

UB-04 FORM AND INSTRUCTIONS

Claims for home health services must be filed by electronic claims submission 837I or on the UB 04 claim form.

Instructions for Completing the UB04 Form

Locator No.	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/Identification (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 Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	Required. Enter the appropriate 3-digit code as follows: <u>a. First digit-type facility</u> 3 = Home Health <u>b. Second digit-classification</u> 2 = Home health services under a plan of care (POC) <u>c. Third digit-frequency</u> 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 Number	Optional.	
6	Statement Covers Period (from and through dates) dates of the period covered by this bill.	Required. Enter the beginning and ending service dates.	

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Locator No.	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.	
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	Required. Enter the source of admission: 1 = Physician referral B = Transfer from another home health agency	
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 30 = Still a patient	

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Locator No.	Description	Instructions	Alerts
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	
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 - visit charge	

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Locator No.	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	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	Healthcare Common Procedure Coding System (HCPCS)/Rates Health Insurance Prospective Payment System (HIPPS) Code	<p>Required. Enter the appropriate 5-character alphanumeric procedure code followed by the appropriate modifier, if applicable:</p> <p><u>Procedure Codes</u></p> <p>G0156 = Services of HH aide in HH setting</p> <p>G0151 = Services of physical therapy in HH setting; (15) minutes</p> <p>G0152 = Services of occupational therapy in HH setting; (15) minutes</p> <p>G0153 = Speech/language path. in HH setting; (15) minutes</p> <p>G0299 = Skilled nursing services: RN; (15) minutes</p> <p>G0300 = Skilled nursing services: LPN; (15) minutes</p> <p>G0154 = Skilled nurse in HH setting; (15) minutes</p> <p>S9123 = Nurse care in home: RN</p> <p>S9124 = Nurse care in home: LPN</p>	<p>G0299 Effective 01/01/16</p> <p>G0300: Effective 01/01/2016</p> <p>G0154: Discontinued 01/01/2016</p>

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Locator No.	Description	Instructions	Alerts
44 (cont'd)	HCPCS Rates/HIPPS Code (cont'd)	<p>Modifiers:</p> <p>TD = RN</p> <p>TE = LPN</p> <p>TT = Multiple recipients</p> <p>UD = Wheelchair seating evaluation</p> <p>U2 = 2nd visit on same day</p> <p>U3 = 3rd visit on same day</p> <p>Note: For procedure codes G0154, G0156, G0299, and G0300: prior to April 1, 2016, one (1) unit equaled one (1) visit.</p>	<p>TD: Discontinued 01/01/2016</p> <p>TE: Discontinued 01/01/2016</p> <p>Effective for dates of service on or after April 1, 2016, providers are required to bill for skilled nursing visits in 15-minute units.</p>
45	Service Date	<p>Required. Enter the appropriate service date (MMDDYY) for each service.</p> <p>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.</p>	
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	<p>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.</p> <p>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.</p>	

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Locator No.	Description	Instructions	Alerts
51-A,B,C	Health Plan Identification (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 Certification Indicator (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 Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI	The 10-digit NPI must be entered here.
57	Other Provider Identification (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 appear on paper claims.
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	Patient'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	

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Locator No.	Description	Instructions	Alerts
59-A,B,C (cont'd)	Patient's. Relationship Insured (cont'd)	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 Identification (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.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter the Medicaid third party liability (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 HMOs 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.

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Locator No.	Description	Instructions	Alerts
62-A,B,C	Insured's Group Number (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 Authorization Code	Situational. Enter the 9-digit prior authorization number if required for services on the claim in 63A.	
64-A,B,C	Document Control Number	<p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	To adjust or void more than one claim line, 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	Diagnosis and Procedure Code Qualifier (DX Version Qualifier)	<p>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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p>	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Code	Required. Enter the ICD code for the principal diagnosis which necessitated home health services.	The most specific diagnosis codes must be used. General codes are not

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Locator No.	Description	Instructions	Alerts
67 67 A-Q (cont'd)	Principal Diagnosis Codes Other Diagnosis Code (cont'd)	<p>Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim.</p> <p>Use the most specific and accurate diagnosis code. A code is invalid if it has not been coded to the full number of digits required for that code.</p> <p>NOTE:</p> <p>ICD-9-CM Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.</p> <p>ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>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).</p>
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting diagnosis code.	Refer to field locator 67.
70	Patient Reason for Visit	Leave blank.	
71	Prospective Payment System (PPS) Code	Leave blank.	
72 A,B,C	ECl (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 physician ordering the plan of care.	<p>This field must be completed.</p> <p>The attending provider name and NPI cannot be the billing provider.</p>

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76 (cont'd)	Attending (cont'd)		The individual attending provider information must be entered in this field. The attending provider must be enrolled with Louisiana Medicaid.
77	Operating	Leave blank.	
78	Other	Situational. If applicable, enter the name and NPI Number of the referring provider or other physician. Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.	A referring provider is NOT required on the claim. However, if a referring provider is entered on the 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 Louisiana 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.

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SAMPLE HOME HEALTH CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

XYZ HOME HEALTH 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CNTL. # 11111111 3b MED. REG. # 111111111111 5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090715 THROUGH 090715		7		4 TYPE OF BILL 323	
8 PATIENT NAME a DOE, JOHN				9 PATIENT ADDRESS a 1235 ANYSTREET							
b ANYWHERE				c LA				d 71111			
10 BIRTH DATE MMDDYY M 090115		11 SEX I		12 DATE OF BIRTH 30		13 STAT 18		14 19		15 20	
16 DHR 30		17 ADMIT DATE 30		18 DISCH DATE 30		19 20		21 22		23 24	
24 25		26 27		28 29		30 31		32 33		34 35	
36 37		38 39		40 41		42 43		44 45		46 47	
48 49		50 51		52 53		54 55		56 57		58 59	
60 61		62 63		64 65		66 67		68 69		70 71	
72 73		74 75		76 77		78 79		80 81		82 83	
84 85		86 87		88 89		90 91		92 93		94 95	
96 97		98 99		100 101		102 103		104 105		106 107	
108 109		110 111		112 113		114 115		116 117		118 119	
120 121		122 123		124 125		126 127		128 129		130 131	
132 133		134 135		136 137		138 139		140 141		142 143	
144 145		146 147		148 149		150 151		152 153		154 155	
156 157		158 159		160 161		162 163		164 165		166 167	
168 169		170 171		172 173		174 175		176 177		178 179	
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192 193		194 195		196 197		198 199		200 201		202 203	
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216 217		218 219		220 221		222 223		224 225		226 227	
228 229		230 231		232 233		234 235		236 237		238 239	
240 241		242 243		244 245		246 247		248 249		250 251	
252 253		254 255		256 257		258 259		260 261		262 263	
264 265		266 267		268 269		270 271		272 273		274 275	
276 277		278 279		280 281		282 283		284 285		286 287	
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384 385		386 387		388 389		390 391		392 393		394 395	
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**SAMPLE HOME HEALTH CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

[illegible]

**SAMPLE HOME HEALTH CLAIM FORM
WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 XYZ HOME HEALTH 987 CORN ST. ANYWHERE, LA 71111										2										3a PAT. CNTRL. # b MED. RESC. # c FED. TAX NO.										4 TYPE OF BILL 323																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS b ANYWHERE c LA d 71111										10 STATEMENT COVERS PERIOD FROM 101416 THROUGH 102516																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
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SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

PAGE 1 OF 1 CREATION DATE 103016 TOTALS 590.00

50 PAYER NAME MEDICAID 51 HEALTH PLAN ID 52 PRIOR PAYMENTS TPL : .. 53 EST. AMOUNT DUE 1234567890 54 PRIOR PAYMENTS TPL : .. 55 EST. AMOUNT DUE 1234567 56 NPI 1234567890 57 OTHER PAYER ID 58 INSURED'S NAME DOE, JOHN 59 INSURED'S UNIQUE ID 1234567890123 60 GROUP NAME TPL CARRIER 61 INSURANCE GROUP NO. 62 INSURANCE GROUP NO. 63 TREATMENT AUTHORIZATION CODES 123456789 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME 66 EMPLOYER NAME 67 EMPLOYER NAME 68 EMPLOYER NAME 69 EMPLOYER NAME 70 EMPLOYER NAME 71 EMPLOYER NAME 72 EMPLOYER NAME 73 EMPLOYER NAME 74 EMPLOYER NAME 75 EMPLOYER NAME 76 EMPLOYER NAME 77 EMPLOYER NAME 78 EMPLOYER NAME 79 EMPLOYER NAME 80 EMPLOYER NAME 81 EMPLOYER NAME 82 EMPLOYER NAME 83 EMPLOYER NAME 84 EMPLOYER NAME 85 EMPLOYER NAME 86 EMPLOYER NAME 87 EMPLOYER NAME 88 EMPLOYER NAME 89 EMPLOYER NAME 90 EMPLOYER NAME 91 EMPLOYER NAME 92 EMPLOYER NAME 93 EMPLOYER NAME 94 EMPLOYER NAME 95 EMPLOYER NAME 96 EMPLOYER NAME 97 EMPLOYER NAME 98 EMPLOYER NAME 99 EMPLOYER NAME 100 EMPLOYER NAME

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UB-04 CMS-1450 APPROVED OMB NO. 0988-0007 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

SAMPLE HOME HEALTH CLAIM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY (WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

1 XYZ HOME HEALTH		2		3a PAT. CHL. # 111111		4 TYPE OF BILL 327	
987 CORN ST.				b. MED. REG. # 111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090715 THROUGH 090715	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET					
b. ANYWHERE				c. LA		d. 71111	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13.1 REASON 14.1 TYPE 15.1 SPC 16.1 DHR	
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42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPP CODE		45 SERV. DATE	
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**SAMPLE HOME HEALTH CLAIM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 XYZ HOME HEALTH 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CONT. # 111111 3b MED. REC. # 111111111111 3c FED. TAX NO. 101415		4 TYPE OF BILL 327	
5 PATIENT NAME a DOE, JOHN		6 PATIENT ADDRESS a 1235 ANYSTREET		7 STATEMENT COVERS PERIOD FROM 101415 THROUGH 101415		8	
9b		9c ANYWHERE		9d LA		9e 71111	
10 BIRTH DATE MMDDYY M 090115		11 SEX F		12 DATE OF ADMISSION 10/15/15		13 ICD-10 CODE I	
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