FORMS AND LINKS

The hospital fee schedules can be obtained from the Louisiana Medicaid web site at: http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

The following forms are included in this appendix:

- The Short Cervix Guide; and
- Sample UB04 instructions and sample claim forms.

An updated list of the ambulatory surgery codes can be obtained from the Louisiana Medicaid web site at:

http://www.lamedicaid.com/provweb1/fee_schedules/Out_Amb_FS_non-Rural_non-State.pdf

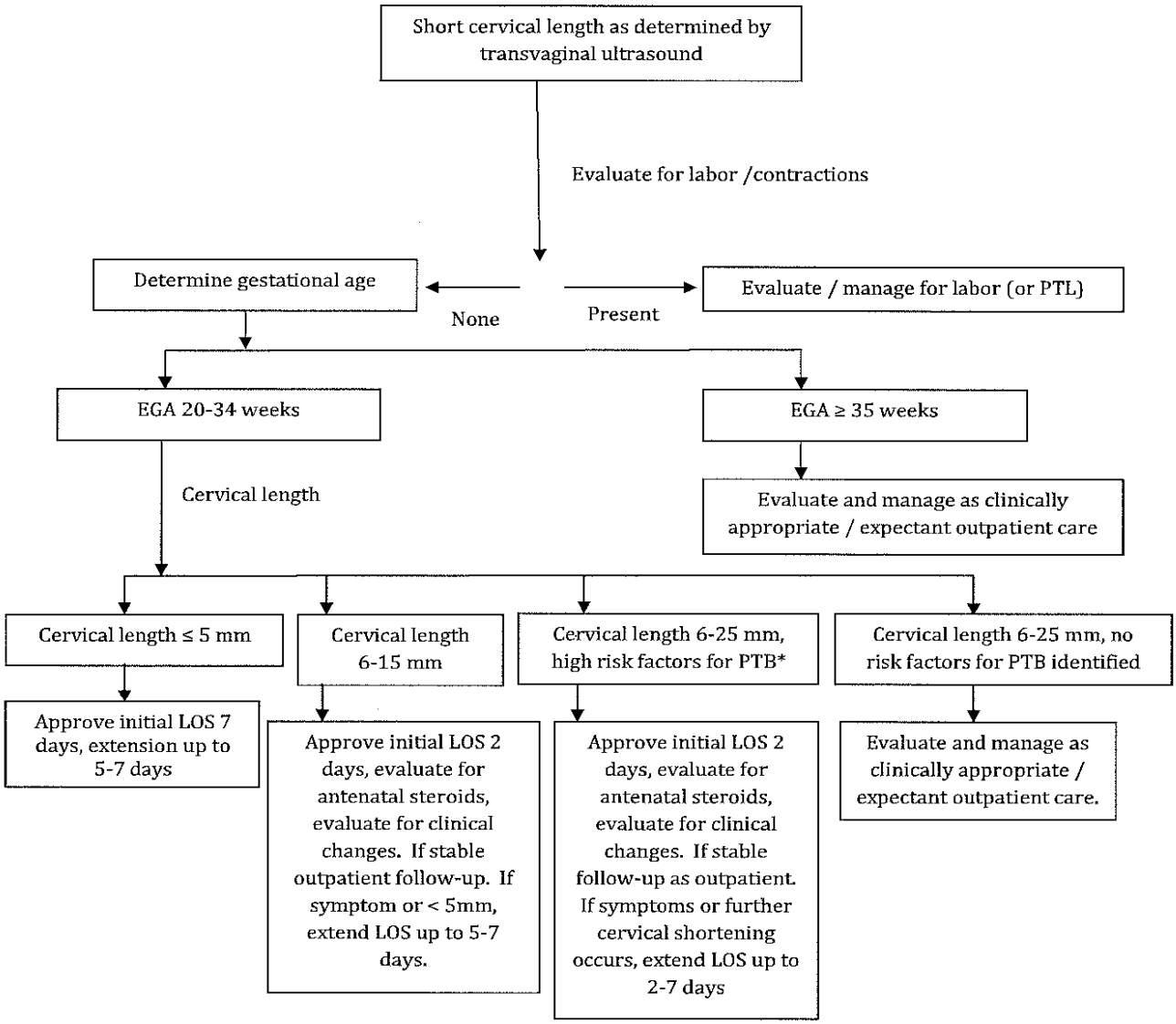
http://www.lamedicaid.com/provweb1/fee_schedules/Out_Amb_FS_Rural_State.pdf

Other hospital related forms can be obtained from the Louisiana Medicaid web site at: http://www.lamedicaid.com/provweb1/Forms/forms.htm

Short Cervix Guide

Short Cervical Length in Pregnancy

A shortened cervical length, as measured by transvaginal ultrasound, has been associated with increased risk of preterm birth in some pregnancies. However, there is no clear published guidance on management of these pregnancies, or that intervention results in improved outcomes. Use of antenatal steroids has shown benefit in appropriately selected patients. The following protocol is suggested as a guide for selection of patients for inpatient evaluation / management. It is not intended to be a strict protocol and should be adapted as clinical conditions warrant, as provided by the patient's provider. Patients with cervical lengths of > 25 mm (20-37 weeks gestation) are generally considered to be at low risk for preterm birth and are not considered in this management protocol.



*Risk factors include, but not limited to, multiple gestation, prior preterm birth / labor, incompetent cervix, FFN status.

Revised 08/24/10

UB04 Instructions for Hospitals (includes NDCs)

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 Number (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.	If you require the patient control number for posting, include it here.
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	If you require the medical record number for posting, include it here.
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 and 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 Number	Optional.	
6	Statement Covers Period - (the 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	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.	If providers do not use the emergency indicator correctly, the claim will deny with a 104 error edit. Covered days are 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.	
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 Birthdate	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 for hospital services. Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	

Locator No.	Description	Instructions	Alerts
13	Admission Hour	Required for hospital services. Enter the 2-digit code which corresponds to the hour the patient was admitted for care as: Code Time 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	
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 5=Trauma	
15	Point of Origin	Required for inpatient hospital services. Enter the appropriate code to indicate the point of patient origin for this admission from the 'Point of Origin' codes listed below.	Formerly Source of Admission. The updated and revised codes are designed to focus on patients' place or point of origin rather than the source of a physician order or referral.

<table>
<tr><th>Locator No.</th><th>Description</th><th>Instructions</th><th>Alerts</th></tr>
<tr><td>15 (cont'd)</td><td>Point of Origin (cont'd)</td><td>NOTE: Newborn codes are at the end of the listing.
<table>
<tr><th>Valid Value</th><th>Name</th><th>Description</th></tr>
<tr><td>1</td><td>Non-health care facility point of origin</td><td>Inpatient: The patient was admitted</td></tr>
<tr><td>2</td><td>Clinic or physician's office</td><td>Inpatient: The patient was admitted</td></tr>
<tr><td>3</td><td>Discontinued</td><td>Reserved for assignment by the National Uniform Billing Committee (NUBC)</td></tr>
<tr><td>4</td><td>Transfer from a hospital (different facility)</td><td>Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.</td></tr>
<tr><td>5</td><td>Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF)</td><td>Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.</td></tr>
<tr><td>6</td><td>Transfer from another health care facility</td><td>Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.</td></tr>
</table></td><td>The point of origin is the direct source for the particular facility.

Some codes previously used have been deleted or discontinued.

Enter the correct revised, updated Point of Origin Code to prevent claim denials.

NOTE: Newborn codes are at the end of this listing.</td></tr>
</table>

Locator No.	Description	Instructions			Alerts
15 (cont'd)	Point of Origin (cont'd)	7	Discontinued	Reserved for assignment by the NUBC.	
		8	Court/law enforcement	Inpatient: The patient was admitted to this facility upon direction of a court of law, or upon the request of a law enforcement agency representative.	
		9	Information not available	Inpatient: The means by which the patient was admitted to this hospital is not known.	
		D	Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer.	Inpatient: The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer.	
		E	Transfer from ambulatory surgery center	Inpatient: The patient was admitted to this facility as a transfer from an ambulatory surgery center.	
		F	Transfer from hospice and is under a hospice plan of care (POC) or enrolled in a Hospice Program.	Inpatient: The patient was admitted to this facility as a transfer from hospice.	

Locator No.	Description	Instructions	Alerts
15 (cont'd)	Point of Origin (cont'd)	<table><tr><td></td><td>Newborns</td><td></td></tr><tr><td>1-4</td><td>Discontinued</td><td>Reserved for assignment by the NUBC</td></tr><tr><td>5</td><td>Born inside the hospital</td><td>A baby born inside this hospital</td></tr><tr><td>6</td><td>Born outside of this hospital</td><td>A baby born outside of this hospital</td></tr></table>	
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.)	
17	Patient Status	Required for hospital services. Enter the appropriate code to indicate patient status as of the 'Statement Covers' through date. Valid codes now include all codes listed in the most current NUBC Official UB-04 Specifications Manual.	
18-28	Condition Codes	Required for hospital services. Enter C1 in Form Locator 18 for inpatient claims. PRO Approval C1 Approved as billed. Optional. Must be a valid code if entered. Valid codes are listed as follows: Insurance 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	
18-28 (cont'd)	Condition Codes (cont'd)	Accommodations 38 = Semi-private room not available 39 = Private room medically necessary 40 = Same day transfer Special Program Indicators A1 = EPSDT/CHAP A2 = Physically Handicapped Children's Program A4 = Family Planning	

Locator No.	Description	Instructions	Alerts
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	
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	
37	Unlabeled	Leave Blank.	
38	Responsible Party Name and Address	Optional.	

Locator No.	Description	Instructions	Alerts
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 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.	Value Code 80 must be used to report covered days. Value Code 81 must be used to report non-covered days. Value Code 82 must be used to report co-insurance days. Value Code 83 must be used to report lifetime reserve days. Please read the instructions carefully for entering the new number of days' information in the Value Code fields. The dollars/cents data must be entered accurately to prevent claim denials.

Locator No.	Description	Instructions	Alerts
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. For outpatient services, in Form Locator 44, all revenue codes require a CPT / HCPC procedure code when applicable based on the National Uniform Billing Standards. Specific revenue codes should be selected if at all possible (i.e. 258 = IV Solutions, 305 = Lab / Hematology, etc.). 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.	Revenue Codes 89x (other donor bank) are now unassigned. Use revenue codes 81x instead.
43	Revenue Description	Required. Enter the narrative description of the corresponding Revenue Code in FL 42. Required for Outpatient Claims. Claims reporting 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 UNITS with a floating decimal for fractional units limited to 3 digits (to the right of the decimal). Any spaces unused for the quantity are 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.	It is necessary for hospital OUTPATIENT claims to include NDC information for all physician-administered drugs identified with an alphanumeric HCPCS code. The NDC data must be entered in FL 43 as indicated in the adjacent "Instructions" field. Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units. Providers may now use multiple lines with Revenue Code 636 and/or the 25x category (excluding Revenue Code 258) to report multiple NDCs if needed. This is a reminder that Revenue Code 636 is covered for Medicaid billing.

Locator No.	Description	Instructions	Alerts
43 (cont'd)	Revenue Description (cont'd)	N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 5 6 7. 5 6 7 Two page claims are accepted for Medicaid inpatient hospital claims. We now accept two-page Medicaid outpatient hospital claims (without TPL). Use "Page ___ of ___" on line 23 as needed for two-page claims. Enter "Page 1 of 2" or "Page 2 of 2" as appropriate.	A total of 10 digits may be entered – 7 preceding the decimal and 3 following the decimal. We now accept two page Medicaid hospital outpatient claims without TPL.
44	HCPCS/Rates HIPPS Code	Required for inpatient services. Enter the accommodation rate for any accommodation Revenue Codes indicated in FL 42. The accommodation rate must be numeric. For pharmacy outpatient 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. For other outpatient services: In Form Locator 44, all Revenue Codes require a CPT/HCPCS procedure code when applicable based on the National Uniform Billing Standards. If a modifier is required for the service, enter the appropriate modifier following the CPT/HCPCS procedure code when applicable.	It is necessary for hospital OUTPATIENT claims to include NDC information for all physician-administered drugs identified with an alphanumeric HCPCS code. The NDC data must be entered in FL 43 as indicated in the adjacent "Instructions" field. Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units. Providers may now use multiple lines with Revenue Code 636 and/or the 25x category (excluding Revenue Code 258) to report multiple NDCs if needed. This is a reminder that Revenue Code 636 is covered for Medicaid billing. NOTE: Revenue Code 258 is excluded from this requirement. A total of 10 digits may be entered – 7 preceding the decimal and 3 following the decimal. We now accept two page Medicaid hospital outpatient claims without TPL.

Locator No.	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.	Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.
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.	
51-A,B,C	Health Plan Identification Number (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	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.	

Locator No.	Description	Instructions	Alerts
55-A,B,C	Estimated Amount Due	Optional.	
56	NPI	Required. Enter the provider's National Provider Identifier (NPI)	The 10-digit 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 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 = 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	
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 No.	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 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
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. If the services on the claim require prior authorization or pre-certification, enter the prior authorization or pre-certification number 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: <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 (Diagnosis and Procedure Code 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	

Locator No.	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. Enter the ICD-9-CM/ICD-10-CM code for the principal diagnosis. Situational. Enter the ICD-9-CM/ICD-10-CM code or codes for all other applicable diagnoses for this claim. NOTE: ICD-9-CM Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code. ICD-10-CM "V", "W", "X", and "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. Present on Admission (POA) information is required for all diagnoses on all inpatient claims. The POA indicator is assigned to the principal and all other diagnoses. The values for these fields are as follows: • Y=Present at the time of inpatient admission • N=Not present at the time of inpatient admission • U=Documentation is insufficient to determine if condition is present on admission • W=Provider is unable to clinically determine whether condition was present on admission or not	The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that code. 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	Situational. If the claim is for inpatient services, enter the admitting Diagnosis Code.	Refer to form locator 67.
70	Patient Reason for Visit	Optional. Enter the appropriate Diagnosis Code indicating the patient's presenting symptom.	Refer to form locator 67.
71	Prospective Payment System (PPS) Code	Leave blank.	
72 A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	

Locator No.	Description	Instructions	Alerts
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	Situational. Enter a valid current ICD-9-CM/ICD-10-PCS procedure code when an inpatient procedure is performed. Situational. Enter valid current ICD-9-CM/ICD-10-PCS procedure codes as appropriate for multiple inpatient procedures.	ICD-9 procedure codes must be used on claims for dates of service prior to 10/1/15. ICD-10 procedure 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).
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and NPI number of the attending physician.	This field must be completed. The attending provider name and 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	Situational. If applicable, enter the name and NPI number of the operating physician. Note: For sterilization procedures, the surgeon's name must appear in Form Locator 77.	

Locator No.	Description	Instructions	Alerts
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. 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.	Special handling instructions are entered in FL 80.
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.

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

1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111 | b. MED. REC. # | 4 TYPE OF BILL 131
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 093015 THROUGH 093015

8 PATIENT NAME: a DOE, JANE | 9 PATIENT ADDRESS: a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	29 ACDT STATE	30
//**	F		15	1	1	18	01			

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 DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

	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	272	STERILE SUPPLY		091015	2	65 00		1
2	301	LAB/CHEMISTRY	80053	091015	1	130 00		2
3	305	LAB/HEMATOLOGY	85025	091015	1	40 00		3
4	307	LAB/UROLOGY	81001	091015	1	50 00		4
5	324	CHEST X-RAY	71010	091015	1	300 00		5
6	450	EMERGENCY ROOM	99284	091015	1	900 00		6
7	636	N454321432121 ML1.00	J2270	091015	1	50 00		7
8–22								8–22
23		PAGE 1 OF 1	CREATION DATE	100715	TOTALS	1535 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, JANE		0123456789012	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

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

66 DX	78959	5712	7824	2768	30390							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

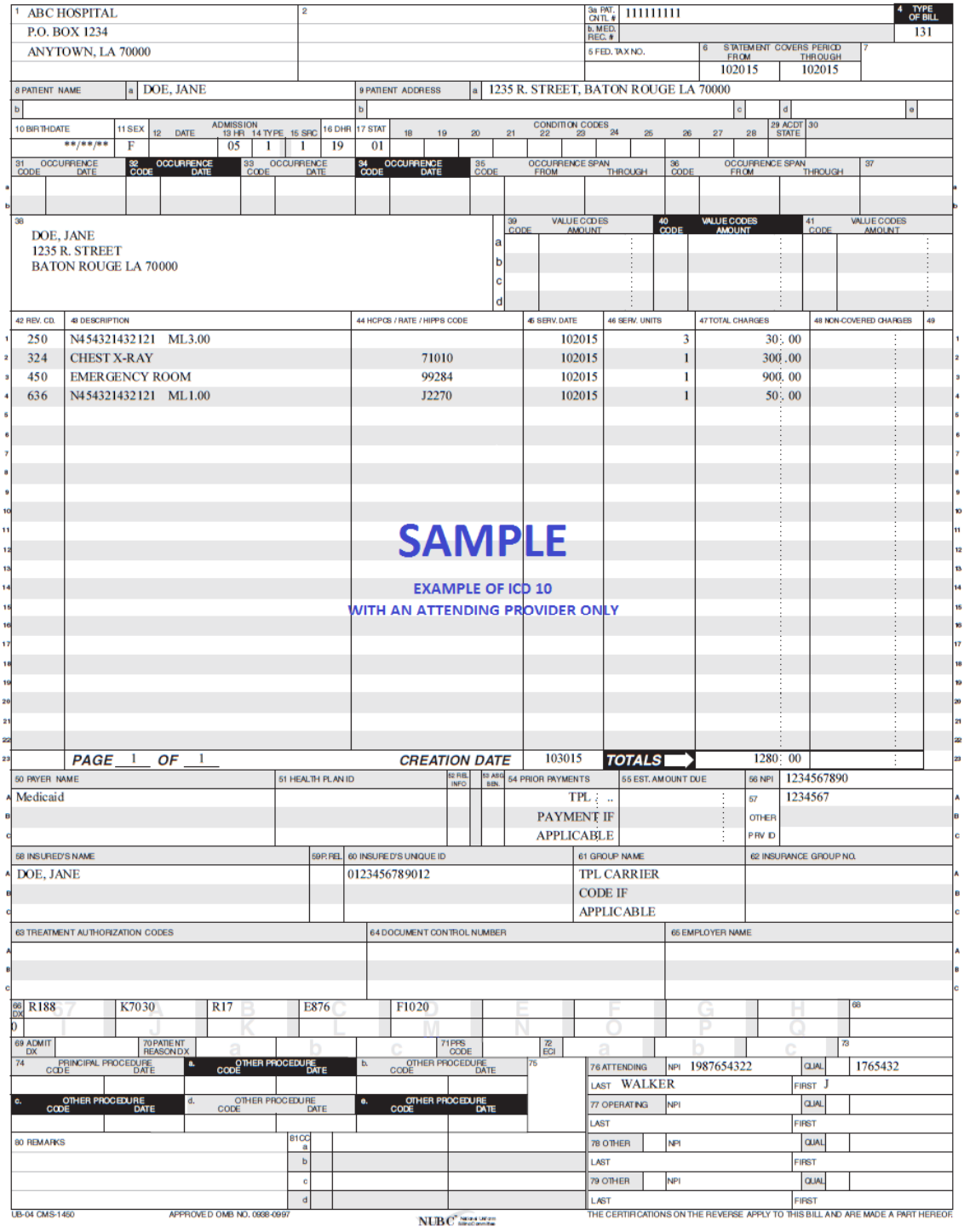
76 ATTENDING	NPI 1987654322	QUAL	1765432
LAST WALKER		FIRST J	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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.

SAMPLE OUTPATIENT HOSPITAL CLAIM FORM WITH AN ATTENDING PROVIDER ONLY

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



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 102015 THROUGH 102015

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000
10 BIRTHDATE **/**/**
11 SEX F
12 DATE
ADMISSION 13 HR 05 14 TYPE 1 15 SRC 1
16 DHR 19
17 STAT 01
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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

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
250	N454321432121 ML3.00		102015	3	30.00		
324	CHEST X-RAY	71010	102015	1	300.00		
450	EMERGENCY ROOM	99284	102015	1	900.00		
636	N454321432121 ML1.00	J2270	102015	1	50.00		
	PAGE 1 OF 1	CREATION DATE	103015	TOTALS	1280.00		

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 1234567
PRV ID

58 INSURED'S NAME A DOE, JANE
59 P. REL
60 INSURED'S UNIQUE ID 012345678912
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 0 R188 | K7030 | R17 | E876 | F1020
67 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

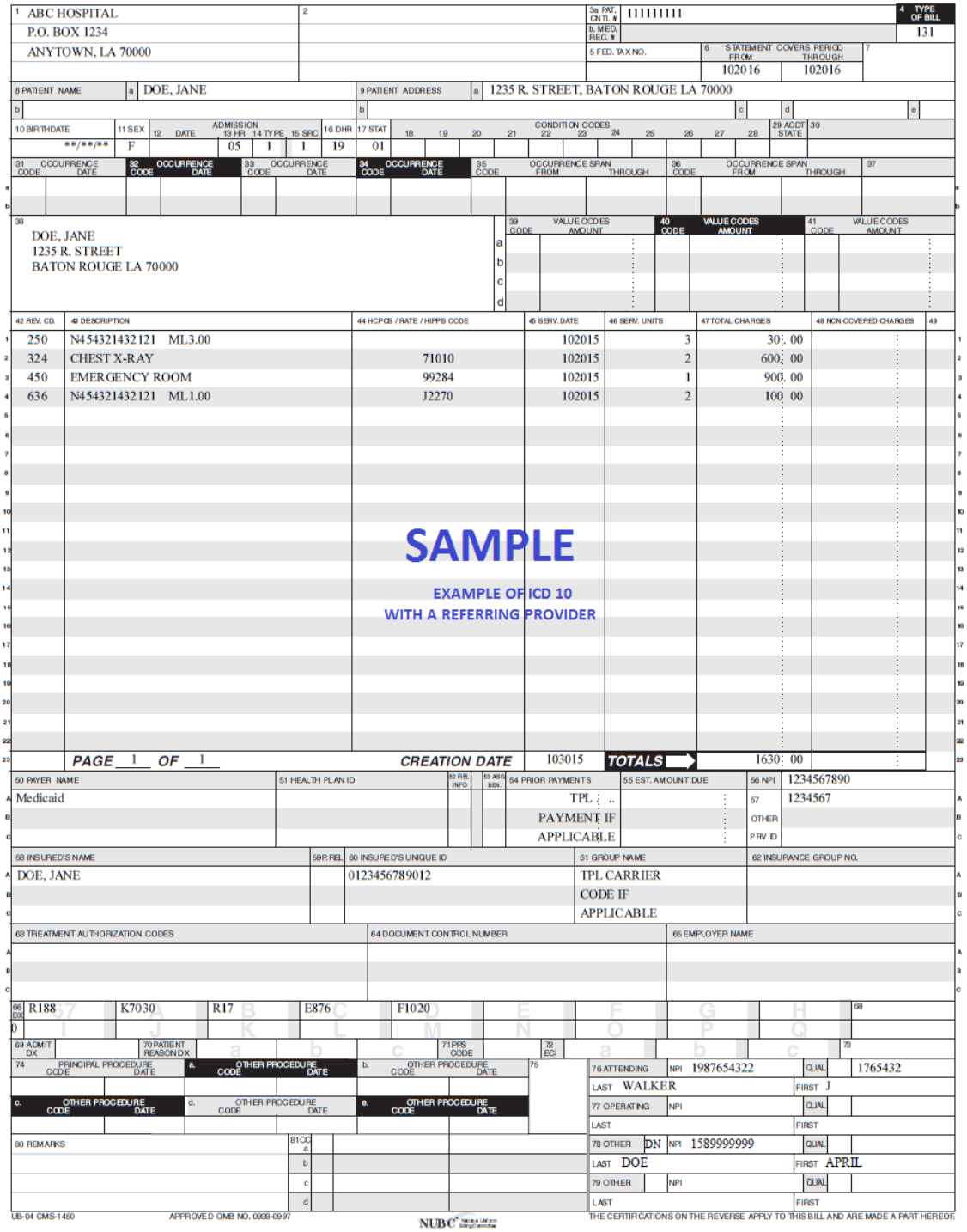
76 ATTENDING NPI 1987654322 QUAL 1765432 LAST WALKER FIRST J
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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 OUTPATIENT HOSPITAL CLAIM FORM WITH A REFERRING PROVIDER

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



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111 | b. MED. REC. # | 4 TYPE OF BILL 131

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 102016 THROUGH 102016

8 PATIENT NAME: DOE, JANE | 9 PATIENT ADDRESS: 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE **/**/** | 11 SEX F | 12 DATE | ADMISSION 13 HR 05 | 14 TYPE 1 | 15 SRC 1 | 16 DHR 19 | 17 STAT 01 | 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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

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
250	N454321432121 ML3.00		102015	3	30 00		
324	CHEST X-RAY	71010	102015	2	600 00		
450	EMERGENCY ROOM	99284	102015	1	900 00		
636	N454321432121 ML1.00	J2270	102015	2	100 00		
	PAGE 1 OF 1	CREATION DATE	103015	TOTALS	1630 00		

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

50 PAYER NAME: 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: DOE, JANE | 59 P. REL | 60 INSURED'S UNIQUE ID: 0123456789012 | 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: R188 | K7030 | R17 | E876 | F1020 | 67 | 68

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

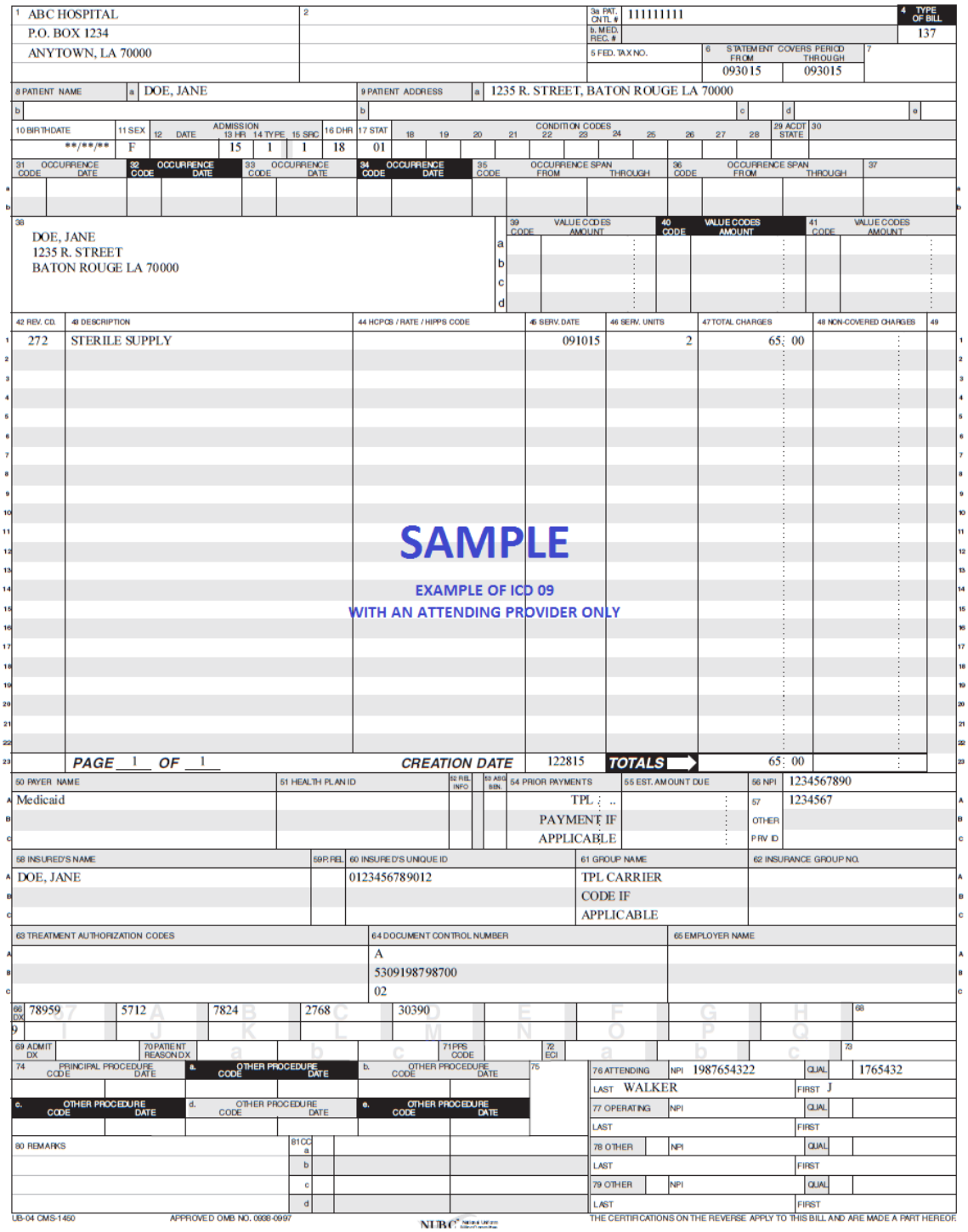
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

80 REMARKS | 81CC a b c d

76 ATTENDING NPI 1987654322 QUAL | 1765432 | LAST WALKER | FIRST J
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 OUTPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
4 TYPE OF BILL 137
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 093015 THROUGH 093015

8 PATIENT NAME: DOE, JANE
9 PATIENT ADDRESS: 1235 R. STREET, BATON ROUGE LA 70000
10 BIRTHDATE **/**/**
11 SEX F
12 DATE
ADMISSION 13 HR 15 | 14 TYPE 1 | 15 SRC 1
16 DHR 18
17 STAT 01
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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

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
272	STERILE SUPPLY		091015	2	65 00		
	PAGE 1 OF 1		CREATION DATE 122815		TOTALS 65 00		

SAMPLE
EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME: 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: DOE, JANE
59 P REL
60 INSURED'S UNIQUE ID: 0123456789012
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER: A 5309198798700 02
65 EMPLOYER NAME

66 DX 9: 78959 | 5712 | 7824 | 2768 | 30390
67 A–Q
68

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

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

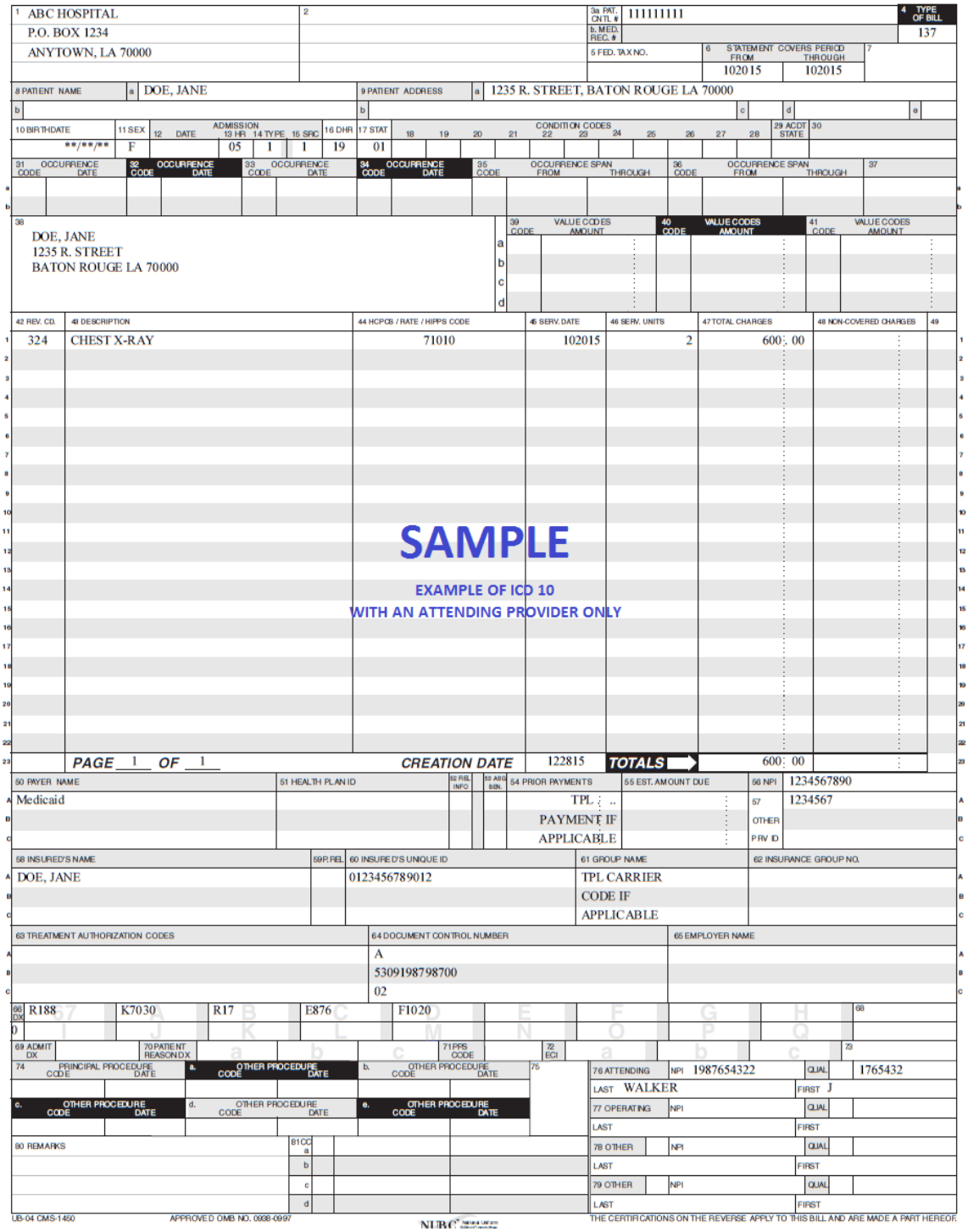
76 ATTENDING NPI 1987654322 QUAL 1765432 LAST WALKER FIRST J
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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.

SAMPLE OUTPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL #: 111111111
4 TYPE OF BILL: 137
6 STATEMENT COVERS PERIOD FROM: 102015 THROUGH: 102015

8 PATIENT NAME: DOE, JANE
9 PATIENT ADDRESS: 1235 R. STREET, BATON ROUGE LA 70000
10 BIRTHDATE: **/**/**
11 SEX: F
12 DATE: 05
13 HR: 1
14 TYPE: 1
15 SRC: 19
16 DHR:
17 STAT: 01

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
324	CHEST X-RAY	71010	102015	2	600 00	
	PAGE 1 OF 1	CREATION DATE	122815	TOTALS	600 00	

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID:
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI: 1234567890
57 OTHER PRV ID: 1234567

58 INSURED'S NAME: DOE, JANE
60 INSURED'S UNIQUE ID: 0123456789012
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

64 DOCUMENT CONTROL NUMBER: A 5309198798700 02

66 DX: R188 K7030 R17 E876 F1020

76 ATTENDING NPI: 1987654322 QUAL: 1765432
LAST: WALKER FIRST: J

LB-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 INPATIENT HOSPITAL CLAIM FORM
SPLIT BILLED WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL #: 111111111
b. MED. REC. #
4 TYPE OF BILL: 112
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 093015 THROUGH: 093015

8 PATIENT NAME: a DOE, JANE
9 PATIENT ADDRESS: a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
//**	F	093015	23	1	2	15	30	C1

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES: a CODE 80 AMOUNT 1 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board	1000.00		1	1000 00	
450	Emergency Room				570 89	

SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 100715 TOTALS 1570 89

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicaid		TPL PAYMENT IF APPLICABLE		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, JANE		0123456789012	TPL CARRIER CODE IF APPLICABLE	

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9: 64201 Y V270 N 66541 N 66411 N V0481 N V061 N

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J

77 OPERATING NPI QUAL
LAST FIRST

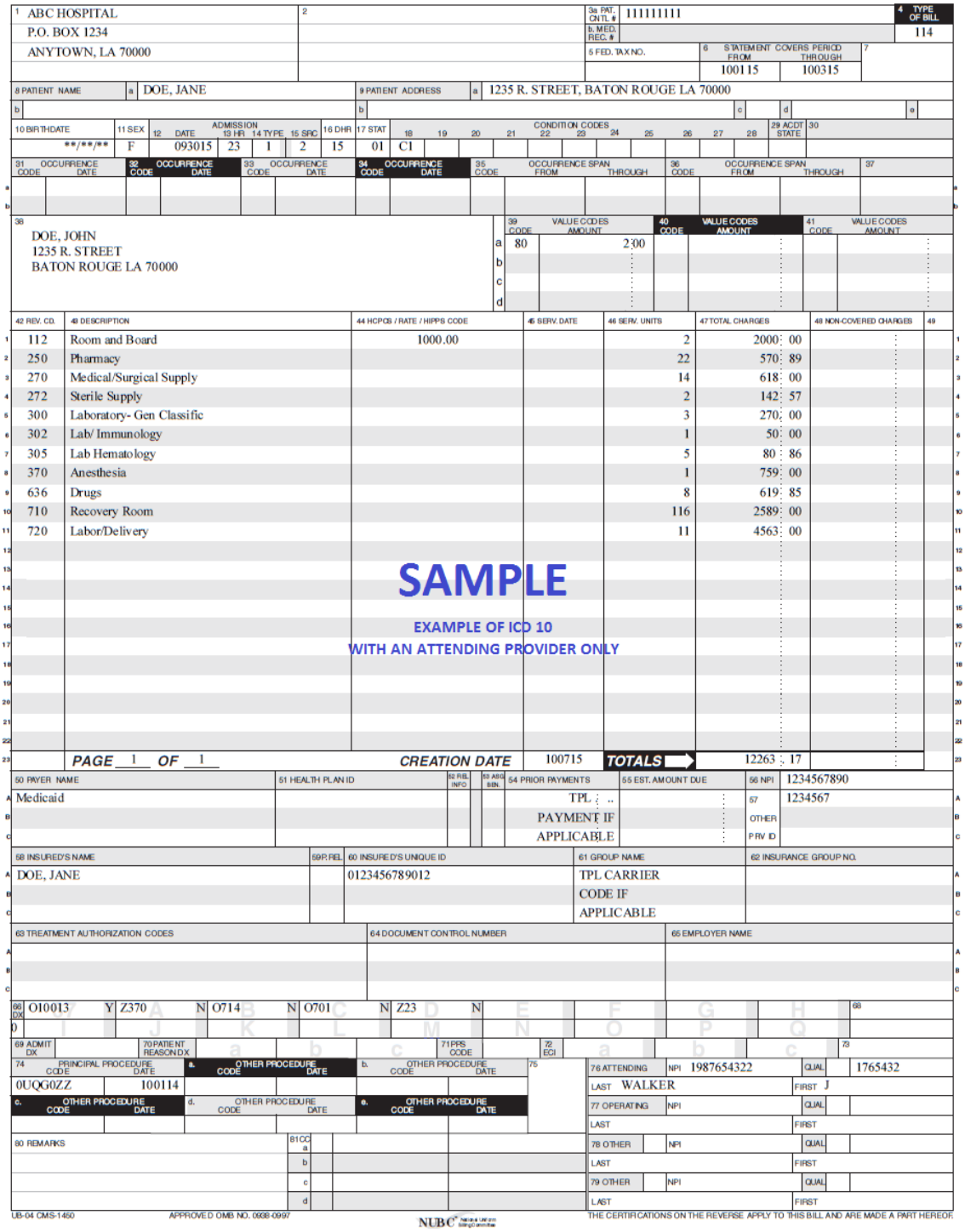
78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

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

SAMPLE INPATIENT HOSPITAL CLAIM FORM
SPLIT BILLED WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 114
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100315

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	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
//**	F	093015	23	1	2	15	01	C1												

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
DOE, JOHN
1235 R. STREET
BATON ROUGE LA 70000

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	200				
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	112	Room and Board	1000.00		2	2000 00		1
2	250	Pharmacy			22	570 89		2
3	270	Medical/Surgical Supply			14	618 00		3
4	272	Sterile Supply			2	142 57		4
5	300	Laboratory- Gen Classific			3	270 00		5
6	302	Lab/ Immunology			1	50 00		6
7	305	Lab Hematology			5	80 86		7
8	370	Anesthesia			1	759 00		8
9	636	Drugs			8	619 85		9
10	710	Recovery Room			116	2589 00		10
11	720	Labor/Delivery			11	4563 00		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	100715	TOTALS	12263 17		23

SAMPLE

EXAMPLE OF ICD 10
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, JANE		012345678912	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

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

66 DX: O10013 Y | Z370 N | O714 N | O701 N | Z23 N | 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
0UQG0ZZ	100114					

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

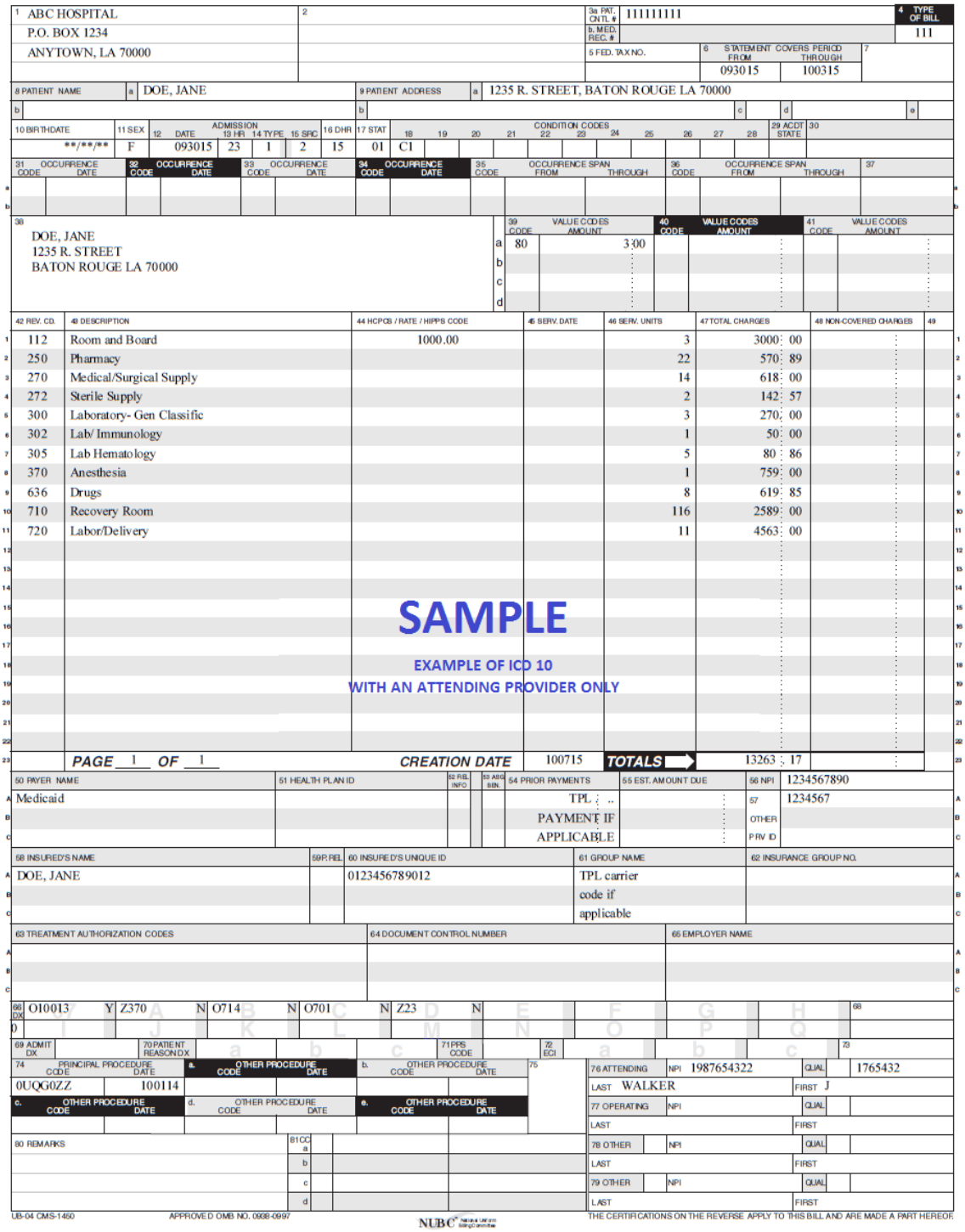
80 REMARKS

81 CC	
a	
b	
c	
d	

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
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 INPATIENT HOSPITAL CLAIM FORM
NOT SPLIT BILLED WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE AND A THROUGH DATE ON OR AFTER 10/1/15)



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 093015 THROUGH 100315

8 PATIENT NAME: a DOE, JANE
9 PATIENT ADDRESS: a 1235 R. STREET, BATON ROUGE LA 70000

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
//**	F	093015	23	1	2	15	01	C1		

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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	3:00				
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	112	Room and Board	1000.00		3	3000: 00		1
2	250	Pharmacy			22	570: 89		2
3	270	Medical/Surgical Supply			14	618: 00		3
4	272	Sterile Supply			2	142: 57		4
5	300	Laboratory- Gen Classific			3	270: 00		5
6	302	Lab/ Immunology			1	50: 00		6
7	305	Lab Hematology			5	80: 86		7
8	370	Anesthesia			1	759: 00		8
9	636	Drugs			8	619: 85		9
10	710	Recovery Room			116	2589: 00		10
11	720	Labor/Delivery			11	4563: 00		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	100715	TOTALS	13263: 17		23

SAMPLE

EXAMPLE OF ICD 10
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, JANE		0123456789012	TPL carrier	
B				code if	
C				applicable	

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

66 DX																	66
	O10013	Y	Z370	N	O714	N	O701	N	Z23	N							
0																	

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
0UQG0ZZ / 100114			

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

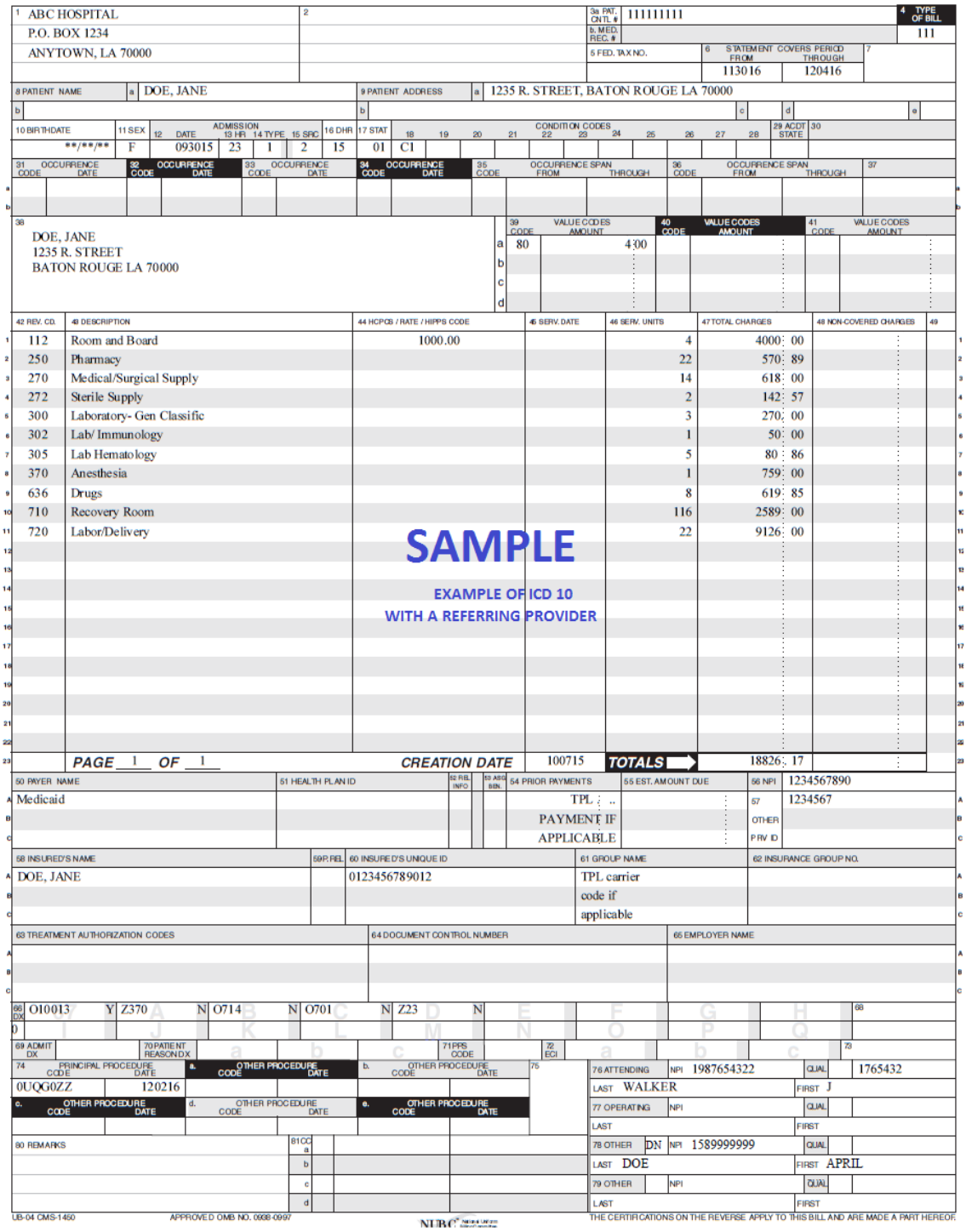
76 ATTENDING	NPI 1987654322	QUAL	1765432
LAST WALKER		FIRST J	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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 INPATIENT HOSPITAL CLAIM FORM
NOT SPLIT BILLED WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111 | 4 TYPE OF BILL 111
b. MED. REC. #
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 113016 THROUGH 120416

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE **/**/** | 11 SEX F | 12 ADMISSION DATE 093015 | 13 HR 23 | 14 TYPE 1 | 15 SRC 2 | 16 DHR 15 | 17 STAT 01 | CONDITION CODES 18 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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES CODE AMOUNT: a 80 4:00 | 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
1	112	Room and Board	1000.00		4	4000 00		
2	250	Pharmacy			22	570 89		
3	270	Medical/Surgical Supply			14	618 00		
4	272	Sterile Supply			2	142 57		
5	300	Laboratory- Gen Classific			3	270 00		
6	302	Lab/ Immunology			1	50 00		
7	305	Lab Hematology			5	80 86		
8	370	Anesthesia			1	759 00		
9	636	Drugs			8	619 85		
10	710	Recovery Room			116	2589 00		
11	720	Labor/Delivery			22	9126 00		
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	100715	TOTALS	18826 17		

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 OTHER 1234567 | PRV ID

58 INSURED'S NAME: A DOE, JANE | 59 P REL | 60 INSURED'S UNIQUE ID: 0123456789012 | 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: 0 O10013 Y Z370 N O714 N O701 N Z23 N | 68

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

74 PRINCIPAL PROCEDURE CODE DATE: 0UQG0ZZ 120216 | 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 1987654322 QUAL 1765432 LAST WALKER FIRST J
77 OPERATING NPI QUAL LAST FIRST
78 OTHER DN NPI 1589999999 QUAL LAST DOE FIRST APRIL
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.

SAMPLE INPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL: 117
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 093015 THROUGH 093015

8 PATIENT NAME: a DOE, JANE
9 PATIENT ADDRESS: a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
//**	F	093015	23	1	2	15	30	C1

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES: a CODE 80, AMOUNT 1:00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board	1000.00		1	1000:00	
250	Pharmacy			3	80:60	
					570:89	
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	1651:49	

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
A Medicaid				TPL PAYMENT IF APPLICABLE		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, JANE		0123456789012	TPL CARRIER CODE IF APPLICABLE	

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER: A 5250198798700 02
65 EMPLOYER NAME

66 DX: 9 | 67 64201 Y | A V270 N | B 66541 N | C 66411 N | D V0481 N | E V061 N

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 1987654322 QUAL 1765432
LAST WALKER FIRST J
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 INPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000	2	3a PAT. CNTL # 111111111 b. MED. REC. #	4 TYPE OF BILL 117
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100415

8 PATIENT NAME	9 PATIENT ADDRESS
a DOE, JANE	a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
//**	F	093015	23	1	2	15	01	C1												

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

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000	a 80	3:00				
	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	112	Room and Board	1000.00		3	3000 00		1
2	250	Pharmacy			22	570 89		2
3	270	Medical/Surgical Supply			14	618 00		3
4	272	Sterile Supply			2	142 57		4
5	300	Laboratory- Gen Classific			3	270 00		5
6	302	Lab/ Immunology			1	50 00		6
7	305	Lab Hematology			5	80 86		7
8	370	Anesthesia			1	759 00		8
9	636	Drugs			8	619 85		9
10	710	Recovery Room			116	2589 00		10
11	720	Labor/Delivery			11	4563 00		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	122815	TOTALS	13263 17		23

SAMPLE

EXAMPLE OF ICD 10
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, JANE		0123456789012	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	A	A
B	5309198798700	B
C	02	C

66 DX	A	B	C	D	E	F	G	H	68
0	O10013 Y	Z370 N	O714 N	O701 N	Z23 N				
	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
0UQG0ZZ	100114					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

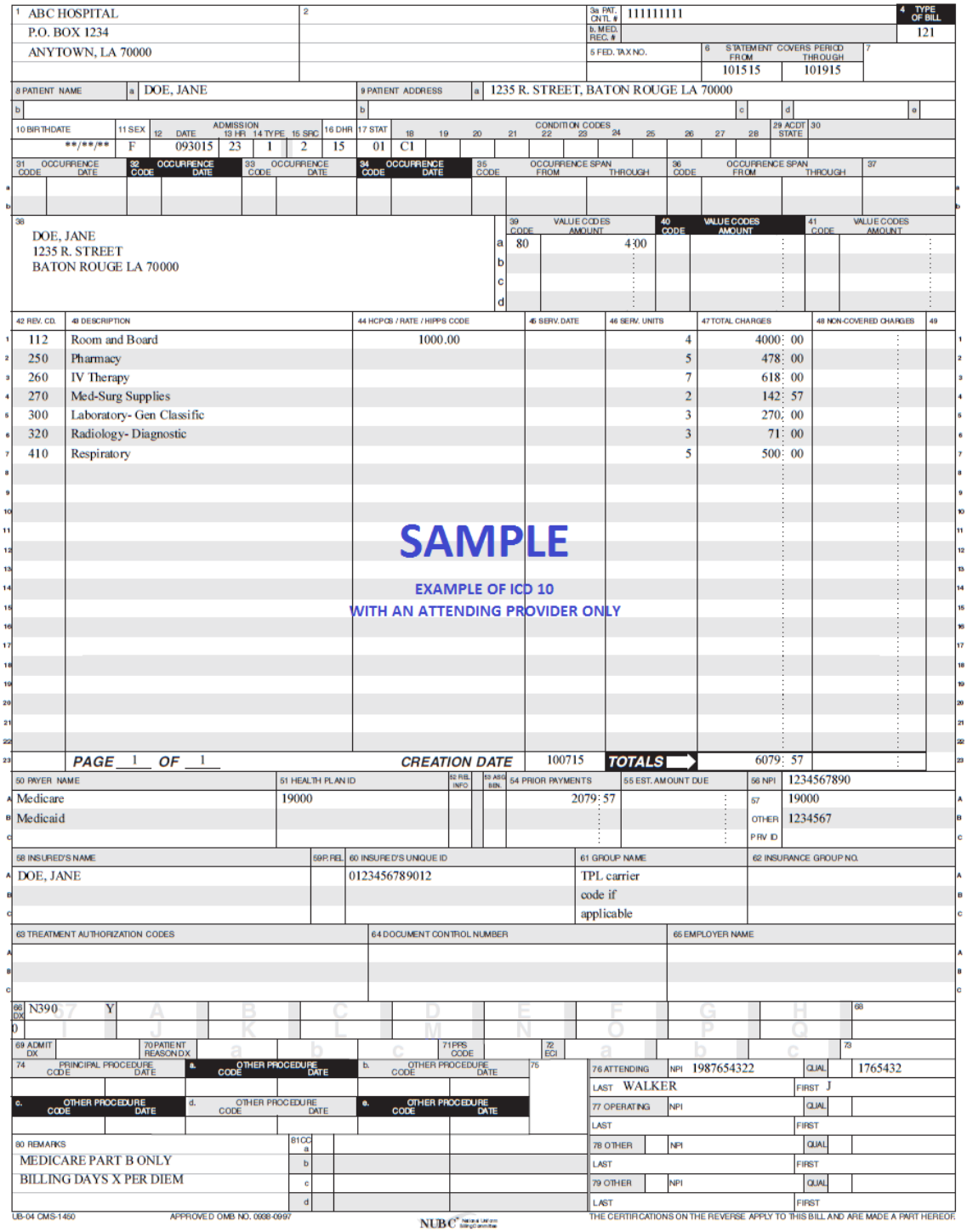
76 ATTENDING	NPI 1987654322	QUAL	1765432
LAST WALKER		FIRST J	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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.

SAMPLE INPATIENT HOSPITAL DAYS X PER DIEM CLAIM FORM WITH AN ATTENDING PROVIDER ONLY

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



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
4 TYPE OF BILL: 121
6 STATEMENT COVERS PERIOD: FROM 101515 THROUGH 101915

8 PATIENT NAME: DOE, JANE
9 PATIENT ADDRESS: 1235 R. STREET, BATON ROUGE LA 70000
10 BIRTHDATE: **/**/**
11 SEX: F
12 ADMISSION DATE: 093015
13 HR: 23
14 TYPE: 1
15 SRC: 2
16 DHR: 15
17 STAT: 01
18 CONDITION CODES: C1

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES: a 80 4:00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board	1000.00		4	4000: 00	
250	Pharmacy			5	478: 00	
260	IV Therapy			7	618: 00	
270	Med-Surg Supplies			2	142: 57	
300	Laboratory- Gen Classific			3	270: 00	
320	Radiology- Diagnostic			3	71: 00	
410	Respiratory			5	500: 00	
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	6079: 57	

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A Medicare	19000	2079: 57	
B Medicaid			

56 NPI 1234567890
57 19000
OTHER 1234567
PRV ID

58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JANE	0123456789012	TPL carrier	
B		code if	
C		applicable	

66 DX 0: N390

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J
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

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.