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: a. First digit-type facility 3 = Home Health b. Second digit-classification 2 = Home health services under a plan of care (POC) 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 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.	

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	

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	

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	Required. Enter the appropriate 5-character alphanumeric procedure code followed by the appropriate modifier, if applicable: <u>Procedure Codes</u> 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 G0299 = Skilled nursing services: RN; (15) minutes G0300 = Skilled nursing services: LPN; (15) minutes G0154 = Skilled nurse in HH setting; (15) minutes S9123 = Nurse care in home: RN S9124 = Nurse care in home: LPN	G0299 Effective 01/01/16 G0300: Effective 01/01/2016 G0154: Discontinued 01/01/2016

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

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.

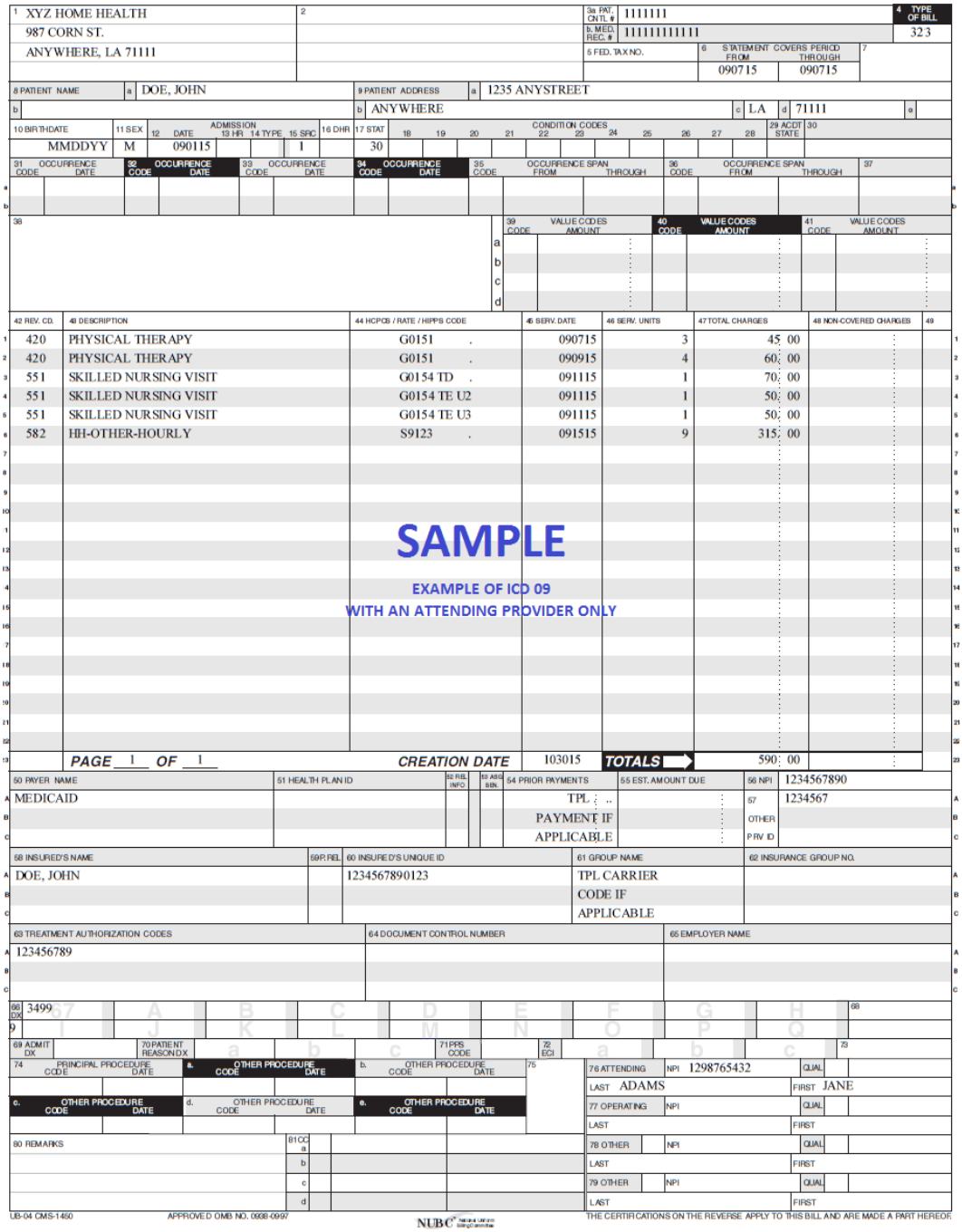
Locator No.	Description	Instructions	Alerts
62-A,B,C	Insured's Group Number (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group 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	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: 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	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)	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 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

Locator No.	Description	Instructions	Alerts
67 67 A-Q (cont'd)	Principal Diagnosis Codes Other Diagnosis Code (cont'd)	Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim. 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. NOTE: ICD-9-CM Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code. 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.	acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. 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).
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	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 physician ordering the plan of care.	This field must be completed. The attending provider name and NPI cannot be the billing provider.

Locator No.	Description	Instructions	Alerts
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.

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



1 XYZ HOME HEALTH 987 CORN ST. ANYWHERE, LA 71111	2	3a PAT. CNTL # 1111111 b. MED. REC. # 111111111111	4 TYPE OF BILL 323
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 090715 THROUGH 090715

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

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
MMDDYY	M	090115			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	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	420	PHYSICAL THERAPY	G0151 .	090715	3	45 00			1
2	420	PHYSICAL THERAPY	G0151 .	090915	4	60 00			2
3	551	SKILLED NURSING VISIT	G0154 TD .	091115	1	70 00			3
4	551	SKILLED NURSING VISIT	G0154 TE U2	091115	1	50 00			4
5	551	SKILLED NURSING VISIT	G0154 TE U3	091115	1	50 00			5
6	582	HH-OTHER-HOURLY	S9123 .	091515	9	315 00			6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE 1 OF 1	CREATION DATE	103015	TOTALS	590 00			23

SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

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		123456789012 3	TPL CARRIER	
B			CODE IF	
C			APPLICABLE	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 123456789		
B		
C		

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

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	

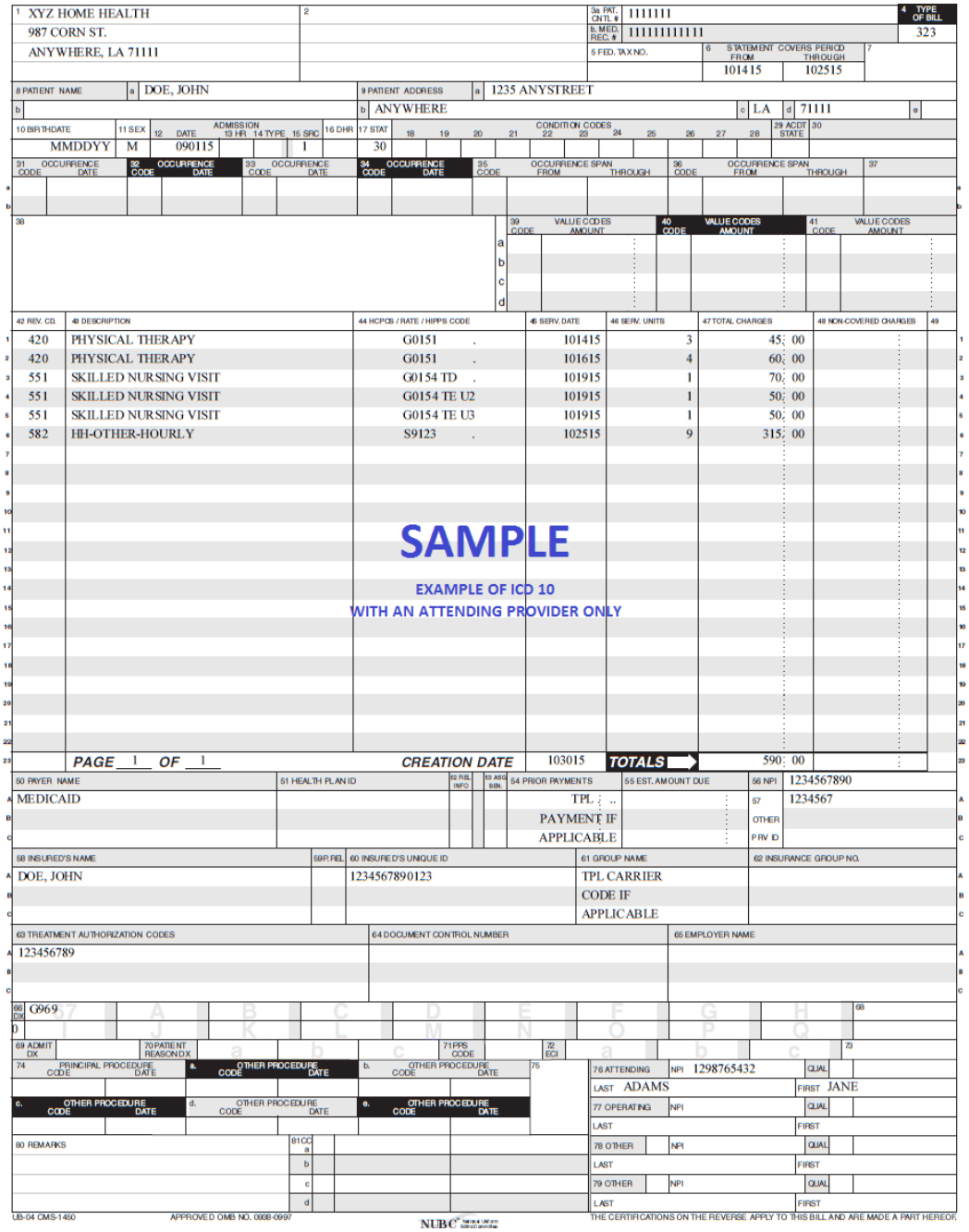
76 ATTENDING	NPI 1298765432	QUAL	
LAST ADAMS		FIRST JANE	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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 HOME HEALTH CLAIM FORM 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

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 323
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 101415 THROUGH 102515

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

10 BIRTHDATE MMDDYY | 11 SEX M | 12 ADMISSION DATE 090115 | 13 HR | 14 TYPE | 15 SRC 1 | 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

	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	420	PHYSICAL THERAPY	G0151	101415	3	45: 00		
2	420	PHYSICAL THERAPY	G0151	101615	4	60: 00		
3	551	SKILLED NURSING VISIT	G0154 TD	101915	1	70: 00		
4	551	SKILLED NURSING VISIT	G0154 TE U2	101915	1	50: 00		
5	551	SKILLED NURSING VISIT	G0154 TE U3	101915	1	50: 00		
6	582	HH-OTHER-HOURLY	S9123	102515	9	315: 00		
23		PAGE 1 OF 1	CREATION DATE	103015	TOTALS	590: 00		

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

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

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

63 TREATMENT AUTHORIZATION CODES A 123456789 | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX G969

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

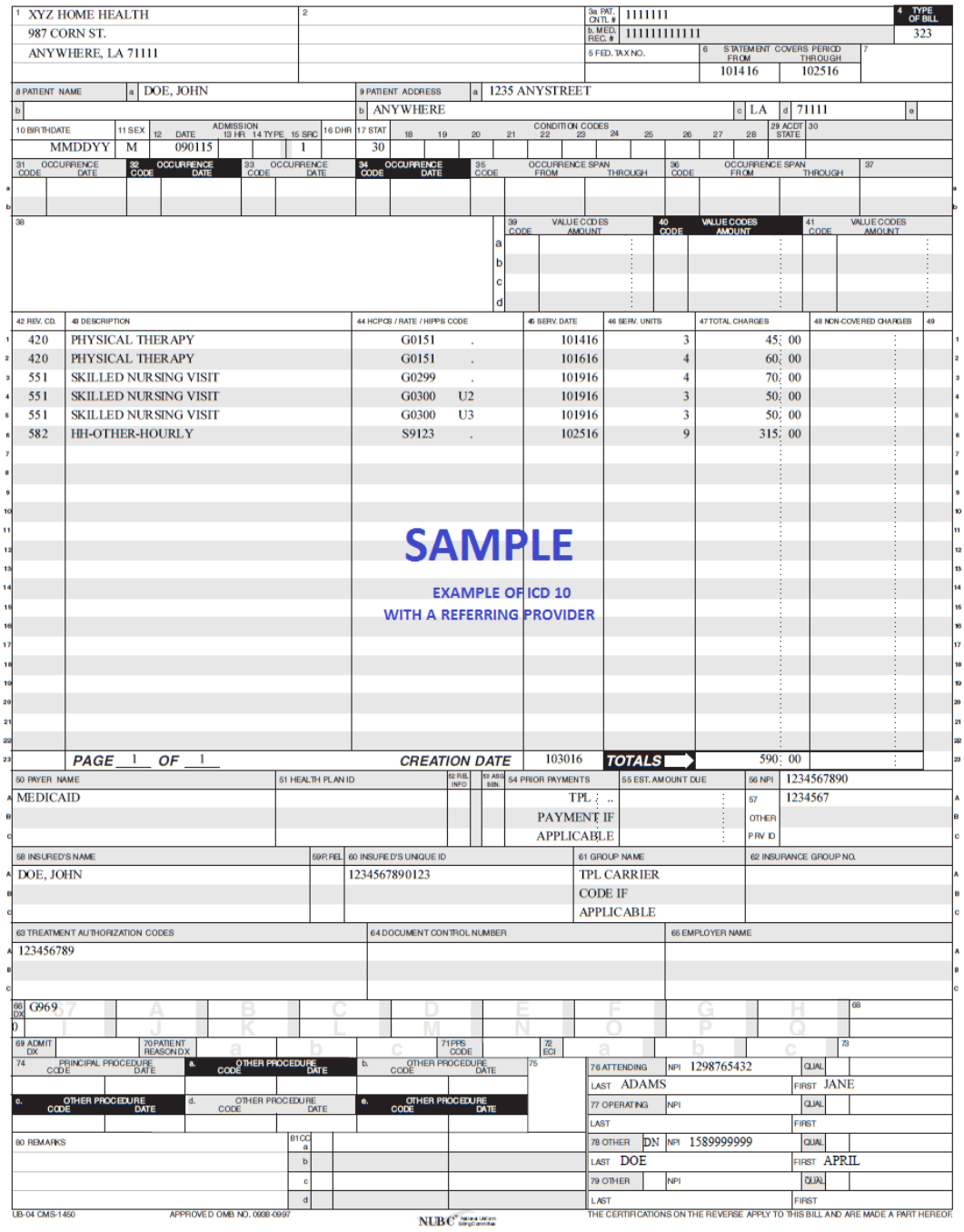
76 ATTENDING NPI 1298765432 QUAL LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

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

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

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 323
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 101416 THROUGH 102516

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

10 BIRTHDATE MMDDYY | 11 SEX M | 12 ADMISSION DATE 090115 | 13 HR | 14 TYPE | 15 SRC 1 | 16 DHR | 17 STAT 30 | 29 ACDT STATE | 30

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 420	PHYSICAL THERAPY	G0151 .	101416	3	45 00		
2 420	PHYSICAL THERAPY	G0151 .	101616	4	60 00		
3 551	SKILLED NURSING VISIT	G0299 .	101916	4	70 00		
4 551	SKILLED NURSING VISIT	G0300 U2	101916	3	50 00		
5 551	SKILLED NURSING VISIT	G0300 U3	101916	3	50 00		
6 582	HH-OTHER-HOURLY	S9123 .	102516	9	315 00		
23	PAGE 1 OF 1	CREATION DATE	103016	TOTALS	590 00		

SAMPLE

EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

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

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

63 TREATMENT AUTHORIZATION CODES A 123456789 | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX 0 G0969 | 67 | 68

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

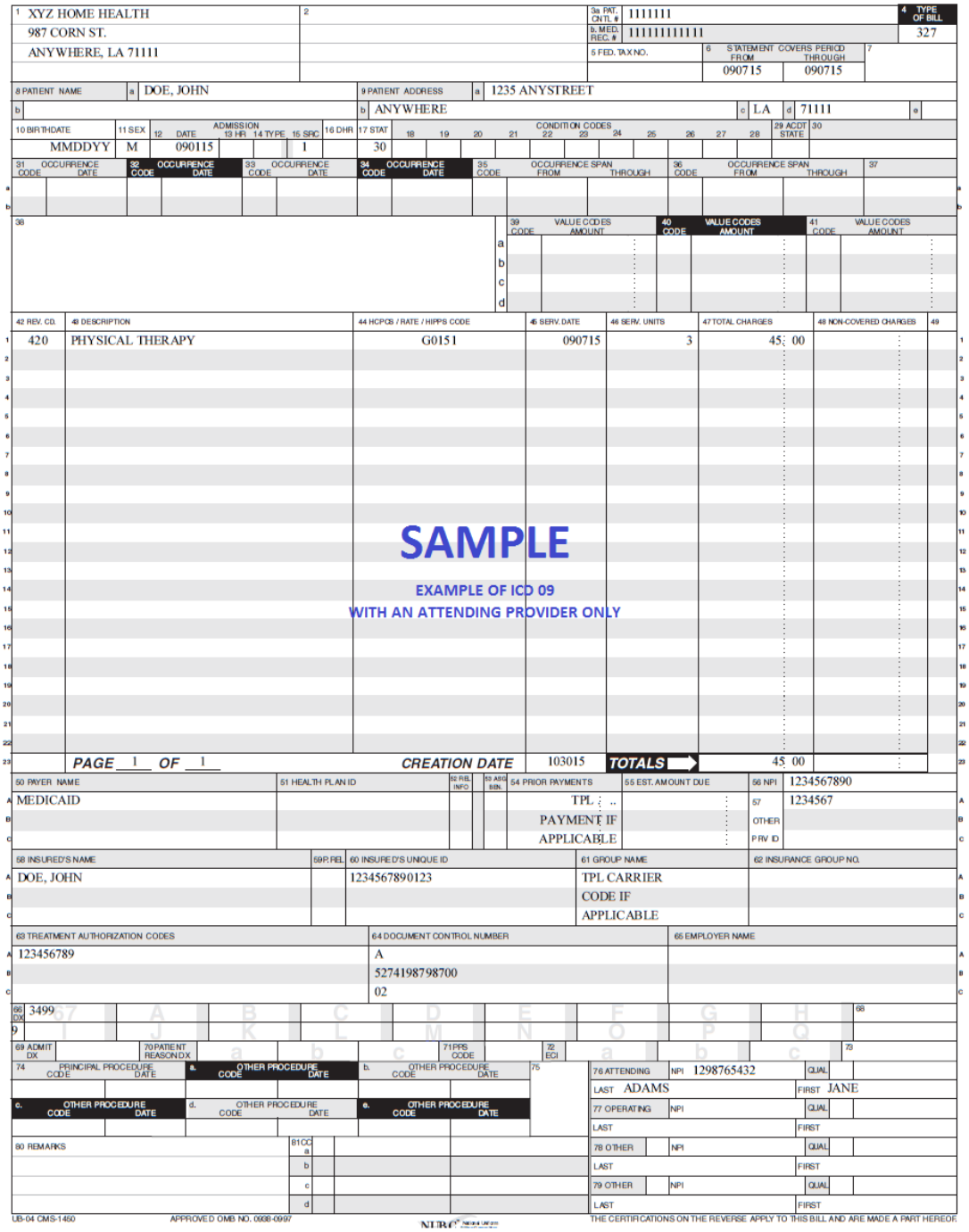
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

80 REMARKS | 81 CC a b c d

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

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

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



SAMPLE HOME HEALTH CLAIM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)