UB04 INSTRUCTIONS
END STAGE RENAL DISEASE

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 Number	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: a. First digit-type facility 7= Clinic or Hospital Based Renal Dialysis Facility b. Second digit-classification 2 = Hospital Based or Independent Renal Dialysis Facility 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.**	

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.	
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	
10	Patient's Birth date	**Required.** Enter the patient's date of birth using 6 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	
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.	
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.**	

Locator #	Description	Instructions	Alerts
37	Unlabeled	**Leave Blank.**	
38	Responsible Party Name and Address	**Optional.**	
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.**

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 for services other than physician-administered drugs.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42. **Required for physician-administered drugs.** Hemodialysis Claims reporting Epogen or other physician-administered drugs must contain the following: Report the N4 qualifier in the first two (2) positions, left-justified. Immediately following the N4 qualifier, report the 11 character National Drug Code number in the 5-4-2 format (no hyphens). Immediately following the last digit of the NDC (no delimiter), report the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows: F2 -International Unit GR-Gram ML-Milliliter UN- Unit Immediately following the Unit of Measurement Qualifier, report the unit quantity in **NDC**	**it is necessary for Hemodialysis claims to include NDC information for all physician-administered drugs identified with an alphanumeric HCPCS code and billed with Revenue Codes 634, 635, and 636.**

Locator #	Description	Instructions	Alerts
		UNITS with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal). Any spaces unused for the quantity are to be left blank. Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below. **N41234567890 1UN1234.567**	
44	HCPCS/Rates HIPPS Code HCPCS/CPT Code (Outpatient DX Lab)	**Required.** Enter the appropriate Five (5)-digit Procedure Code. **For physician-administered drug services:** Claims reporting Physician Administered Drugs identified with alphanumeric HCPCS codes must contain the following: Enter the corresponding HCPCS Code for the NDC reported in FL 43.	**Epogen must be reported using procedure code Q4081. No other HCPC codes will be accepted for Epogen.**
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.	

Locator #	Description	Instructions	Alerts
46	Units of Service	**Required.** Enter the appropriate unit(s) for the procedure code entered on the same line in FL 44.	**Hemodialysis providers should no longer enter "1" in the units of service field (FL 46) for EPO.** **The units of service for EPO (Q4081) must now be reported based on the HCPC code dosage description as is done with all other physician – administered drugs.** **For example:** **The HCPC code description for Q4081 is: Injection, Epoetin Alfa, 100 units (for ESRD on dialysis).** **If a provider administers 12,400 units of EPO on that date of service, then 124 should be entered as the service units in FL 46.**
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes.	
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**. If the patient is a Medically	

Locator #	Description	Instructions	Alerts
		Needy Spend-down recipient. 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**.	
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits	**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.	**Do not report Medicare or Medicare Replacement plan payments 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 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	

Locator #	Description	Instructions	Alerts
		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	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number 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.	**ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE**
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 a "7" for an adjustment or an "8" 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	**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.** **When claims for EPOGEN services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero.**

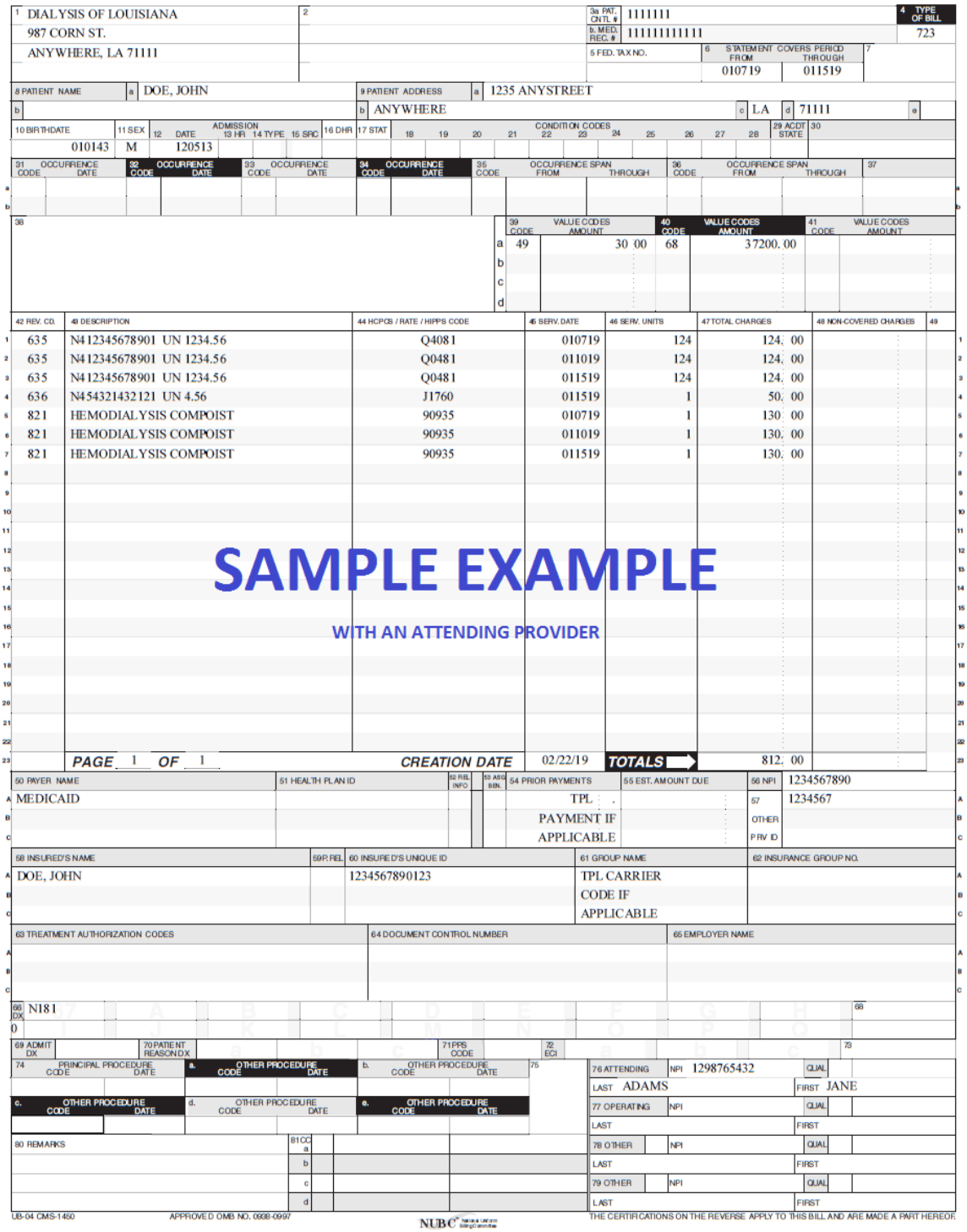
Locator #	Description	Instructions	Alerts
		Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**This does not allow providers to submit adjustments if the claims are paid incorrectly.** **Therefore, providers must submit a VOID and allow the successfully voided claim to process and appear on the remittance advice before re-submitting the corrected claim for processing.**
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 the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	
67 67 A-Q	Principal Diagnoses Codes Other Diagnosis code	**Required.** Enter the most current ICD diagnosis code **Situational.** Enter all other applicable ICD diagnoses code or codes for this claim. **NOTE:** **ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as <u>non-primary</u> diagnosis codes.**	The most specific diagnosis codes must be used. General codes are not acceptable. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).

Locator #	Description	Instructions	Alerts
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Situational**. If the claim is for inpatient services, enter the admitting Diagnosis Code.	**Refer to field locator 67.**
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 NPI number of the attending physician. Optional. Enter the taxonomy code of the attending physician behind the "QUAL" field.	**This field must be completed.** **The Attending provider name & NPI cannot be the billing provider.** **The individual attending provider information must be entered in this field.** **The Attending provider must be enrolled with LA Medicaid.**
77	Operating	**Leave blank.**	
78	Other	**Situational.** If applicable, enter the name and NPI Number of the referring provider or other physician.	**A referring provider is NOT required on the claim. However, if a referring provider is entered on the**

Locator #	Description	Instructions	Alerts
		Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier **DN**.	**claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider.** **The referring provider cannot be the billing provider. The individual referring provider information should be entered in this field.** **If entered, the Referring provider must be enrolled with LA Medicaid.**
79	Other	**Situational.** If applicable, enter the name and NPI number of any other physician.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

SAMPLE END STAGE RENAL DISEASE CLAIM FORM WITH AN ATTENDING PROVIDER ONLY



1 DIALYSIS OF LOUISIANA
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 723
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010719 THROUGH 011519

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE 010143 | 11 SEX M | 12 ADMISSION DATE 120513 | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 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	49	30.00	68	37200.00		
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	N412345678901 UN 1234.56	Q4081	010719	124	124.00		
2	635	N412345678901 UN 1234.56	Q0481	011019	124	124.00		
3	635	N412345678901 UN 1234.56	Q0481	011519	124	124.00		
4	636	N454321432121 UN 4.56	J1760	011519	1	50.00		
5	821	HEMODIALYSIS COMPOIST	90935	010719	1	130.00		
6	821	HEMODIALYSIS COMPOIST	90935	011019	1	130.00		
7	821	HEMODIALYSIS COMPOIST	90935	011519	1	130.00		
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21								
22								
23		PAGE 1 OF 1		CREATION DATE 02/22/19	TOTALS	812.00		

SAMPLE EXAMPLE

WITH AN ATTENDING PROVIDER

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
A	MEDICAID				TPL .		57	1234567
B					PAYMENT IF		OTHER	
C					APPLICABLE		PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN		1234567890123	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

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

66 DX N181
0

67 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z | 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 1298765432	QUAL	
	LAST ADAMS		FIRST JANE	
	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	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

SAMPLE END STAGE RENAL DISEASE CLAIM FORM WITH A REFERRING PROVIDER

1 DIALYSIS OF LOUISIANA
987 CORN ST.
ANYWHERE, LA 71111

2

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 723
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010319 THROUGH 011419
7

8 PATIENT NAME a DOE, JOHN
b
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111 e

10 BIRTHDATE 010143
11 SEX M
ADMISSION 12 DATE 120513 13 HR 14 TYPE 15 SRC
16 DHR 17 STAT
CONDITION CODES 18 19 20 21 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	49	30 00	68	37200. 00		
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	N412345678901 UN 1234.56	Q4081	010319	124	124. 00		
2	635	N412345678901 UN 1234.56	Q0481	010819	124	124. 00		
3	635	N412345678901 UN 1234.56	Q0481	011419	124	124. 00		
4	636	N454321432121 UN 4.56	J1760	010819	1	50. 00		
5	821	HEMODIALYSIS COMPOIST	90935	010319	1	130 00		
6	821	HEMODIALYSIS COMPOIST	90935	010819	1	130. 00		
7	821	HEMODIALYSIS COMPOIST	90935	011419	1	130. 00		
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10								
11								
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22								
23		PAGE 1 OF 1	CREATION DATE	02/01/2019	TOTALS	812. 00		

SAMPLE EXAMPLE

WITH AN ATTENDING PROVIDER
AND A REFERRING PROVIDER

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	MEDICAID				TPL .	
B					PAYMENT IF	
C					APPLICABLE	

56 NPI 1234567890
57 OTHER PRV ID 1234567

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN		1234567890123	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX N181
0
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 1298765432 QUAL
LAST ADAMS FIRST JANE

77 OPERATING NPI QUAL
LAST FIRST

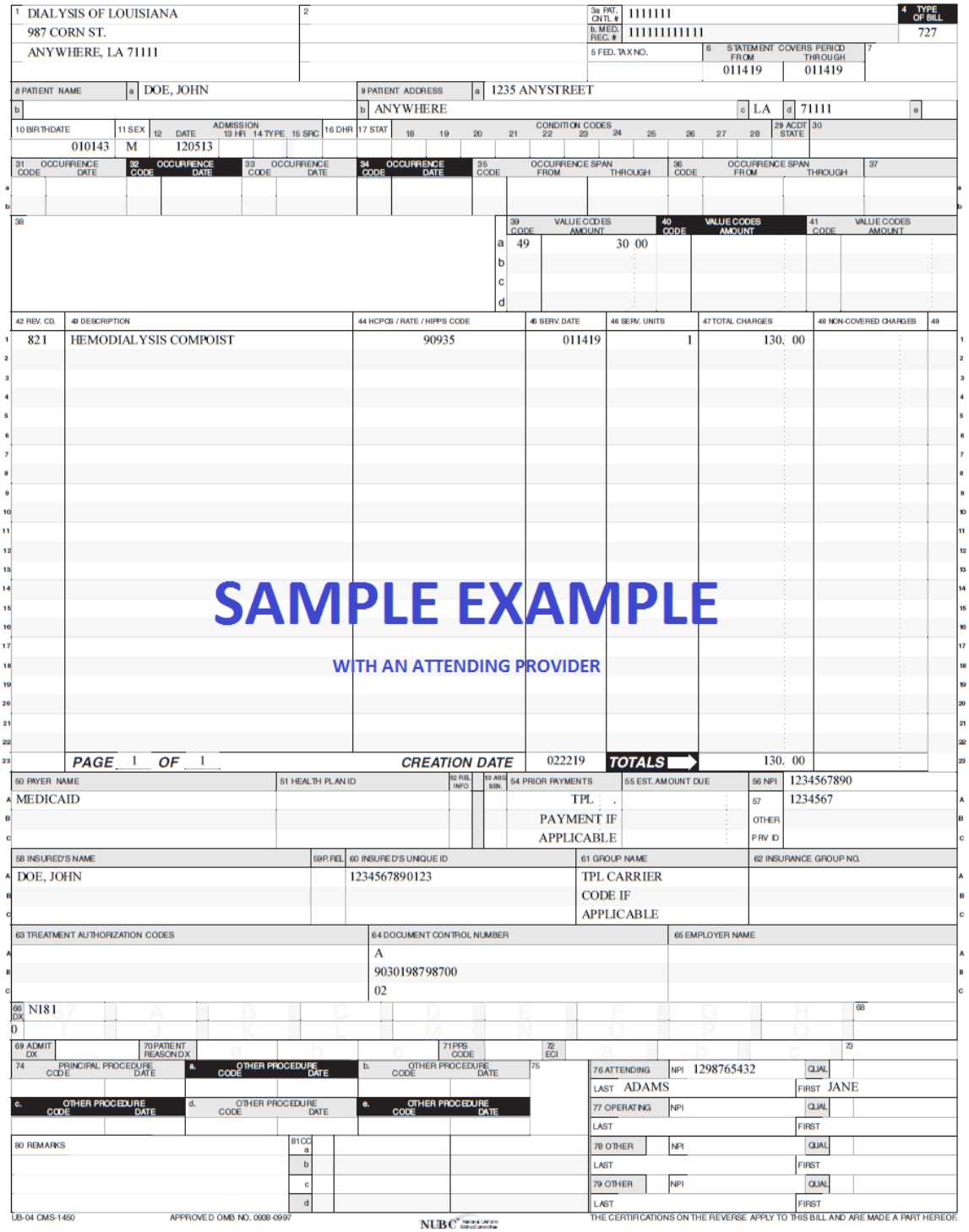
78 OTHER DN NPI 1589999999 QUAL
LAST DOE FIRST APRIL

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE END STAGE RENAL DISEASE CLAIM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY



1 DIALYSIS OF LOUISIANA
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 727
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 011419 THROUGH 011419

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE 010143 | 11 SEX M | 12 ADMISSION DATE 120513 | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 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	49	30 00				
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	821	HEMODIALYSIS COMPOIST	90935	011419	1	130. 00		
23		PAGE 1 OF 1	CREATION DATE	022219	TOTALS	130. 00		

SAMPLE EXAMPLE

WITH AN ATTENDING PROVIDER

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
A	MEDICAID				TPL		57	1234567
B					PAYMENT IF		OTHER	
C					APPLICABLE		PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN		1234567890123	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A	
B		9030198798700	
C		02	

66 DX N181
0

67 A B C D E F G H I J K L M N O P Q R S T 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | A B C D E F G H I J K L M N O P 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 1298765432 QUAL
LAST ADAMS FIRST JANE
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 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.