.	**The CommunityCARE Referral Authorization Number was formerly entered in Form Locator 83A of the UB-92.**

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Optional.** Enter the diagnosis/procedure code version qualifier of "9."	**The diagnosis/procedure code version qualifier was formerly entered in Form Locator 79 of the UB-92.**

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Situational.** If the claim is for inpatient services, enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Optional.** Enter the appropriate Diagnosis Code indicating the patient's presenting symptom.	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Situational**. Enter a valid current ICD-9-CM procedure code when an inpatient procedure is performed. **Situational.** Enter valid current ICD-9-CM procedure codes as appropriate for multiple inpatient procedures.	
75	Unlabeled	**Leave blank.**	

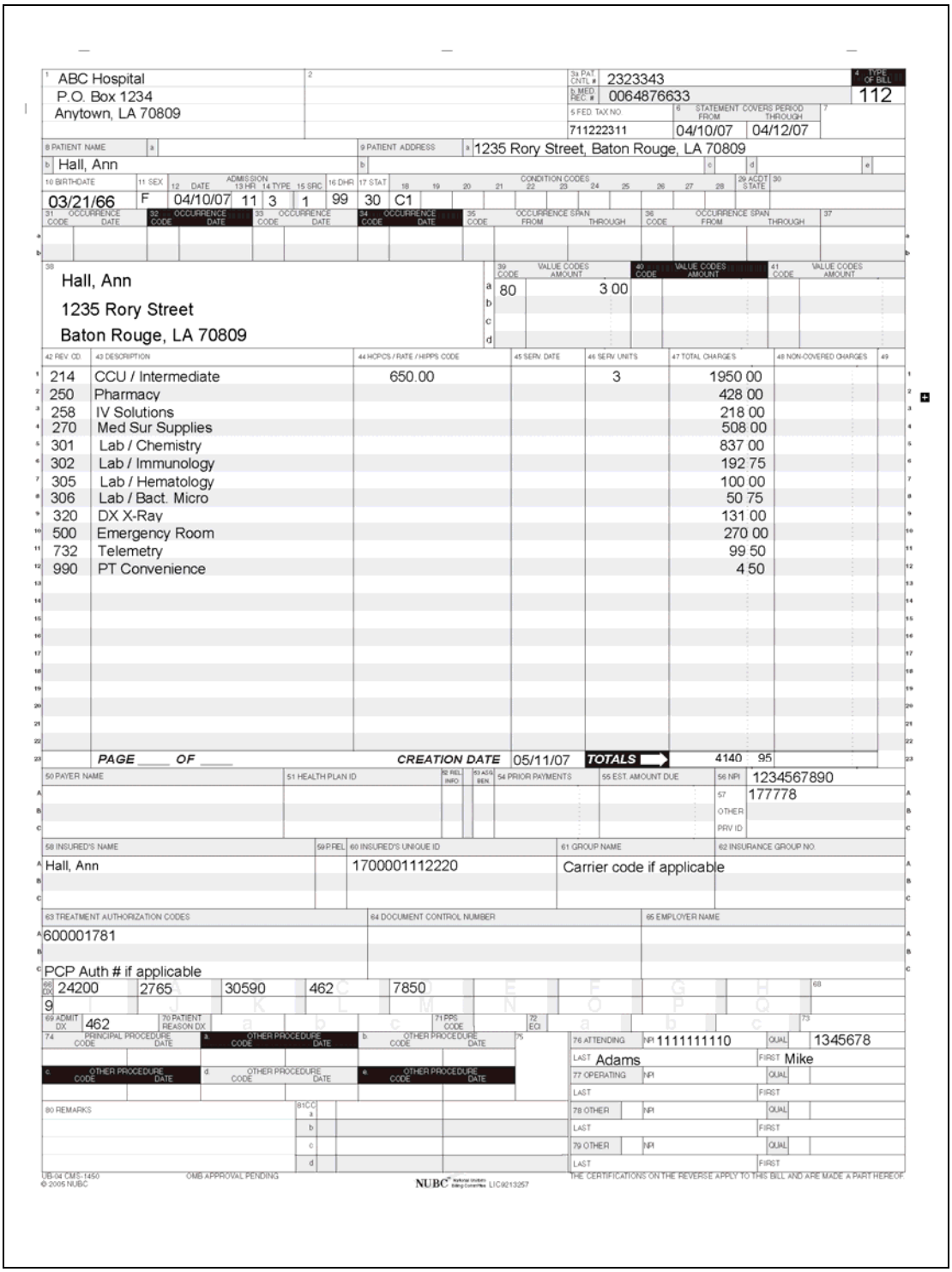
Locator #	Description	Instructions	Alerts
76	Attending	**Required**. Enter the name and/or number of the attending physician.	**Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.**
77	Operating	**Situational**. If applicable, enter the name and/or number of the operating physician. **Note**: **For sterilization procedures, the surgeon's name must appear in Form Locator 77**.	**Operating physician name and/or number is new to the UB-04.** **Operating physician name for sterilization procedures was formerly entered in Form Locator 82.**
78	Other	**Situational.** If applicable, enter the name and/or number of any other physician.	**CommunityCARE referral authorization number, formerly entered in 83A (Other Physician) of the UB-92, has been moved to Form Locator 63C of the UB-04.**
79	Other	**Situational**. If applicable, enter the name and/or number of any other physician.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of**

Locator #	Description	Instructions	Alerts
			the UB-04.
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

UB04 SAMPLES FOR HOSPITAL

Inpatient



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 2323343
b MED REC # 0064876633
4 TYPE OF BILL 112
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04/10/07 THROUGH 04/12/07

8 PATIENT NAME b Hall, Ann
9 PATIENT ADDRESS a 1235 Rory Street, Baton Rouge, LA 70809

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	29 ACDT STATE	30
03/21/66	F	04/10/07	11	3	1	99	30	C1		

31–37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH

38 Hall, Ann
1235 Rory Street
Baton Rouge, LA 70809

39–41 VALUE CODES / AMOUNT
a 80 3 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
214	CCU / Intermediate	650.00		3	1950 00		
250	Pharmacy				428 00		
258	IV Solutions				218 00		
270	Med Sur Supplies				508 00		
301	Lab / Chemistry				837 00		
302	Lab / Immunology				192 75		
305	Lab / Hematology				100 00		
306	Lab / Bact. Micro				50 75		
320	DX X-Ray				131 00		
500	Emergency Room				270 00		
732	Telemetry				99 50		
990	PT Convenience				4 50		
	PAGE ____ OF ____		CREATION DATE 05/11/07	TOTALS	4140 95		

50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER 177778
PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Hall, Ann		1700001112220	Carrier code if applicable	

63 TREATMENT AUTHORIZATION CODES
A 600001781
C PCP Auth # if applicable
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 24200 2765 30590 462 7850
9
67 A–Q
68

69 ADMIT DX 462
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

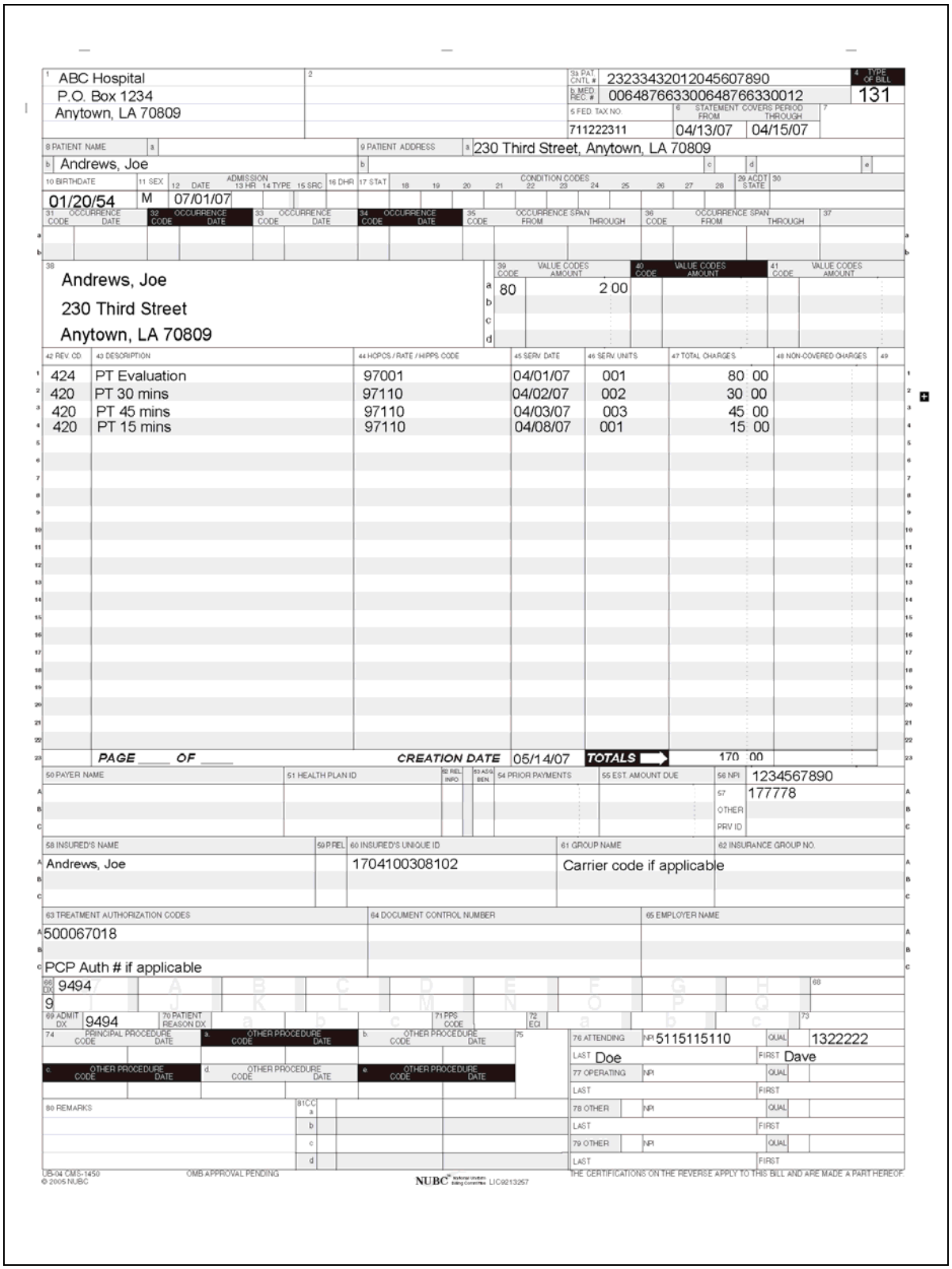
74 PRINCIPAL PROCEDURE CODE / DATE
a. OTHER PROCEDURE CODE / DATE
b. OTHER PROCEDURE CODE / DATE
75
c. OTHER PROCEDURE CODE / DATE
d. OTHER PROCEDURE CODE / DATE
e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI 1111111110 QUAL 1345678
LAST Adams FIRST Mike
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

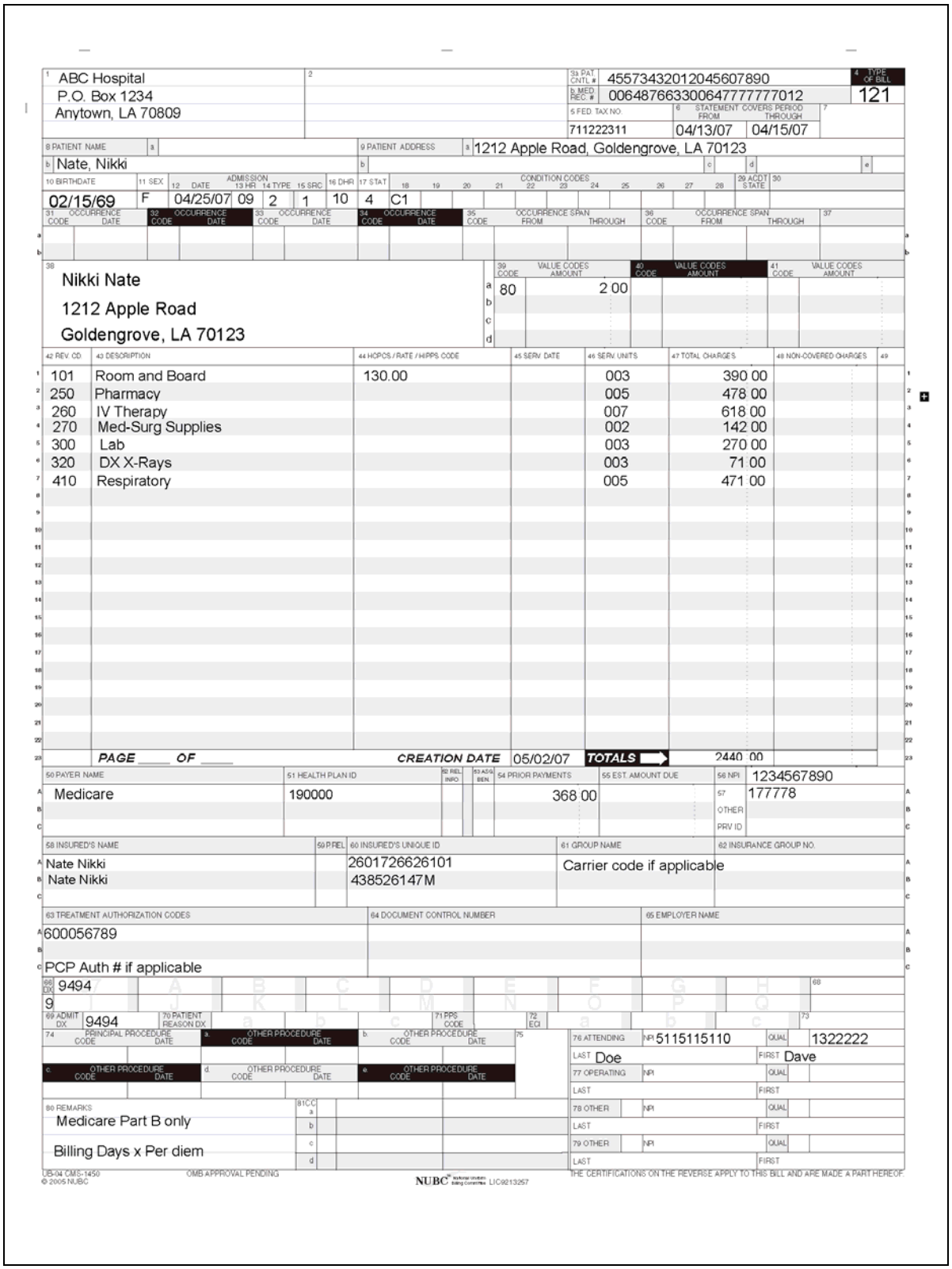
80 REMARKS
81 CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING
© 2005 NUBC
NUBC National Uniform Billing Committee LIC#213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Outpatient


1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809
3a PAT. CNTL # 23233432012045607890
b MED REC. # 00648766330064876633 0012
4 TYPE OF BILL 131
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04/13/07 THROUGH 04/15/07
8 PATIENT NAME b Andrews, Joe
9 PATIENT ADDRESS a 230 Third Street, Anytown, LA 70809
10 BIRTHDATE 01/20/54
11 SEX M
12 ADMISSION DATE 07/01/07
38 Andrews, Joe
230 Third Street
Anytown, LA 70809
39 VALUE CODES a 80 2 00
42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES
1 424 PT Evaluation 97001 04/01/07 001 80 00
2 420 PT 30 mins 97110 04/02/07 002 30 00
3 420 PT 45 mins 97110 04/03/07 003 45 00
4 420 PT 15 mins 97110 04/08/07 001 15 00
PAGE ____ OF ____
CREATION DATE 05/14/07
TOTALS 170 00
50 PAYER NAME
56 NPI 1234567890
57 177778
58 INSURED'S NAME A Andrews, Joe
60 INSURED'S UNIQUE ID 1704100308102
61 GROUP NAME Carrier code if applicable
63 TREATMENT AUTHORIZATION CODES A 500067018
c PCP Auth # if applicable
66 DX 9494
76 ATTENDING NPI 5115115110 QUAL 1322222
LAST Doe FIRST Dave
77 OPERATING
78 OTHER
79 OTHER
80 REMARKS
UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

CROSSOVER



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

2

3a PAT. CNTL # 45573432012045607890
b. MED REC. # 00648766330064777777012
4 TYPE OF BILL 121
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04/13/07 THROUGH 04/15/07
7

8 PATIENT NAME
b Nate, Nikki

9 PATIENT ADDRESS
a 1212 Apple Road, Goldengrove, LA 70123

10 BIRTHDATE 02/15/69
11 SEX F
12 ADMISSION DATE 04/25/07
13 HR 09
14 TYPE 2
15 SRC 1
16 DHR 10
17 STAT 4
18 CONDITION CODES C1
29 ACDT STATE
30

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

38
Nikki Nate
1212 Apple Road
Goldengrove, LA 70123

39 VALUE CODES CODE AMOUNT
a 80 2 00
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
101	Room and Board	130.00		003	390 00		
250	Pharmacy			005	478 00		
260	IV Therapy			007	618 00		
270	Med-Surg Supplies			002	142 00		
300	Lab			003	270 00		
320	DX X-Rays			003	71 00		
410	Respiratory			005	471 00		
	PAGE ____ OF ____	CREATION DATE	05/02/07	TOTALS	2440 00		

50 PAYER NAME
A Medicare
51 HEALTH PLAN ID
A 190000
52 REL. INFO.
53 ASG. BEN.
54 PRIOR PAYMENTS
A 368 00
55 EST. AMOUNT DUE
56 NPI
A 1234567890
57 OTHER PRV ID
A 177778

58 INSURED'S NAME
A Nate Nikki
B Nate Nikki
59 P REL
60 INSURED'S UNIQUE ID
A 2601726626101
B 438526147M
61 GROUP NAME
Carrier code if applicable
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
A 600056789
C PCP Auth # if applicable
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9494
9
67
68

69 ADMIT DX 9494
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

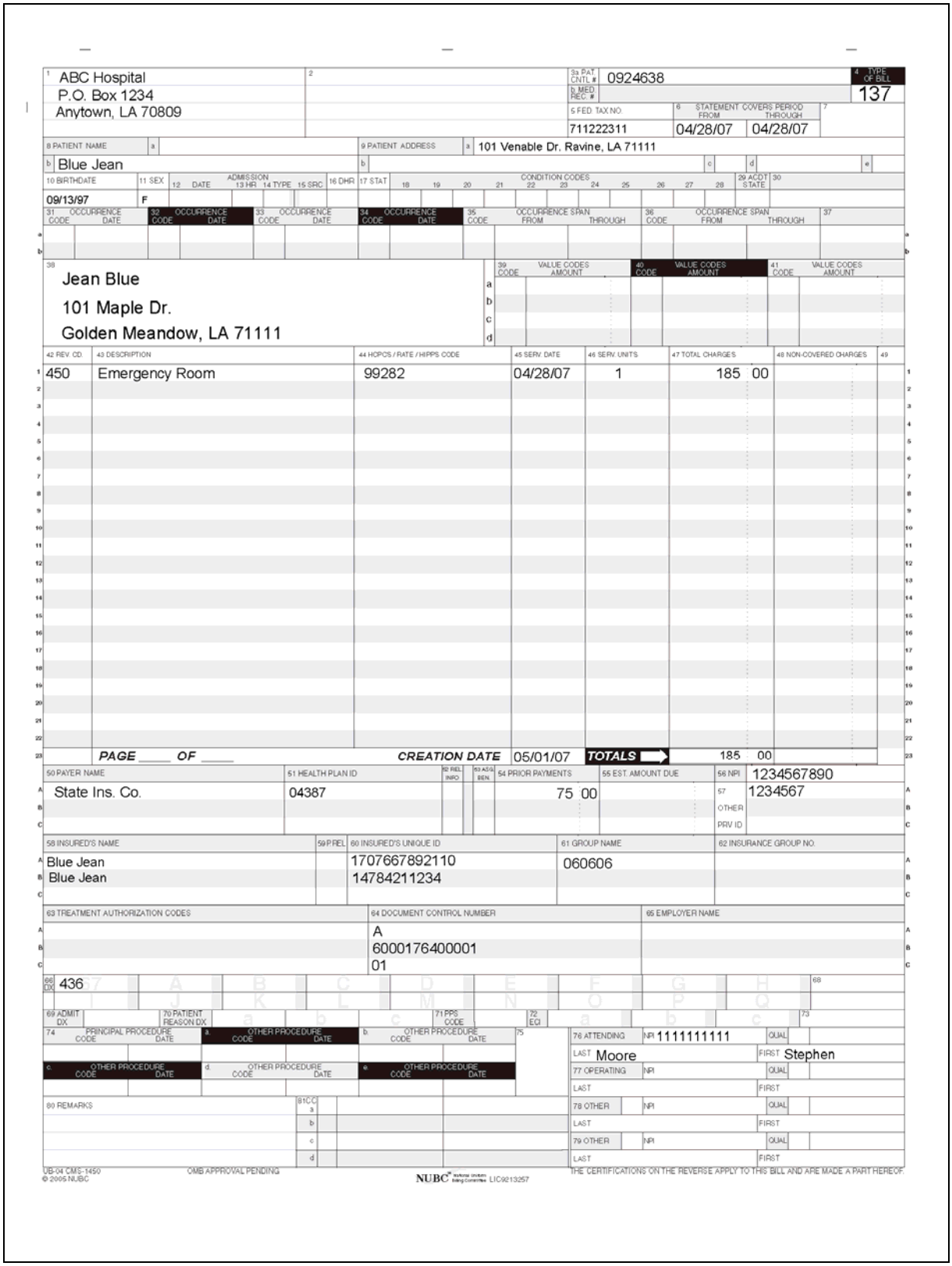
76 ATTENDING NPI 5115115110 QUAL 1322222
LAST Doe FIRST Dave
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
Medicare Part B only
Billing Days x Per diem

81 CC
a
b
c
d

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Adjustment/Void



1 ABC Hospital
P.O. Box 1234
Anytown, LA 70809

3a PAT CNTL # 0924638
4 TYPE OF BILL 137
5 FED. TAX NO. 711222311
6 STATEMENT COVERS PERIOD FROM 04/28/07 THROUGH 04/28/07

8 PATIENT NAME: Blue Jean
9 PATIENT ADDRESS: 101 Venable Dr. Ravine, LA 71111
10 BIRTHDATE: 09/13/97
11 SEX: F

38: Jean Blue
101 Maple Dr.
Golden Meandow, LA 71111

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
450	Emergency Room	99282	04/28/07	1	185 00	
	PAGE ____ OF ____	CREATION DATE	05/01/07	TOTALS	185 00	

50 PAYER NAME: State Ins. Co.
51 HEALTH PLAN ID: 04387
54 PRIOR PAYMENTS: 75 00
56 NPI: 1234567890
57 OTHER PRV ID: 1234567

58 INSURED'S NAME: Blue Jean / Blue Jean
60 INSURED'S UNIQUE ID: 1707667892110 / 14784211234
61 GROUP NAME: 060606

64 DOCUMENT CONTROL NUMBER: A / 6000176400001 / 01

66 DX: 436

76 ATTENDING NPI 1111111111 LAST Moore FIRST Stephen

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HOSPICE SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR HOSPICE PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: a. First digit-type facility 8 = Special facility (hospice) b. Second digit-classification 1 = Hospice (Non-hospital based) 2 = Hospice (Hospital based) c. Third digit-frequency 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates. **Note: Do not show days before the patient's entitlement began.** **Note: A claim may not span more than one month of service at a time.**	

Locator #	Description	Instructions	Alerts
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required.** Enter the admission date in MMDDYY format, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the From date in the Statement Covers Period (Form Locator 6). The date of admission may not precede the physician's certification by more than two calendar days. **Note: If the Notice of Election form and the Certification of Terminal Illness are not received within 10 calendar**	**Formerly entered in UB-92 Form Locator 17.**

Locator #	Description	Instructions	Alerts
		days, the date of admission (election) will be the date that BHSF receives the proper documentation.	
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	
17	Patient Status	**Required.** Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). Valid Codes 01 = Discharged to home or self care (routine discharge) 30 = Still patient or expected to return for outpatient services. 40 = Expired at home. 41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice. 42 = Expired – place unknown	**Formerly entered in UB-92 Form Locator 22.**
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Required.** Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MMDDYY). If there are more occurrences than there are spaces on the form, use Form Locators 35 and 36 (Occurrence Spans) to record additional occurrences and dates. Use the following codes where appropriate: **27 = Date of Hospice Certification**. Code indicates	**Formerly entered in UB-92 Form Locators 32-35.**

Locator #	Description	Instructions	Alerts
		the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject. Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date. **42 = Termination date**. Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)	
35-36	Occurrence Spans (Code and Dates)	**Situational.** If a specific event relating to this billing period should be indicated, then enter the code(s) and associated beginning and ending date(s). Event codes are two alphanumeric characters, and dates are shown numerically as MMDDYY. Use the following code when appropriate: **M2 = Dates of Inpatient Respite Care**. Code indicates	**Formerly entered in UB-92 Form Locators 36.**

Locator #	Description	Instructions	Alerts
		From/Through dates of a period of inpatient respite care for hospice patients.	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required.** Enter the appropriate Value Code(s). Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state codes for each service are required for correct claim payment. Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of "a" codes is used before entering information in "b" codes.) Enter value code 61 in the "code" section of the field; the MSA code/rural state code in the dollar portion of the "amount" section of the field; and double zeros (00) in the "cents" portion of the "amount" section of the field. Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Form Locators 42 and 45.) **Note: Medicaid will continue to reimburse based on MSA**	**Covered days are now reported with Value Code 80. Entry of covered days is not required on your claim form for Medicaid Services.** **If your system is programmed to enter Covered Days, they must be entered AFTER the MSA Value Codes.** **Value Code 80 must be entered in the Code portion of the field, and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.**

Locator #	Description	Instructions	Alerts
		Codes and will not use the Core Based Statistical Area (CSBA) Codes that Medicare has implemented. Please use the appropriate MSA codes.	
42	Revenue Code	**Required**. Enter a revenue code for each service. Revenue codes must be listed vertically in ascending order. If there is more than one (1) occurrence of any hospice service during the billing period, list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.) Example: 651 Routine Home Care 07/01/05 651 Routine Home Care 07/08/05 652 Continuous Home Care 07/06/05 656 General Inpatient Care 07/31/05 Use these revenue codes to bill Medicaid: 651 = Routine Home Care (RTN Home) 652 = Continuous Home Care (CTNS Home – a minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.) 655 = Inpatient Respite Care (IP Respite) 656 = General Inpatient Care (GNP IP) 657 = Physician Services (PHY Ser – must be accompanied by a physician procedure code) **Note: Revenue code 001 (Total Charges) MUST always be the final revenue code.**	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	

Locator #	Description	Instructions	Alerts
44	HCPCS/Rates HIPPS Code	**Situational.** When using Revenue Code 657 (Physician Services), entry of appropriate Procedure Code(s) is **required**. Procedure Codes should be obtained from the physician providing the service in order for the intermediary to make reasonable charge determinations when paying for Physician Services.	
45	Service Date	**Required.** Enter the appropriate service date (MMDDYY) for each service. The service date must be the first date that a service began. Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42). For example: Routine care is provided beginning the first day of the month of service for five days; then the patient has continuous care beginning the sixth day of the month for two days, followed by routine care again for the eighth day through the 30th day of the month. The revenue code for routine care must be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eighth day of the month.	

Locator #	Description	Instructions	Alerts
		Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter the number of units of service for each type of service on the line adjacent to the Revenue Code, Description, and Service Date. RC 651 is measured in DAYS. RC 652 is measured in HOURS. (Remember that a minimum of 8 hours – not necessarily consecutive – in a 24-hour period is required. Less than 8 hours is considered routine care.) RC 655 is measured in DAYS. RR 656 is measured in DAYS. RC 657 is measured in NUMBER OF PROCEDURES. PLEASE BE SURE THAT THE UNITS AND DATES BILLED FOR EACH OCCURRENCE CORRESPOND.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes. Must be numeric. (Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue Code 001 in Form Locator 42.)	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0 00’ in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI FIELD	**Required.** Enter the provider’s National Provider Identifier.	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be**

Locator #	Description	Instructions	Alerts
			entered here.
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	

Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal**

Locator #	Description	Instructions	Alerts
		Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis for the terminal illness. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**

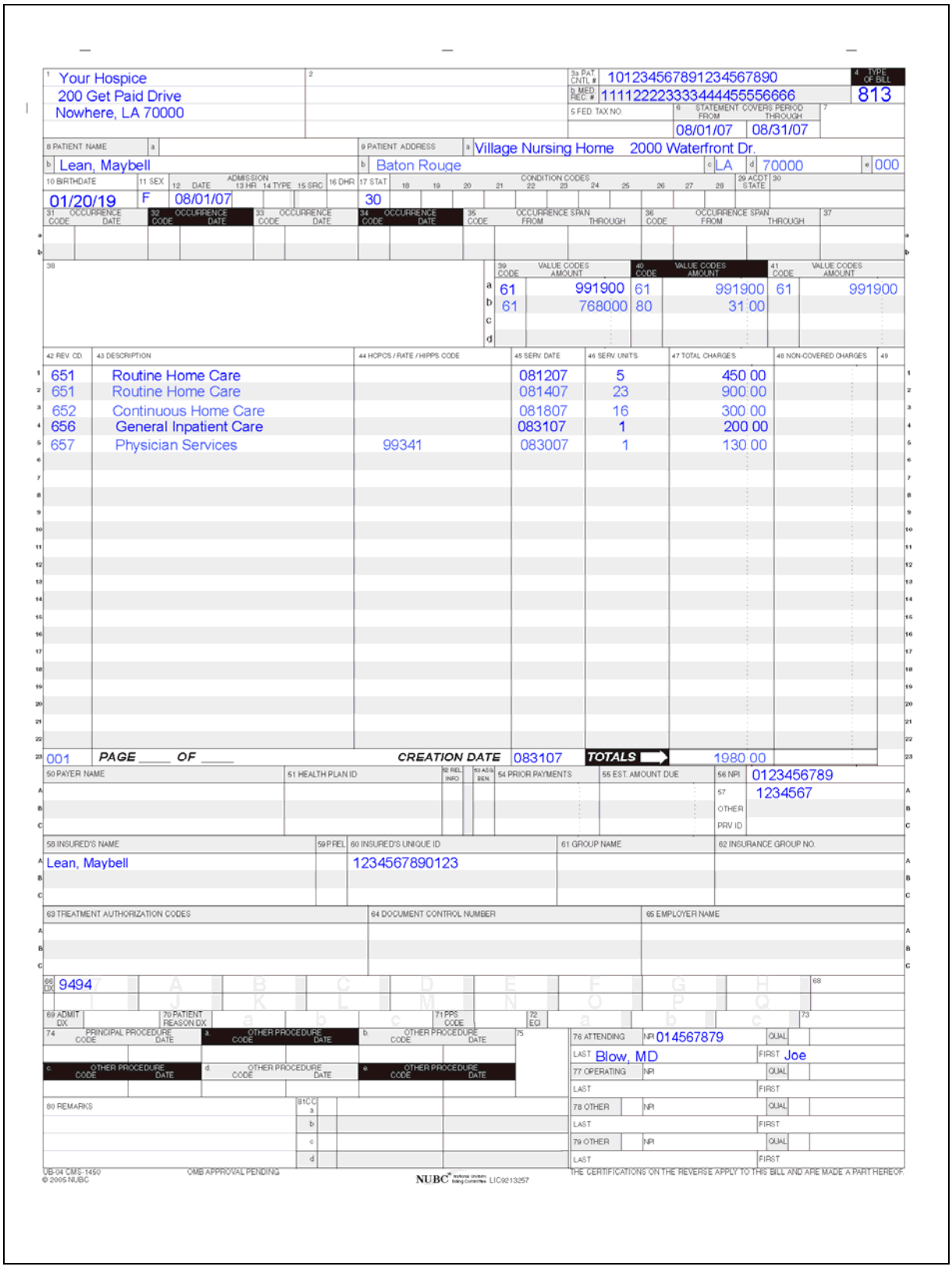
Locator #	Description	Instructions	Alerts
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code for the terminal illness.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Required**. Enter the name and/or the 7-digit Medicaid Provider identification number of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.	**Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.**
77	Operating	**Leave blank.**	
78	Other	**Required.** Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Form Locator 76 is an employee of the hospice agency. If the attending physician volunteers for the hospice, he or she is considered an employee.	**Formerly entered in UB-92 Form Locator 83.**
79	Other	**Leave blank**.	

Locator #	Description	Instructions	Alerts
80	Remarks	**Required**. Enter the signature of the appropriate person at the facility who is authorized to submit Medicaid claims (stamped signatures must be initialed). A hospice representative verifies that the required physician's certification and a signed hospice election statement are in the records before signing the form. **Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

A hospice representative must verify that the required physicians' certification and a signed hospice election statement are in the records.

UB04 SAMPLE FOR HOSPICE



1 Your Hospice
200 Get Paid Drive
Nowhere, LA 70000

2

3a PAT CNTL # 10123456789123456789
b MED REC # 11112222333344445555666
4 TYPE OF BILL 813
5 FED TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/01/07 THROUGH 08/31/07
7

8 PATIENT NAME a b Lean, Maybell
9 PATIENT ADDRESS a Village Nursing Home 2000 Waterfront Dr. b Baton Rouge c LA d 70000 e 000
10 BIRTHDATE 01/20/19
11 SEX F
12 ADMISSION DATE 08/01/07
13 HR 14 TYPE 15 SRC
16 DHR
17 STAT 30
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

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

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	991900	61	991900	61	991900
b	61	768000	80	31 00		
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	651	Routine Home Care		081207	5	450 00		
2	651	Routine Home Care		081407	23	900 00		
3	652	Continuous Home Care		081807	16	300 00		
4	656	General Inpatient Care		083107	1	200 00		
5	657	Physician Services	99341	083007	1	130 00		
23	001	PAGE ____ OF ____	CREATION DATE	083107	TOTALS	1980 00		

50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 0123456789
57 OTHER 1234567
PRV ID

58 INSURED'S NAME Lean, Maybell
59 P REL
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9494
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 014567879 QUAL
LAST Blow, MD FIRST Joe
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

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OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HOME HEALTH SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR HOME HEALTH PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: a. First digit-type facility 3 = Home Health b. Second digit-classification 3 = Outpatient c. Third digit-frequency 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates.	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility	**Formerly entered in UB-92 Form Locator 12.**

Locator #	Description	Instructions	Alerts
		card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Required.** Enter the source of admission: 1 = Physician Referral B = Transfer from another home health agency	**Formerly entered in UB-92 Form Locator 20.**
16	Discharge Hour	**Leave blank.**	
17	Patient Status	**Required.** Enter the appropriate 2-digit Patient Status Code, as follows: 01 = Discharged to home or self care (routine discharge) 04 = Discharged to an Intermediate Care Facility (ICF) 07 = Discontinued care 20 = Expired	**Formerly entered in UB-92 Form Locator 22.**

Locator #	Description	Instructions	Alerts
		30 = Still a patient	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Situational.** Enter the 2-digit alphanumeric code and date if applicable: 01 = Auto accident 02 = No fault insurance involved 03 = Accident/tort liability 04 = Accident/employment related 05 = Other accident 06 = Crime victim 24 = Date insurance denied 25 = Date benefits terminated by primary payer	**Formerly entered in UB-92 Form Locators 32-35.**
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Leave blank.**	
39-41	Value Codes and Amounts	**Situational**. Enter a 2-digit alphanumeric Value Code if appropriate.	
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. 420 = Physical Therapy – general 421 = Physical Therapy – Visit charge 424 = Physical Therapy – evaluation 430 = Occupational Therapy – general 431 = Occupational Therapy – Visit charge 434 = Occupational Therapy – evaluation 440 = Speech/Language Path – general 441 = Speech/Language Path –	

Locator #	Description	Instructions	Alerts
		Visit charge 444 = Speech/Language – evaluation 550 = HH – Skilled Nurse –other 551 = HH – Skilled Nurse – visit 552 = HH - Skilled Nurse – hourly 570 = Aide – general 571 = Aide - visit 580 = HH – other – general 581 = HH – other - visit 582 = HH – other – hourly	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	**Required.** Enter the appropriate 5-character alphanumeric Procedure Code **followed by the appropriate modifier if applicable**: <u>Procedure Codes</u> G0154 = Skilled Nurse HH setting; (15) minutes G0156 = Services of HH Aide in HH setting G0151 = Services of Physical Therapy in HH setting; (15) minutes G0152 = Services of Occupational Therapy in HH setting; (15) minutes G0153 = Speech/Language path. In HH setting; (15) minutes S9123 = Nurse care in home: RN S9124 = Nurse care in home: LPN <u>Modifiers</u> TD = RN TE = LPN TT = Multiple Recipients UD = Wheelchair Seating	**Modifiers were formerly entered in UB-92 Form Locator 49.**

Locator #	Description	Instructions	Alerts
		Evaluation **Note: Although the CPT code book indicates 15min. is equal to one (1) unit for procedure codes G0154 and G0156, per Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.**	
45	Service Date	**Required.** Enter the appropriate service date (MMDDYY) for each service. **Required.** Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter the appropriate unit(s) for all services.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes. Must be numeric.	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	

Locator #	Description	Instructions	Alerts
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B	

Locator #	Description	Instructions	Alerts
		and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	

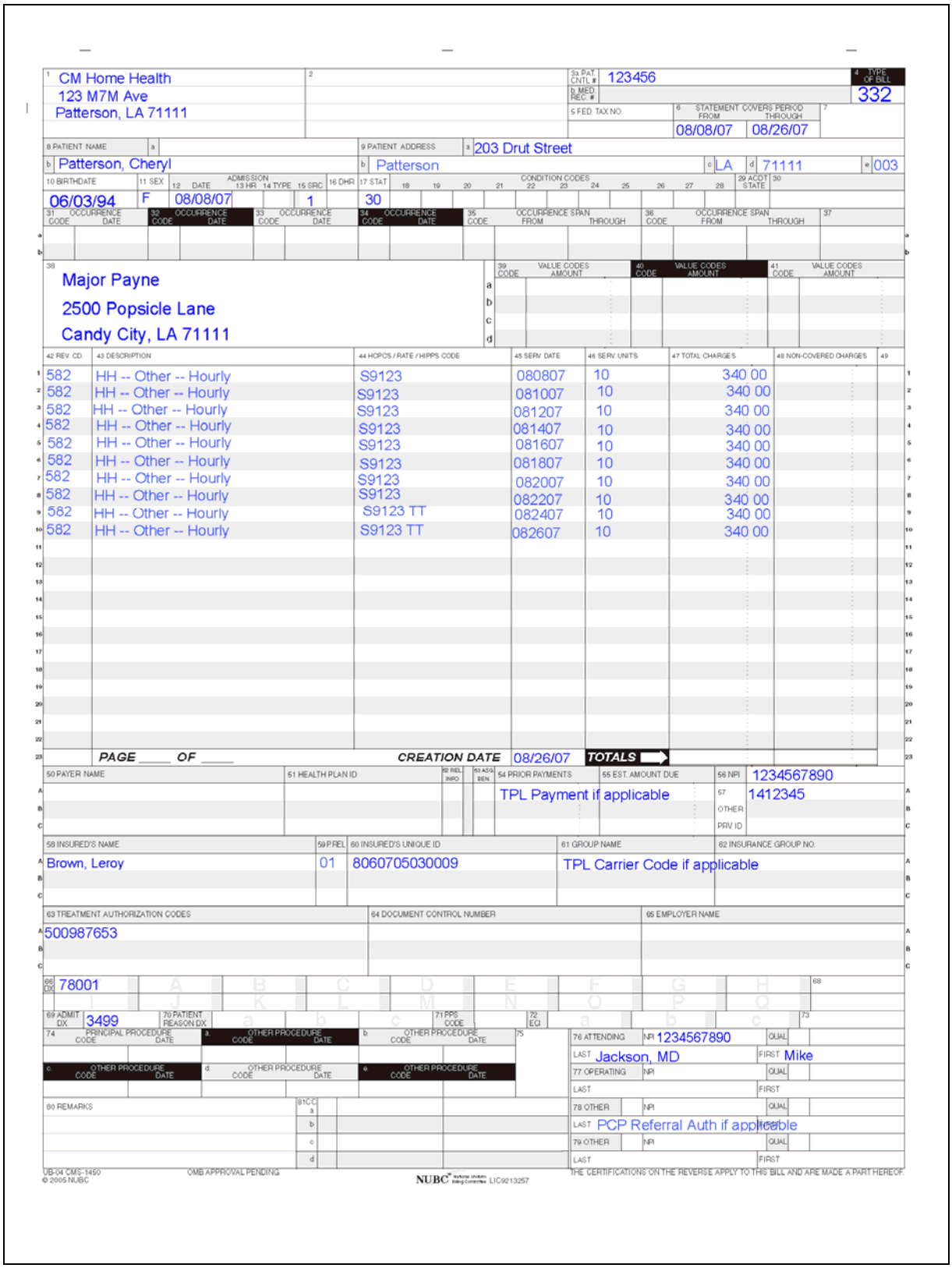
Locator #	Description	Instructions	Alerts
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Situational.** Enter the 9-digit Prior Authorization number if required for services on the claim in 63A. If the services require a CommunityCARE PCP referral authorization number, enter the PCP 7-digit Medicaid referral authorization number or the unique electronic 9-digit referral authorization number (assigned through e-RA) in 63C, as appropriate.	**The CommunityCARE Referral Authorization Number was formerly entered in Form Locator 83A of the UB-92.**

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Required.** Enter '5' to indicate HCPCS (HCFA Common Procedure Coding System)	**Formerly entered in UB-92 Form Locator 79.**

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis which necessitated Home Health services **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.**	
70	Patient Reason for Visit	**Optional.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	

Locator #	Description	Instructions	Alerts
76	Attending	**Required**. Enter the name and/or 7-digit Medicaid provider number of the physician ordering the plan of care.	**Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.**
77	Operating	**Leave blank.**	
78	Other	**Leave blank.**	**CommunityCARE referral authorization number, formerly entered in 83A (Other Physician) of the UB-92, has been moved to Form Locator 63C of the UB-04.**
79	Other	**Leave blank**.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	
Signature is not required on the UB-04.			

SAMPLE UB04 FOR HOME HEALTH



1	2	3a PAT CNTL #	4 TYPE OF BILL
CM Home Health 123 M7M Ave Patterson, LA 71111		123456 b MED REC #	332
		5 FED TAX NO.	6 STATEMENT COVERS PERIOD FROM 08/08/07 THROUGH 08/26/07

8 PATIENT NAME	9 PATIENT ADDRESS
a b Patterson, Cheryl	a 203 Drut Street b Patterson c LA d 71111 e 003

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
06/03/94	F	08/08/07			1		30			

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

38
Major Payne
2500 Popsicle Lane
Candy City, LA 71111

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	582	HH -- Other -- Hourly	S9123	080807	10	340 00		1
2	582	HH -- Other -- Hourly	S9123	081007	10	340 00		2
3	582	HH -- Other -- Hourly	S9123	081207	10	340 00		3
4	582	HH -- Other -- Hourly	S9123	081407	10	340 00		4
5	582	HH -- Other -- Hourly	S9123	081607	10	340 00		5
6	582	HH -- Other -- Hourly	S9123	081807	10	340 00		6
7	582	HH -- Other -- Hourly	S9123	082007	10	340 00		7
8	582	HH -- Other -- Hourly	S9123	082207	10	340 00		8
9	582	HH -- Other -- Hourly	S9123 TT	082407	10	340 00		9
10	582	HH -- Other -- Hourly	S9123 TT	082607	10	340 00		10
11-22								
23		PAGE ____ OF ____	CREATION DATE	08/26/07	TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A				TPL Payment if applicable		1234567890	1412345
B							
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Brown, Leroy	01	8060705030009	TPL Carrier Code if applicable	
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 500987653		
B		
C		

66 DX: 78001 (A B C D E F G H I J K L M N O P Q) 67

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
3499	a b c		a b c	

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

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

76 ATTENDING	NPI 1234567890	QUAL
LAST Jackson, MD	FIRST Mike	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST PCP Referral Auth if applicable	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS	81 CC
	a
	b
	c
	d

UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC National Uniform Billing Committee LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HEMODIALYSIS SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR HEMODIALYSIS PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: a. First digit-type facility 7 b. Second digit-classification 2 = Inpatient Medicaid and Medicare Part B only c. Third digit-frequency 1 = Admission through discharge 7 = Replacement of prior claim 8 = Void of prior claim That is, 721 for claims, 727 for adjustments, 728 for voids.	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates.	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility	**Formerly entered in UB-92 Form Locator 12.**

Locator #	Description	Instructions	Alerts
		card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	
17	Patient Status	**Leave blank.**	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Leave blank.**	
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	**Required**. Enter the following value codes when billing for Epogen (EPO): 49 = Hematocrit Reading – Enter the patient's hematocrit reading to justify administering more than 10,000 units of EPO. Enter 49 in the "Code" field. Enter the hematocrit reading in the "Amount" field, right justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field. 68 = EPO Drug – Enter the total number of units of EPO administered and/or supplied relating to the billing period. Enter 68 in the "Code" field. Enter the total number of EPO units administered in the "Amount" field. Report amount in whole units right-justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field. **No other value codes are required for processing Hemodialysis claims; if optional codes are entered, they must be entered after 49 and 68, above.**	**When billing for EPO, providers must enter Value Codes 49 and 68 first in the Value Code fields; other Value Codes are optional, and if they are entered, they must be entered below 49 and 68.** **Covered days are not required but are now reported with Value Code 80, which if entered must be AFTER Value Codes 49 and 68. If your system is programmed to enter Covered Days, Value Code 80 must be entered in the Code portion of the field, and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.**

Locator #	Description	Instructions	Alerts
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Codes must be valid. Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42. When billing for EPO, enter the total number of EPO units to the right of the description.	
44	HCPCS/Rates HIPPS Code	**Required.** Enter the appropriate 5-digit Procedure Code.	
45	Service Date	**Required.** Enter the appropriate service date (MMDDYY) for each service. **Required.** Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter "1" as the quantity for EPO service line. Enter the appropriate unit(s) for all other services.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes. (Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue Code 001 in Form Locator 42.)	

Locator #	Description	Instructions	Alerts
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0 00’ in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI FIELD	**Required.** Enter the provider’s National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**

Locator #	Description	Instructions	Alerts
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent	

Locator #	Description	Instructions	Alerts
		18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Required**. Enter the name and/or number of the attending physician.	**Attending physician name and/or number was**

Locator #	Description	Instructions	Alerts
			formerly entered in Form Locator 82 of the UB-92.
77	Operating	**Leave blank.**	
78	Other	**Leave blank.**	
79	Other	**Leave blank**.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

UB04 SAMPLE FOR HEMODIALYSIS

1	Dialysis Provider 123 Help Lane Dreamcity, LA 70000
3a PAT. CNTL #	A230924638897174567
b. MED. REC. #	1111122222333344455556666
4 TYPE OF BILL	721
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	08/01/07 / 08/05/07
8 PATIENT NAME	b Payne, Major
9 PATIENT ADDRESS	a 2500 Popsicle Lane b Candy City c LA d 71111
10 BIRTHDATE	06/12/12
11 SEX	F
12 ADMISSION DATE	01/01/96
38	Major Payne 2500 Popsicle Lane Candy City, LA 71111

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	49	30 00	68	3720000		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	635	EPO 12400 Units		080107	1	124 00		
2	635	EPO 12400 Units		080307	1	124 00		
3	635	EPO 12400 Units		080507	1	124 00		
4	636	INFED 100 MG	J1760	080307	1	34 96		
5	821	TMT HIGH FLUX HEMO	90935	080107	1	127 19		
6	821	TMT HIGH FLUX HEMO	90935	080307	1	127 19		
7	821	TMT HIGH FLUX HEMO	90935	080507	1	127 19		
23	001	PAGE ___ OF ___	CREATION DATE	08/05/07	TOTALS	788 53		

56 NPI	1234567890
57 OTHER PRV ID	1234567
58 INSURED'S NAME	A Payne, Major
60 INSURED'S UNIQUE ID	0123456789012
66 DX	5850
69 ADMIT DX	40300
76 ATTENDING NPI	1234567890
LAST / FIRST	Moore, MD / Stephen

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

LTC SERVICES

UB04 Instructions

UB04 INSTRUCTIONS FOR LTC PROVIDERS

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility.	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: ***FOR NURSING FACILITY PROVIDERS:*** *1st Digit - Type of Facility* 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF Technology Dependent Care) (LOC = SNF Infectious Disease) (LOC = NF Rehab) (LOC = NF Complex Care) Skilled Nursing/ Intermediate Care (LOC = Case Mix)	

Locator #	Description	Instructions	Alerts
		2nd Digit – Classification 1 = Skilled Nursing – Inpatient ***FOR ICF/DD PROVIDERS:*** *1st Digit - Type of Facility* 6 = Intermediate Care (LOC = ICF/DD) *2nd Digit - Classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II ***FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:*** *1st Digit - Type of Facility* 8 = Special Facility (LOC = Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) ***FOR NURSING FACILITY, ICF/MR, AND ADHC PROVIDERS:*** *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment.	**2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by NUBC. Use 2nd Digit "1" instead.**

Locator #	Description	Instructions	Alerts
		3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**

Locator #	Description	Instructions	Alerts
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required.** This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure** 01 = Discharged to home or self care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 = Discharged/transferred to a long term care hospital	**Formerly entered in UB-92 Form Locator 22.** **Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**

Locator #	Description	Instructions	Alerts
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Leave blank.**	
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). *80 = Covered days 81 = Non-covered days 82 = Co-insurance days (required only for Medicare crossover claims) 83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field. ***No other value codes are required for processing LTC claims.**	**Formerly entered in Form Locator 7 of the UB-92. Covered Days is now reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.** **Please read the instructions carefully for entering the new number of days information in the Value Code fields.**
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the	

Locator #	Description	Instructions	Alerts
		LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: **FOR ALL PROVIDERS (Excluding ADHC Providers):** <u>Revenue Code & Description Leave of Absence</u> 183 = Leave of Absence – Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence – Subcategory Nursing Home (for Hospitalization) **FOR NURSING FACILITY PROVIDERS**: <u>Revenue Code & Description *(Corresponding Level of Care)*</u> 022 = Skilled Nursing Facility Prospective Payment System (RUGS) *(88 = Case Mix -- Formerly LOC 20, 21, 22)* 118 = Room & Board-Private Subacute Rehabilitation *(31 = NF Rehabilitation* *20 = SNF/Hospice in Nursing Facility* *21 = ICF I/Hospice in Nursing Facility* *22 = ICF II)* 193 = Subacute Care Level III (Complex Care) *(32 = NF Complex Care)*	

Locator #	Description	Instructions	Alerts
		194 = Subacute Care Level IV *(28 = SNF Technology Dependent Care)* 199 = Other Subacute Care *(30 = SNF Infectious Disease)* **FOR ICF-DD PROVIDERS**: Revenue Code & Description *(Corresponding Level of Care)* **ICAP Revenue codes to be used for dates of service October 1, 2005 and forward:** 193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39 191 = Limited Level of Care (ICAP Score 40-69) 190 = Intermittent Level of Care (ICAP Score 70-99) **NOTE:** Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file. **FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:** Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	

Locator #	Description	Instructions	Alerts
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	**Leave blank.**	
45	Service Date	**Required.** Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 6 – 12, the Service Date should be entered 07-12, -- **If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).** **Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service.**	

Locator #	Description	Instructions	Alerts
		Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of Care revenue code, description, and service date. Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. **Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the from and to days in Form Locator 45.** Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank. **Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.**	
47	Total Charges	**Leave blank.**	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0 00’ in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI FIELD	**Required.** Enter the provider’s National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**

Locator #	Description	Instructions	Alerts
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent	

Locator #	Description	Instructions	Alerts
		17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.**

Locator #	Description	Instructions	Alerts
		Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim.	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**

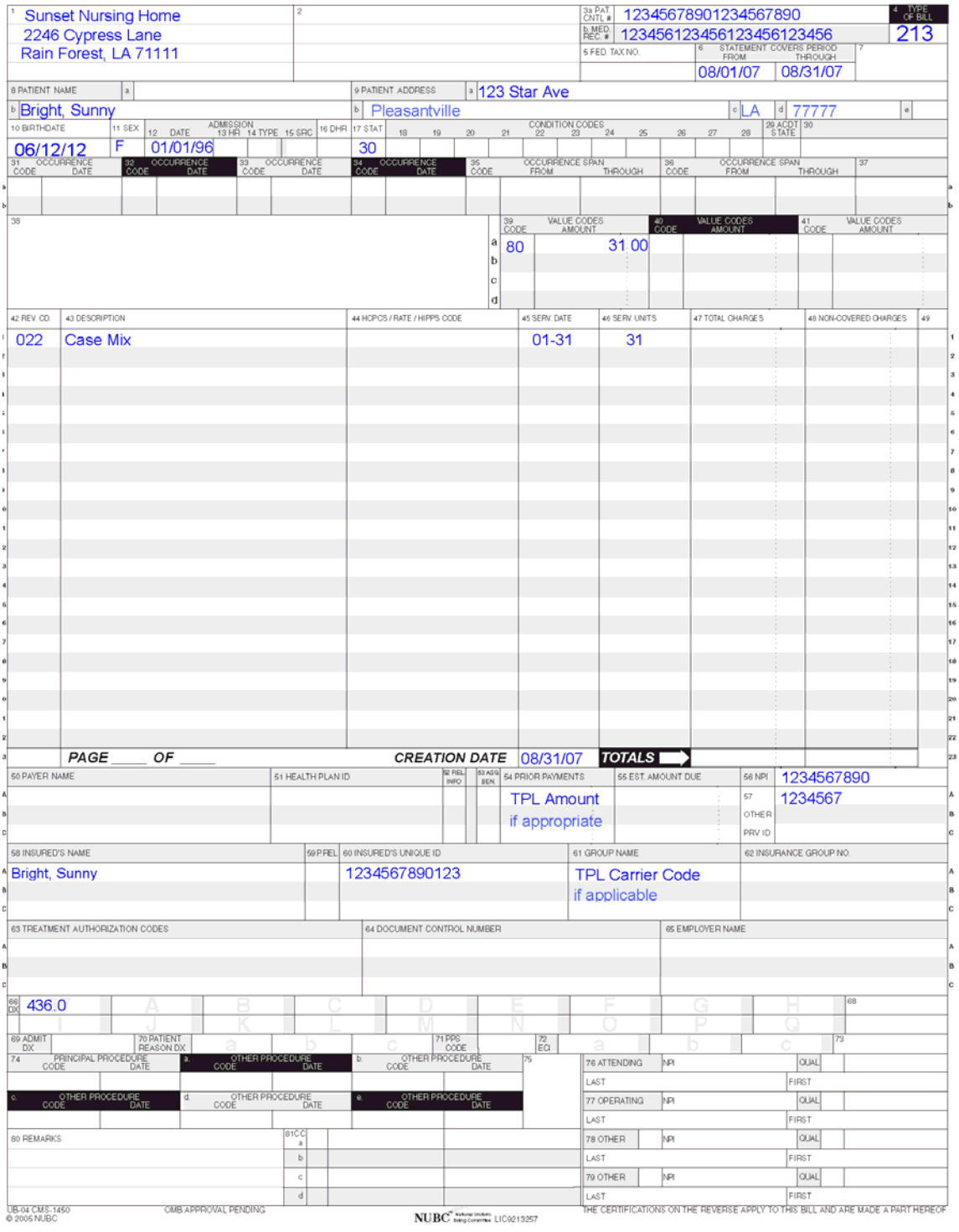
Locator #	Description	Instructions	Alerts
		Note: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Leave blank.**	
77	Operating	**Leave blank.**	
78	Other	**Leave blank.**	
79	Other	**Leave blank**.	

Locator #	Description	Instructions	Alerts
80	Remarks	**Situational.** Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

UB04 SAMPLES FOR LTC

Nursing Facility



1 Sunset Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111

3a PAT CNTL # 12345678901234567890
b MED REC # 12345612345612345612345
4 TYPE OF BILL 213
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/01/07 THROUGH 08/31/07

8 PATIENT NAME: b Bright, Sunny
9 PATIENT ADDRESS: a 123 Star Ave; b Pleasantville; c LA; d 77777

10 BIRTHDATE: 06/12/12
11 SEX: F
12 ADMISSION DATE: 01/01/96
17 STAT: 30

38

39 VALUE CODES CODE AMOUNT: a 80 31.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
022	Case Mix		01-31	31		

PAGE ____ OF ____ CREATION DATE 08/31/07 TOTALS

50 PAYER NAME
51 HEALTH PLAN ID
54 PRIOR PAYMENTS: TPL Amount if appropriate
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME: Bright, Sunny
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL Carrier Code if applicable
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 436.0

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

80 REMARKS

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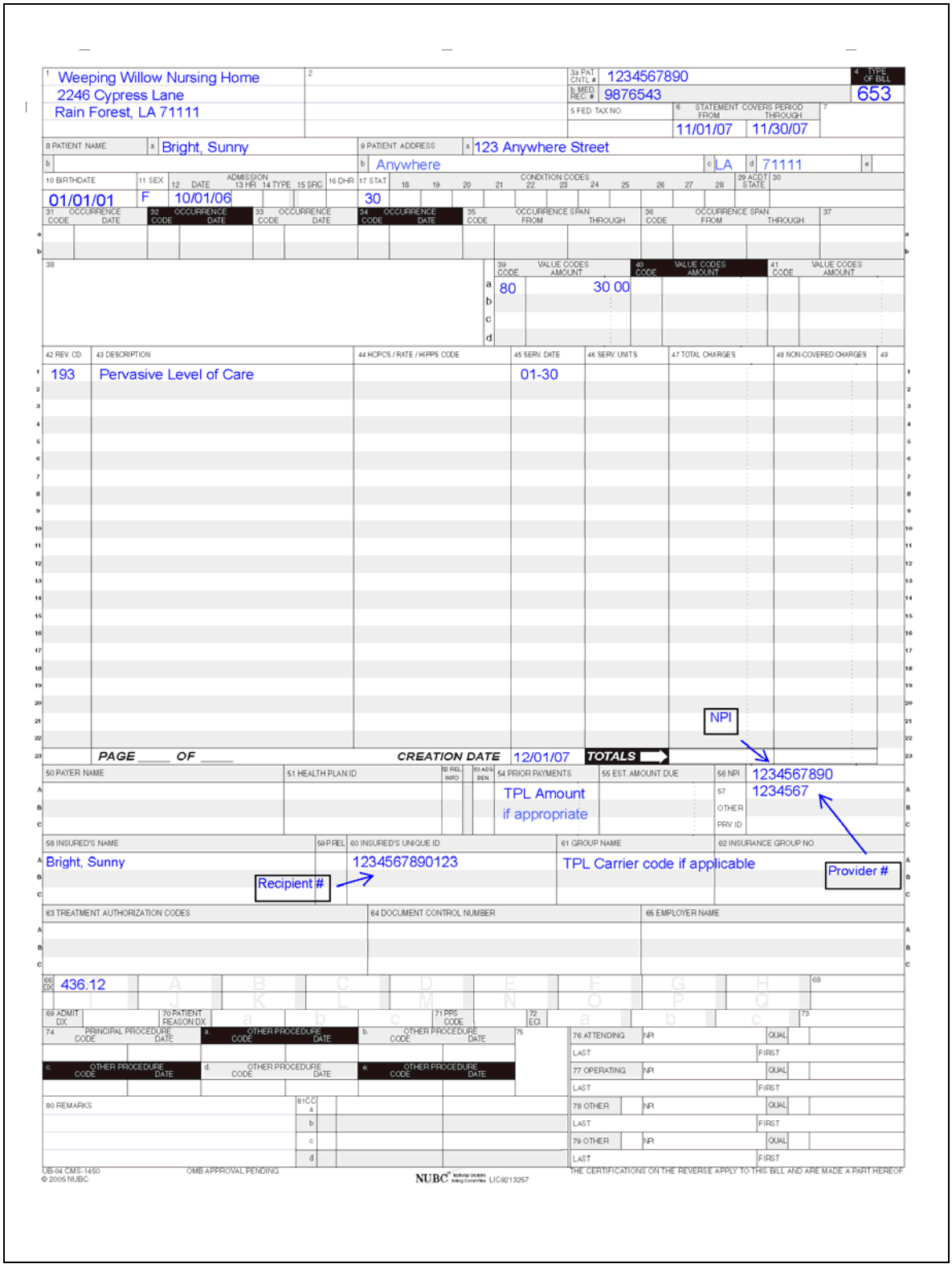
ICF-DD


1 Weeping Willow Nursing Home
2246 Cypress Lane
Rain Forest, LA 71111
3a PAT. CNTL # 1234567890
b MED. REC. # 9876543
4 TYPE OF BILL 653
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 11/01/07 THROUGH 11/30/07
8 PATIENT NAME a Bright, Sunny
9 PATIENT ADDRESS a 123 Anywhere Street
b Anywhere
c LA
d 71111
10 BIRTHDATE 01/01/01
11 SEX F
12 ADMISSION DATE 10/01/06
17 STAT 30
39 VALUE CODES CODE 80 AMOUNT 30 00
42 REV. CD. 193
43 DESCRIPTION Pervasive Level of Care
45 SERV. DATE 01-30
PAGE ____ OF ____
CREATION DATE 12/01/07
TOTALS
NPI
50 PAYER NAME
51 HEALTH PLAN ID
54 PRIOR PAYMENTS
TPL Amount if appropriate
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID 1234567
58 INSURED'S NAME Bright, Sunny
60 INSURED'S UNIQUE ID 1234567890123
Recipient #
61 GROUP NAME TPL Carrier code if applicable
62 INSURANCE GROUP NO.
Provider #
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX 436.12
76 ATTENDING
77 OPERATING
78 OTHER
79 OTHER
80 REMARKS
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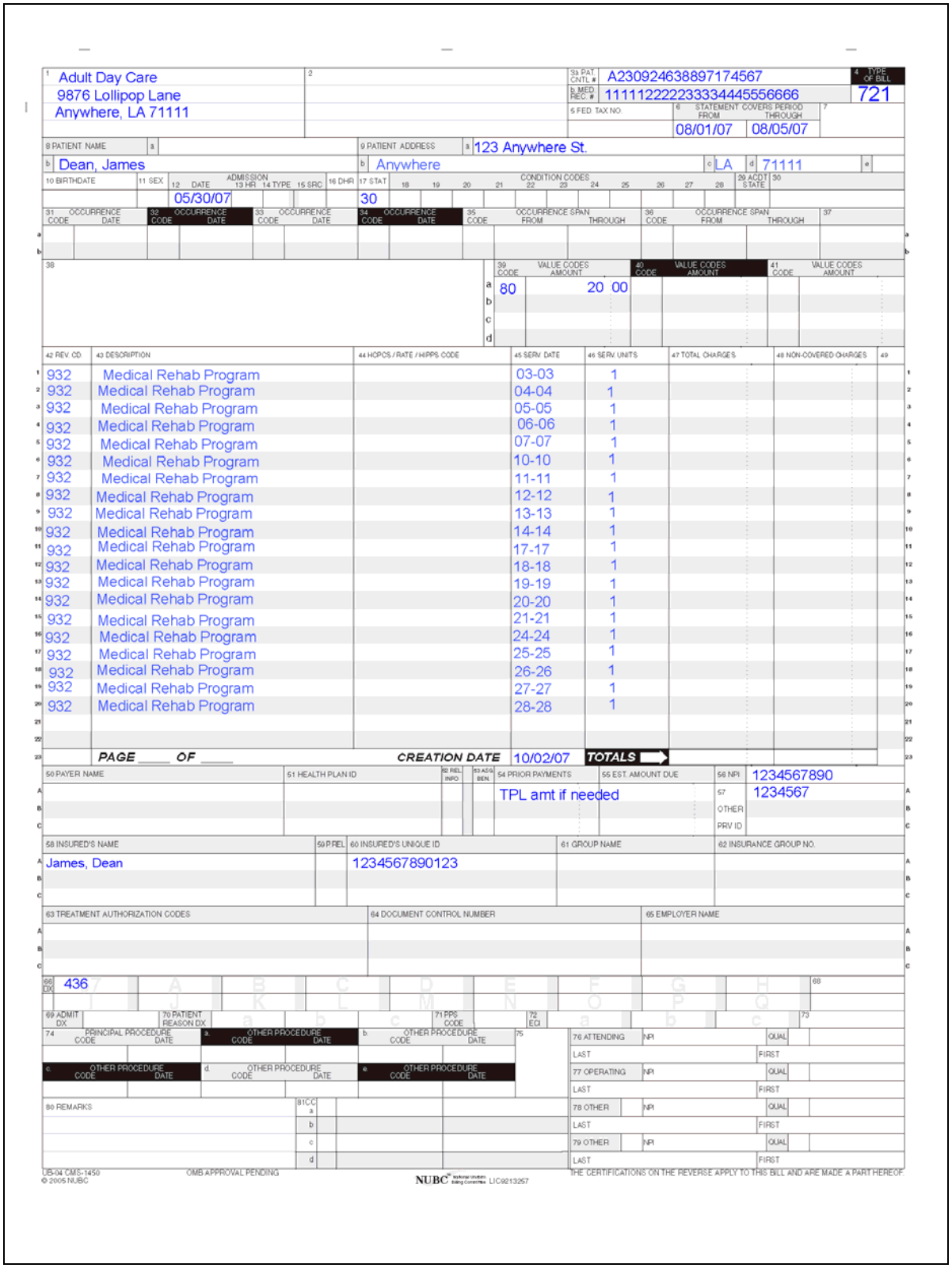
NUBC LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ADHC



1 Adult Day Care
9876 Lollipop Lane
Anywhere, LA 71111

3a PAT. CNTL # A230924638897174567
b MED REC. # 11111222223333444555666 6
4 TYPE OF BILL 721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/01/07 THROUGH 08/05/07

8 PATIENT NAME b Dean, James
9 PATIENT ADDRESS a 123 Anywhere St. b Anywhere c LA d 71111
10 BIRTHDATE
11 SEX
12 ADMISSION DATE 05/30/07
13 HR 14 TYPE 15 SRC
16 DHR
17 STAT 30
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE 30

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

38
39 VALUE CODES CODE AMOUNT a 80 20 00
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	932	Medical Rehab Program		03-03	1		
2	932	Medical Rehab Program		04-04	1		
3	932	Medical Rehab Program		05-05	1		
4	932	Medical Rehab Program		06-06	1		
5	932	Medical Rehab Program		07-07	1		
6	932	Medical Rehab Program		10-10	1		
7	932	Medical Rehab Program		11-11	1		
8	932	Medical Rehab Program		12-12	1		
9	932	Medical Rehab Program		13-13	1		
10	932	Medical Rehab Program		14-14	1		
11	932	Medical Rehab Program		17-17	1		
12	932	Medical Rehab Program		18-18	1		
13	932	Medical Rehab Program		19-19	1		
14	932	Medical Rehab Program		20-20	1		
15	932	Medical Rehab Program		21-21	1		
16	932	Medical Rehab Program		24-24	1		
17	932	Medical Rehab Program		25-25	1		
18	932	Medical Rehab Program		26-26	1		
19	932	Medical Rehab Program		27-27	1		
20	932	Medical Rehab Program		28-28	1		
21							
22							
23		PAGE ____ OF ____		CREATION DATE 10/02/07	TOTALS		

50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS TPL amt if needed
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME James, Dean
59 P REL
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 436
67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

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

80 REMARKS
81 CC a b c d

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NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

LIST OF FIELD ANALYSTS

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Jefferson Orleans Plaquemines	St. Bernard St. Tammany **(Slidell Only)**
Stacey Fairchild (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin **(below Iberia)** St. Mary Terrebonne Vermillion Beaumont (TX)
Tracey Guidroz (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany **(except Slidell**)	Washington Centerville (MS) McComb (MS) Woodville (MS)
Ursula Mercer (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)
Kelli Nolan (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin **(above Iberia)**
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us**.

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT					
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES					
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to question	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION:					

Do you have internet access in the workplace?_____

Do you use www.lamedicaid.com?_____

What topic was most beneficial to you?_____

Please provide us with your business email address:_____

Please provide constructive comments and suggestions:_____

_____

_____

_____

_____

_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040**