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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>

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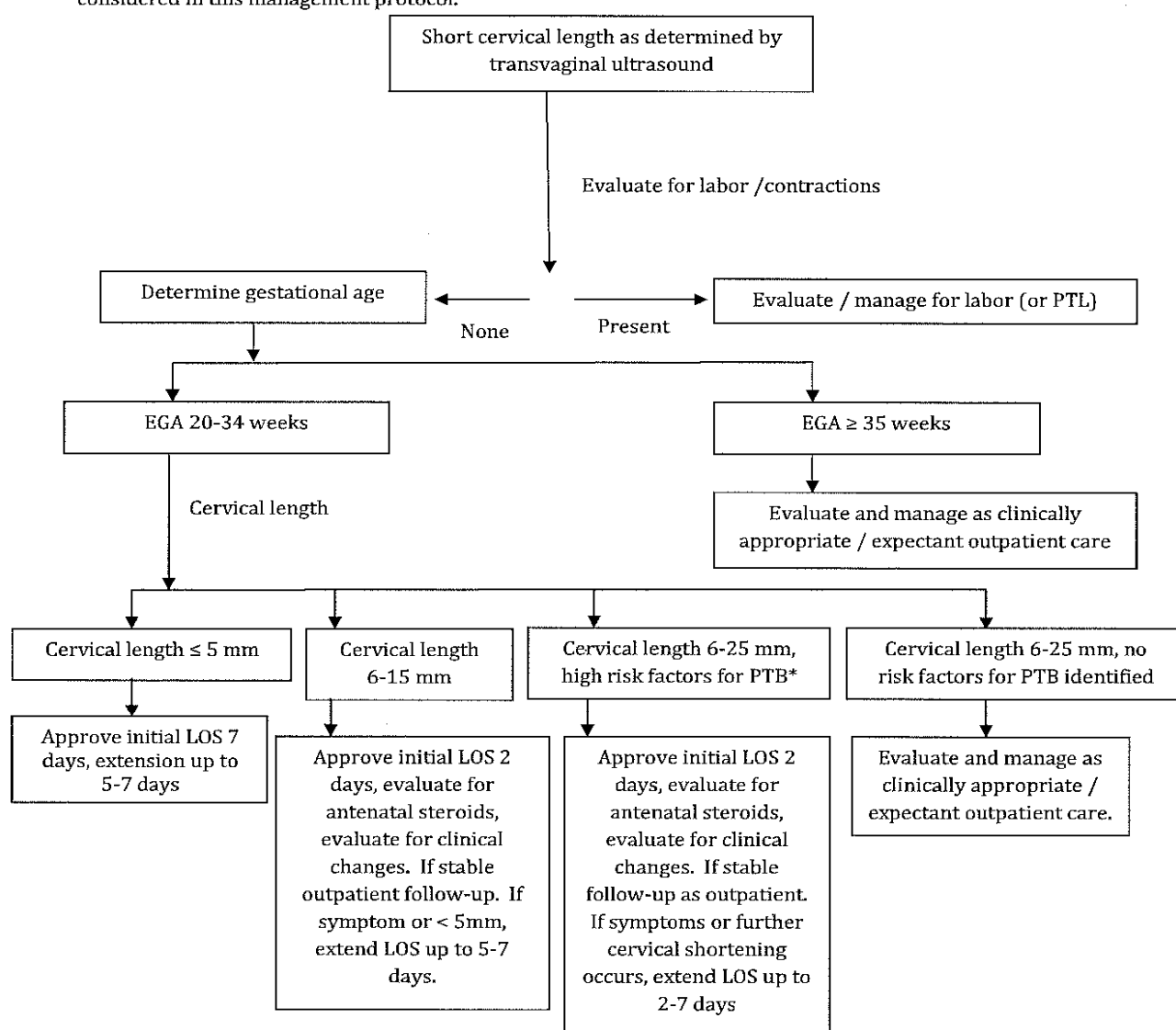
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Short Cervix Guide

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.

CHAPTER 25: HOSPITALS SERVICES**APPENDIX A: FORMS AND LINKS****PAGE(S) 30****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	<p>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:</p> <p><u>a. First digit-type facility</u> 1 = Hospital</p> <p><u>b. Second digit-classification</u> 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</p> <p><u>c. Third digit-frequency</u> 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</p>	
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.	

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Locator No.	Description	Instructions	Alerts
7	Unlabeled	<p>Optional. State Assigned.</p> <p>Note: Hospitals billing for services associated with moderate to high level emergency physician care (99283, 99284, 99285) should place a '3' in Form Locator 7 on the UB-04.</p> <p>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.</p>	<p>If providers do not use the emergency indicator correctly, the claim will deny with a 104 error edit.</p> <p>Covered days are reported in the value code field (39-41) as value code 80.</p>
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)	<p>Required. Enter patient's permanent address appropriately in Form Locator 9a-e.</p> <p>9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus</p>	
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	<p>Required. Enter sex of the patient as:</p> <p>M = Male F = Female U = Unknown</p>	
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.	

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Locator No.	Description	Instructions	Alerts
13	Admission Hour	<p>Required for hospital services. Enter the 2-digit code which corresponds to the hour the patient was admitted for care as:</p> <p><u>Code Time</u> 00 = 12:00 - 12:59 midnight 01 = 01:00 - 01:59 A.M. 02 = 02:00 - 02:59 03 = 03:00 - 03:59 04 = 04:00 - 04:59 05 = 05:00 - 05:59 06 = 06:00 - 06:59 07 = 07:00 - 07:59 08 = 08:00 - 08:59 09 = 09:00 - 09:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 noon 13 = 01:00 - 01:59 P.M. 14 = 02:00 - 02:59 15 = 03:00 - 03:59 16 = 04:00 - 04:59 17 = 05:00 - 05:59 18 = 06:00 - 06:59 19 = 07:00 - 07:59 20 = 08:00 - 08:59 21 = 09:00 - 09:59 22 = 10:00 - 10:59 23 = 11:00 - 11:59</p>	
14	Type Admission	<p>Required for hospital services. Enter one of the appropriate codes indicating the priority of this admission.</p> <p>1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5=Trauma</p>	
15	Point of Origin	<p>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.</p>	<p>Formerly Source of Admission.</p> <p>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.</p>

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Locator No.	Description	Instructions			Alerts
15 (cont'd)	Point of Origin (cont'd)	NOTE: Newborn codes are at the end of the listing.			<p>The point of origin is the <u>direct source</u> for the particular facility.</p> <p>Some codes previously used have been deleted or discontinued.</p> <p>Enter the correct revised, updated Point of Origin Code to prevent claim denials.</p> <p><u>NOTE:</u> Newborn codes are at the end of this listing.</p>
		Valid Value	Name	Description	
		1	Non-health care facility point of origin	Inpatient: The patient was admitted	
		2	Clinic or physician's office	Inpatient: The patient was admitted	
		3	Discontinued	Reserved for assignment by the National Uniform Billing Committee (NUBC)	
		4	Transfer from a hospital (different facility)	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.	
		5	Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF)	Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.	
		6	Transfer from another health care facility	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.	

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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.	

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Locator No.	Description	Instructions	Alerts												
15 (cont'd)	Point of Origin (cont'd)	<table border="1"> <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>		Newborns		1-4	Discontinued	Reserved for assignment by the NUBC	5	Born inside the hospital	A baby born inside this hospital	6	Born outside of this hospital	A baby born outside of this hospital	
	Newborns														
1-4	Discontinued	Reserved for assignment by the NUBC													
5	Born inside the hospital	A baby born inside this hospital													
6	Born outside of this hospital	A baby born outside of this hospital													
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	<p>Required for hospital services. Enter C1 in Form Locator 18 for inpatient claims.</p> <p><u>PRO Approval</u> C1 Approved as billed.</p> <p>Optional. Must be a valid code if entered. Valid codes are listed as follows:</p> <p><u>Insurance</u> 01 = Military service related 02 = Condition is employment related 03 = Patient is covered by insurance not reflected here 04 = Information only bill 05 = Lien has been filed 06 = End stage renal disease in first 30 months of entitlement covered by employer group insurance</p>													
18-28 (cont'd)	Condition Codes (cont'd)	<p><u>Accommodations</u> 38 = Semi-private room not available 39 = Private room medically necessary 40 = Same day transfer</p> <p><u>Special Program Indicators</u> A1 = EPSDT/CHAP A2 = Physically Handicapped Children's Program A4 = Family Planning</p>													

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Locator No.	Description	Instructions	Alerts
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	<p>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:</p> <p>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</p>	
35-36	Occurrence Spans (Code and Dates)	<p>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:</p> <p>72 = First/last visit 74 = Non-covered level of care</p>	
37	Unlabeled	Leave Blank.	
38	Responsible Party Name and Address	Optional.	

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Locator No.	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p>Required. Enter the appropriate value code (listed below).</p> <p>The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields.</p> <p>02 = Hospital has no semi-private rooms. Entering the code requires \$0.00 amount to be shown.</p> <p>06 = Medicare blood deductible</p> <p>08 = Medicare lifetime reserve first CY</p> <p>09 = Medicare coinsurance first CY</p> <p>10 = Medicare lifetime reserve second year</p> <p>11 = Coinsurance amount second year</p> <p>12 = Working aged recipient/spouse with employer group health plan</p> <p>13 = ESRD (end stage renal disease) recipient in the 12-month coordination period with an employer's group health plan</p> <p>14 = Automobile, no fault or any liability insurance</p> <p>15 = Worker's compensation including Black Lung</p> <p>16 = VA, PHS, or other federal agency</p> <p>30 = Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission.</p> <p>37 = Pints blood furnished</p> <p>38 = Blood not replaced - deductible is patient's responsibility</p> <p>39 = Blood pints replaced</p> <p>*80 = Covered days</p> <p>*81 = Non-covered days</p> <p>*82 = Co-insurance days (required only for Medicare crossover claims)</p> <p>*83 = Lifetime reserve days (required only for Medicare crossover claims)</p> <p>A1,B1,C1 = Deductible</p> <p>A2,B2,C2 = Co-insurance</p> <p><u>*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.</u></p>	<p>Value Code 80 must be used to report covered days.</p> <p>Value Code 81 must be used to report non-covered days.</p> <p>Value Code 82 must be used to report co-insurance days.</p> <p>Value Code 83 must be used to report lifetime reserve days.</p> <p><u>Please read the instructions carefully for entering the new number of days' information in the Value Code fields.</u></p> <p><u>The dollars/cents data must be entered accurately to prevent claim denials.</u></p>

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Locator No.	Description	Instructions	Alerts
42	Revenue Code	<p>Required. Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service.</p> <p>Accommodation codes require a rate in Form Locator 44.</p> <p>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.</p> <p>Specific revenue codes should be selected if at all possible (i.e. 258 = IV Solutions, 305 = Lab / Hematology, etc.).</p> <p>The amount charged must be present in Form Locator 47.</p> <p>Codes must be valid and entered in ascending order, except for the final entry for total charges.</p> <p>Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.</p>	<p>Revenue Codes 89x (other donor bank) are now unassigned. Use revenue codes 81x instead.</p>
43	Revenue Description	<p>Required. Enter the narrative description of the corresponding Revenue Code in FL 42.</p> <p>Required for Outpatient Claims. Claims reporting Physician Administered Drugs must contain the following:</p> <p>Report the N4 qualifier in the first two (2) positions, left-justified.</p> <p>Immediately following the N4 qualifier, report the 11 character National Drug Code number in the 5-4-2 format (no hyphens).</p> <p>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:</p> <p style="padding-left: 40px;">F2 -International Unit GR-Gram ML-Milliliter UN- Unit</p> <p>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).</p> <p>Any spaces unused for the quantity are left blank.</p> <p>Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible.</p> <p>The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.</p>	<p>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.</p> <p>Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.</p> <p>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.</p> <p>This is a reminder that Revenue Code 636 is covered for Medicaid billing.</p>

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Locator No.	Description	Instructions	Alerts
43 (cont'd)	Revenue Description (cont'd)	<p>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</p> <p>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 <u>1</u> of <u>2</u>" or "Page <u>2</u> of <u>2</u>" as appropriate.</p>	<p>A total of 10 digits may be entered – 7 preceding the decimal and 3 following the decimal.</p> <p>We now accept two page Medicaid hospital outpatient claims without TPL.</p>
44	HCPCS/Rates HIPPS Code	<p>Required for inpatient services. Enter the accommodation rate for any accommodation Revenue Codes indicated in FL 42. The accommodation rate must be numeric.</p> <p>For pharmacy outpatient services: Claims reporting Physician Administered Drugs identified with alphanumeric HCPCS codes must contain the following:</p> <p>Enter the corresponding HCPCS Code for the NDC reported in FL 43.</p> <p>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.</p> <p>If a modifier is required for the service, enter the appropriate modifier following the CPT/HCPCS procedure code when applicable.</p>	<p>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.</p> <p>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.</p> <p>This is a reminder that Revenue Code 636 is covered for Medicaid billing.</p> <p>NOTE: Revenue Code 258 is excluded from this requirement.</p> <p>A total of 10 digits may be entered – 7 preceding the decimal and 3 following the decimal.</p> <p>We now accept two page Medicaid hospital outpatient claims without TPL.</p>

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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.	

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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	<p>Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p>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.</p>	
59-A,B,C	Patient's Relationship Insured	<p>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.</p> <p>Acceptable codes are as follows:</p> <p>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</p>	
60-A,B,C	Insured's Unique ID	<p>Required. Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.</p> <p>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.</p>	

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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	

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Locator No.	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	<p>Required. Enter the ICD-9-CM/ICD-10-CM code for the principal diagnosis.</p> <p>Situational. Enter the ICD-9-CM/ICD-10-CM code or codes for all other applicable diagnoses for this claim.</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", 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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 	<p>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.</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	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	ECl (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	

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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.	<u>This field must be completed.</u> The attending provider name and NPI <u>cannot</u> 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.	

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Locator No.	Description	Instructions	Alerts
78	Other	<p>Situational. If applicable, enter the name and NPI number of the referring provider or other physician.</p> <p>Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.</p>	<p>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.</p> <p>If entered, the Referring provider must be enrolled with LA Medicaid.</p>
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.

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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

[illegible]

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

**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		2		3a PAT. CNTL. # b MED. REC. # 111111111		4 TYPE OF BILL 131	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000					
10 BIRTHDATE **/**/**** F		11 SEX F		12 DATE 05/1/19		13 ADMISSION 13.1 ICD-10 TYPE 1	
14 DHR 19		15 STAT 01		16 CONDITION CODES 22 23 24 25 26 27 28		17 ACOT STATE 30	
31 OCCURRENCE DATE 31 CODE		32 OCCURRENCE DATE 32 CODE		33 OCCURRENCE DATE 33 CODE		34 OCCURRENCE DATE 34 CODE	
35 OCCURRENCE DATE 35 CODE		36 OCCURRENCE DATE 36 CODE		37 OCCURRENCE DATE 37 CODE		38 OCCURRENCE DATE 38 CODE	
39 OCCURRENCE DATE 39 CODE		40 OCCURRENCE DATE 40 CODE		41 OCCURRENCE DATE 41 CODE		42 OCCURRENCE DATE 42 CODE	
39 CODE a		40 CODE b		41 CODE c		42 CODE d	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
43 REV. CD 250		44 DESCRIPTION N454321432121 ML3.00		45 HCPCS / RATE / HIPPS CODE 71010		46 SERV. DATE 102015	
47 SERV. UNITS 3		48 TOTAL CHARGES 300.00		49 NON-COVERED CHARGES		50	
324		CHEST X-RAY		71010		102015	
450		EMERGENCY ROOM		99284		102015	
636		N454321432121 ML1.00		J2270		102015	
<p style="font-size: 2em; color: blue;">SAMPLE</p> <p style="color: blue;">EXAMPLE OF ICD 10 WITH AN ATTENDING PROVIDER ONLY</p>							
PAGE 1 OF 1		CREATION DATE		103015		TOTALS 1280.00	
51 PRIOR NAME Medicaid		52 HEALTH PLAN ID		53 PRIOR PAYMENTS TPL : ..		54 EST. AMOUNT DUE	
55 INSURED'S NAME DOE, JANE		56 INSURED'S UNIQUE ID 0123456789012		57 GROUP NAME TPL CARRIER		58 INSURANCE GROUP NO.	
59 TREATMENT AUTHORIZATION CODES		60 DOCUMENT CONTROL NUMBER		61 EMPLOYER NAME		62	
63 R188		K7030		R17		E876	
64 F1020		F1020		F1020		F1020	
65 R188		K7030		R17		E876	
66 F1020		F1020		F1020		F1020	
67 R188		K7030		R17		E876	
68 F1020		F1020		F1020		F1020	
69 R188		K7030		R17		E876	
70 F1020		F1020		F1020		F1020	
71 R188		K7030		R17		E876	
72 F1020		F1020		F1020		F1020	
73 R188		K7030		R17		E876	
74 F1020		F1020		F1020		F1020	
75 R188		K7030		R17		E876	
76 F1020		F1020		F1020		F1020	
77 R188		K7030		R17		E876	
78 F1020		F1020		F1020		F1020	
79 R188		K7030		R17		E876	
80 F1020		F1020		F1020		F1020	
81 R188		K7030		R17		E876	
82 F1020		F1020		F1020		F1020	
83 R188		K7030		R17		E876	
84 F1020		F1020		F1020		F1020	
85 R188		K7030		R17		E876	
86 F1020		F1020		F1020		F1020	
87 R188		K7030		R17		E876	
88 F1020		F1020		F1020		F1020	
89 R188		K7030		R17		E876	
90 F1020		F1020		F1020		F1020	
91 R188		K7030		R17		E876	
92 F1020		F1020		F1020		F1020	
93 R188		K7030		R17		E876	
94 F1020		F1020		F1020		F1020	
95 R188		K7030		R17		E876	
96 F1020		F1020		F1020		F1020	
97 R188		K7030		R17		E876	
98 F1020		F1020		F1020		F1020	
99 R188		K7030		R17		E876	
100 F1020		F1020		F1020		F1020	

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PAGE(S) 30

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

ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000										2										3a PAT. CNTRL. # b. MED. REG. # 1111111111										4 TYPE OF BILL 131																																																	
																				5 FED. TAX NO.										6 STATEMENT FROM 102016										7 COVERS PERIOD THROUGH 102016																																							
8 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS b 1235 R. STREET, BATON ROUGE LA 70000																																																																					
10 BIRTH DATE **/**/** F										11 SEX F										12 DATE 05 1 1 19										13 STAT 01										14 CONDITION CODES 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30																																							
31 OCCURRENCE DATE 32 CODE										33 OCCURRENCE DATE 34 CODE										35 OCCURRENCE DATE 36 CODE										37 OCCURRENCE DATE 38 CODE																																																	
39 VALUE CODES a b c d										40 VALUE CODES a b c d										41 VALUE CODES a b c d										42 VALUE CODES a b c d																																																	
43 REV. CD. 1 250 2 324 3 450 4 636										44 DESCRIPTION N454321432121 ML3.00 CHEST X-RAY EMERGENCY ROOM N454321432121 ML1.00										45 HCPCS / RATE / HIPPS CODE 71010 99284 J2270										46 SERV. DATE 102015 102015 102015 102015										47 SERV. UNITS 3 2 1 2										48 TOTAL CHARGES 30; 00 600; 00 900; 00 100 00										49 NON COVERED CHARGES : : : :										50									
PAGE 1 OF 1										CREATION DATE										103015										TOTALS										1630; 00																																							
51 PRIOR NAME A Medicaid										52 HEALTH PLAN ID										53 PRIOR PAYMENTS TPL : .. PAYMENT IF APPLICABLE										54 EST. AMOUNT DUE										55 NPI 1234567890										56 OTHER 1234567																													
57 INSURED'S NAME A DOE, JANE										58 INSURED'S UNIQUE ID 0123456789012										59 GROUP NAME TPL CARRIER CODE IF APPLICABLE										60 INSURANCE GROUP NO.																																																	
61 TREATMENT AUTHORIZATION CODES										62 DOCUMENT CONTROL NUMBER										63 EMPLOYER NAME																																																											
64 R188 K7030 R17 E876 F1020										65										66										67										68										69																													
70 ADMIT DATE										71 PATIENT REASON DATE										72 PPS CODE										73										74										75																													
76 OTHER PROCEDURE DATE										77 OTHER PROCEDURE DATE										78 OTHER PROCEDURE DATE										79 OTHER PROCEDURE DATE										80 OTHER PROCEDURE DATE										81 OTHER PROCEDURE DATE																													
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**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		2		3a PRI. CNTL. # b. MED. REC. # c. FED. TAX NO.		4 TYPE OF BILL 137	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000					
10 BIRTHDATE **/**/****		11 SEX F		12 DATE 15		13 ACDT STATE 18	
14 TYPE 1		15 SPC 1		16 DHR 01		17 STAT 01	
18		19		20		21	
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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		2		3a PAT. CNTL # 111111111		4 TYPE OF BILL 137	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 102015	
10 BIRTH DATE **/**/**		11 SEX F		12 DATE 05		13 ICD-10 TYPE 1	
14 ICD-10 PROC 1		15 ICD-10 STAT 19		16 DHR 01		17 STAT 01	
18		19		20		21	
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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

ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000										2		3a PAT. CNTL. # 111111111 3b MED. REC. # 5 FED. TAX NO. 6 STATEMENT FROM 093015 7 COVERS PERIOD THROUGH 093015										4 TYPE OF BILL 112																																							
9 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000										c		e																																							
10 BIRTHDATE 11 SEX 12 DATE 13 M1 14 TYPE 15 SPC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACOT STATE 30										CONDITION CODES 31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE 39 OCCURRENCE DATE 40 CODE 41 OCCURRENCE DATE 42 CODE 43 OCCURRENCE DATE 44 CODE 45 OCCURRENCE DATE 46 CODE 47 OCCURRENCE DATE 48 CODE 49 OCCURRENCE DATE 50 CODE 51 OCCURRENCE DATE 52 CODE 53 OCCURRENCE DATE 54 CODE 55 OCCURRENCE DATE 56 CODE 57 OCCURRENCE DATE 58 CODE 59 OCCURRENCE DATE 60 CODE 61 OCCURRENCE DATE 62 CODE 63 OCCURRENCE DATE 64 CODE 65 OCCURRENCE DATE 66 CODE 67 OCCURRENCE DATE 68 CODE 69 OCCURRENCE DATE 70 CODE 71 OCCURRENCE DATE 72 CODE 73 OCCURRENCE DATE 74 CODE 75 OCCURRENCE DATE 76 CODE 77 OCCURRENCE DATE 78 CODE 79 OCCURRENCE DATE 80 CODE 81 OCCURRENCE DATE 82 CODE 83 OCCURRENCE DATE 84 CODE 85 OCCURRENCE DATE 86 CODE 87 OCCURRENCE DATE 88 CODE 89 OCCURRENCE DATE 90 CODE 91 OCCURRENCE DATE 92 CODE 93 OCCURRENCE DATE 94 CODE 95 OCCURRENCE DATE 96 CODE 97 OCCURRENCE DATE 98 CODE 99 OCCURRENCE DATE 100 CODE										31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE 39 OCCURRENCE DATE 40 CODE 41 OCCURRENCE DATE 42 CODE 43 OCCURRENCE DATE 44 CODE 45 OCCURRENCE DATE 46 CODE 47 OCCURRENCE DATE 48 CODE 49 OCCURRENCE DATE 50 CODE 51 OCCURRENCE DATE 52 CODE 53 OCCURRENCE DATE 54 CODE 55 OCCURRENCE DATE 56 CODE 57 OCCURRENCE DATE 58 CODE 59 OCCURRENCE DATE 60 CODE 61 OCCURRENCE DATE 62 CODE 63 OCCURRENCE DATE 64 CODE 65 OCCURRENCE DATE 66 CODE 67 OCCURRENCE DATE 68 CODE 69 OCCURRENCE DATE 70 CODE 71 OCCURRENCE DATE 72 CODE 73 OCCURRENCE DATE 74 CODE 75 OCCURRENCE DATE 76 CODE 77 OCCURRENCE DATE 78 CODE 79 OCCURRENCE DATE 80 CODE 81 OCCURRENCE DATE 82 CODE 83 OCCURRENCE DATE 84 CODE 85 OCCURRENCE DATE 86 CODE 87 OCCURRENCE DATE 88 CODE 89 OCCURRENCE DATE 90 CODE 91 OCCURRENCE DATE 92 CODE 93 OCCURRENCE DATE 94 CODE 95 OCCURRENCE DATE 96 CODE 97 OCCURRENCE DATE 98 CODE 99 OCCURRENCE DATE 100 CODE																																									
38 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000										39 CODE 40 CODE 41 CODE 42 CODE 43 CODE 44 CODE 45 CODE 46 CODE 47 CODE 48 CODE 49 CODE 50 CODE 51 CODE 52 CODE 53 CODE 54 CODE 55 CODE 56 CODE 57 CODE 58 CODE 59 CODE 60 CODE 61 CODE 62 CODE 63 CODE 64 CODE 65 CODE 66 CODE 67 CODE 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE 76 CODE 77 CODE 78 CODE 79 CODE 80 CODE 81 CODE 82 CODE 83 CODE 84 CODE 85 CODE 86 CODE 87 CODE 88 CODE 89 CODE 90 CODE 91 CODE 92 CODE 93 CODE 94 CODE 95 CODE 96 CODE 97 CODE 98 CODE 99 CODE 100 CODE										39 CODE 40 CODE 41 CODE 42 CODE 43 CODE 44 CODE 45 CODE 46 CODE 47 CODE 48 CODE 49 CODE 50 CODE 51 CODE 52 CODE 53 CODE 54 CODE 55 CODE 56 CODE 57 CODE 58 CODE 59 CODE 60 CODE 61 CODE 62 CODE 63 CODE 64 CODE 65 CODE 66 CODE 67 CODE 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE 76 CODE 77 CODE 78 CODE 79 CODE 80 CODE 81 CODE 82 CODE 83 CODE 84 CODE 85 CODE 86 CODE 87 CODE 88 CODE 89 CODE 90 CODE 91 CODE 92 CODE 93 CODE 94 CODE 95 CODE 96 CODE 97 CODE 98 CODE 99 CODE 100 CODE																																									
42 REV. CD. 43 DESCRIPTION 112 Room and Board 450 Emergency Room										44 HCPCS / RATE / HIPPS CODE 1000.00										46 SERV. DATE 100715										48 SERV. UNITS 1										47 TOTAL CHARGES 1000.00 570.89										48 NON COVERED CHARGES										49	
PAGE 1 OF 1										CREATION DATE										100715										TOTALS										1570.89																					
50 PRIOR NAME Medicaid										51 HEALTH PLAN ID										52 REL. INFO 53 ARD BIN										54 PRIOR PAYMENTS TPL : .. PAYMENT IF APPLICABLE										55 EST. AMOUNT DUE 57 OTHER PRV ID										56 NPI 1234567890 1234567											
58 INSURED'S NAME DOE, JANE										59 REL. 60 INSURE D'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 64201 Y V270 N 66541 N 66411 N V0481 N V061 N										67 66541 N 66411 N V0481 N V061 N										68 66541 N 66411 N V0481 N V061 N										69 66541 N 66411 N V0481 N V061 N										70 66541 N 66411 N V0481 N V061 N										71											
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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										2										3a PAY. CNTL. # b. MED. REC. # c. FED. TAX NO.										4 TYPE OF BILL 114																																																	
8 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000										7																																																											
10 BIRTHDATE 11 SEX 12 DATE 13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21										CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30																																																																					
31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37										OCCURRENCE SPAN 38 FROM 39 THROUGH 40 CODE 41 VALUE CODES 42 AMOUNT 43										OCCURRENCE SPAN 44 FROM 45 THROUGH 46 CODE 47 VALUE CODES 48 AMOUNT 49																																																											
38 DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000										a 80 b c d										2300																																																											
42 REV. CD										43 DESCRIPTION										44 HCPCS / RATE / HPPS 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																													
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																														11										4563.00																													
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50 PAYER NAME A Medicaid										51 HEALTH PLAN ID										52 FILL INFO										53 AND BIN										54 PRIOR PAYMENTS										55 EST. AMOUNT DUE										56 NPI 1234567890																			
57																																								TPL : ..										57 1234567																													
58																																								PAYMENT IF APPLICABLE										OTHER PRV ID																													
59 INSURED'S NAME A DOE, JANE										60 INSURED'S UNIQUE ID 0123456789012										61 GROUP NAME										62 INSURANCE GROUP NO.																																																	
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																											
66 OI0013 Y Z370 N O714 N O701 N Z23 N										67										68																																																											
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI										73																																							
74 PRINCIPAL PROCEDURE DATE 0UQG0ZZ										75 OTHER PROCEDURE DATE 100114										76 ATTENDING NPI 1987654322										77 QUAL 1765432																																																	
78 LAST WALKER										79 FIRST J										80 LAST WALKER										81 FIRST J																																																	
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0907

NUBC

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

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

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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		2		3a PAT. CNTL. # b. MED. REC. # 111111111		4 TYPE OF BILL 111	
8 PATIENT NAME a. DOE, JANE		9 PATIENT ADDRESS a. 1235 R. STREET, BATON ROUGE LA 70000					
10 BIRTHDATE 11 SEX 12 DATE 13 HPI 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21		22 23 24 25 26 27 28 29 ACCT STATE 30		CONDITION CODES			
31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE		39 OCCURRENCE DATE 40 CODE 41 OCCURRENCE DATE 42 CODE 43 OCCURRENCE DATE 44 CODE 45 OCCURRENCE DATE 46 CODE		47 OCCURRENCE DATE 48 CODE 49 OCCURRENCE DATE 50 CODE			
38 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000		39 CODE 80		40 CODE 300		41 CODE	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIRPS CODE		45 SERV. DATE	
112		Room and Board		1000.00		3	
250		Pharmacy				22	
270		Medical/Surgical Supply				14	
272		Sterile Supply				2	
300		Laboratory- Gen Classific				3	
302		Lab/ Immunology				1	
305		Lab Hematology				5	
370		Anesthesia				1	
636		Drugs				8	
710		Recovery Room				116	
720		Labor/Delivery				11	
46		SERV. UNITS		47 TOTAL CHARGES		48 NON COVERED CHARGES	
3				3000.00			
22				570.89			
14				618.00			
2				142.57			
3				270.00			
1				50.00			
5				80.86			
1				759.00			
8				619.85			
116				2589.00			
11				4563.00			
13263.17							
PAGE 1 OF 1		CREATION DATE		100715		TOTALS	
50 PRVYR NAME Medicaid		51 HEALTH PLAN ID		52 PRIOR PAYMENTS		53 EST. AMOUNT DUE	
				TPL : ..		54 1234567890	
				PAYMENT IF APPLICABLE		55 1234567	
56 INSURED'S NAME DOE, JANE		57 INSURE D'S UNIQUE ID 0123456789012		58 GROUP NAME TPL carrier		59 INSURANCE GROUP NO.	
				code if applicable			
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 OI0013 Y Z370 N O714 N O701 N Z23 N		67		68			
69 ADMIT DX 0UQG0ZZ		70 PATIENT REASON DX 100114		71 PPS CODE a. b. c.		72	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 ATTENDING NPI 1987654322		77 QUAL 1765432	
78 LAST WALKER		79 FIRST J		76 OTHER NPI		77 QUAL	
77 OPERATING NPI		78 FIRST		79 OTHER NPI		80 QUAL	
78 LAST		79 FIRST		80 OTHER NPI		81 QUAL	
79 LAST		80 FIRST		81 OTHER NPI		82 QUAL	
80 LAST		81 FIRST		82 OTHER NPI		83 QUAL	
81 LAST		82 FIRST		83 OTHER NPI		84 QUAL	
82 LAST		83 FIRST		84 OTHER NPI		85 QUAL	
83 LAST		84 FIRST		85 OTHER NPI		86 QUAL	
84 LAST		85 FIRST		86 OTHER NPI		87 QUAL	
85 LAST		86 FIRST		87 OTHER NPI		88 QUAL	
86 LAST		87 FIRST		88 OTHER NPI		89 QUAL	
87 LAST		88 FIRST		89 OTHER NPI		90 QUAL	
88 LAST		89 FIRST		90 OTHER NPI		91 QUAL	
89 LAST		90 FIRST		91 OTHER NPI		92 QUAL	
90 LAST		91 FIRST		92 OTHER NPI		93 QUAL	
91 LAST		92 FIRST		93 OTHER NPI		94 QUAL	
92 LAST		93 FIRST		94 OTHER NPI		95 QUAL	
93 LAST		94 FIRST		95 OTHER NPI		96 QUAL	
94 LAST		95 FIRST		96 OTHER NPI		97 QUAL	
95 LAST		96 FIRST		97 OTHER NPI		98 QUAL	
96 LAST		97 FIRST		98 OTHER NPI		99 QUAL	
97 LAST		98 FIRST		99 OTHER NPI		100 QUAL	

UB-04 CMS-1450

APPROVED OMB NO. 0938-0097

NUBC

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

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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										2										3a PAT. CNTRL. # 11111111 b. MED. REG. # c. STATEMENT COVERS PERIOD FROM 113016 THROUGH 120416 7										4 TYPE OF BILL 111									
8 PATIENT NAME a. DOE, JANE										9 PATIENT ADDRESS a. 1235 R. STREET, BATON ROUGE LA 70000																													
10 BIRTHDATE 11 SEX F 12 DATE 093015 13 HL 23 14 TYPE 1 15 SPC 2 16 DHR 15 17 STAT 01 C1 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30										CONDITION CODES																													
31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE 39 OCCURRENCE DATE 40 CODE 41 CODE 42 CODE																																							
36 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000										39 VALUE CODES AMOUNT 40 CODE 41 CODE 42 CODE																													
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										b																													
										c																													
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42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPP'S CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49																																							
1 112 Room and Board 1000.00																																							
2 250 Pharmacy																																							
3 270 Medical/Surgical Supply																																							
4 272 Sterile Supply																																							
5 300 Laboratory- Gen Classific																																							
6 302 Lab/ Immunology																																							
7 305 Lab Hematology																																							
8 370 Anesthesia																																							
9 636 Drugs																																							
10 710 Recovery Room																																							
11 720 Labor/Delivery																																							
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PAGE 1 OF 1

CREATION DATE 100715 TOTALS 18826.17

50 PAYER NAME Medicaid 51 HEALTH PLAN ID 52 PRIOR PAYMENTS TPL : .. 53 EST. AMOUNT DUE 1234567890 54 PAYMENT IF APPLICABLE 55 OTHER 1234567 56 INSURED'S NAME DOE, JANE 57 INSURED'S UNIQUE ID 0123456789012 58 GROUP NAME TPL carrier 59 INSURANCE GROUP NO. code if applicable 60 TREATMENT AUTHORIZATION CODES 61 DOCUMENT CONTROL NUMBER 62 EMPLOYER NAME 63 010013 Y Z370 N 0714 N 0701 N Z23 N 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

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

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

**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										2										3a PAT. CNTRL. # b. MED. REC. # 5 FED. TAX NO.										111111111 6 STATEMENT FROM 093015										7 PERIOD COVERS THROUGH 093015										4 TYPE OF BILL 117																													
8 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000																																																																					
b 10 BIRTHDATE **/**/**** F 093015 23 1 2 15 30 C1										b 11 SEX 12 DATE OF ADMISSION 13 HR 14 TYPE 15 SPC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30										c										d										e																																							
31 OCCURRENCE DATE 32 CODE										33 OCCURRENCE DATE 34 CODE										35 OCCURRENCE DATE 36 CODE										37 OCCURRENCE DATE 38 CODE										39 OCCURRENCE DATE 40 CODE										41 OCCURRENCE DATE 42 CODE										43 OCCURRENCE DATE 44 CODE																			
38 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000										39 a 80 b c d										40 a 130 b c d										41 a b c d										42 a b c d										43 a b c d										44 a b c d																			
45 REV. CD.										46 DESCRIPTION										47 HCPCS / RATE / HIPPS CODE										48 SERV. DATE										49 SERV. UNITS										50 TOTAL CHARGES										51 NON-COVERED CHARGES										52									
1 112										Room and Board										1000.00										1										1000.00																																							
2 250										Pharmacy																				3										80.60																																							
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

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

ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000														PAT. CNTRL # S. MED. REC.# 111111111				TYPE OF BILL 117																							
						FED. TAX NO.								STATEMENT COVERS PERIOD FROM 100115				THROUGH 100415																							
PATIENT NAME DOE, JANE						PATIENT ADDRESS 1235 R. STREET, BATON ROUGE LA 70000																																			
BIRTHDATE **/**/**** F 093015 23 1 2 15						ADMISSION DATE TYPE SFG DHR STAT C1														CONDITION CODES 22 23 24 25 26 27 28				ACOT STATE 30																	
OCCURRENCE DATE CODE						OCCURRENCE DATE CODE						OCCURRENCE DATE CODE						OCCURRENCE DATE CODE						OCCURRENCE SPAN THROUGH FROM						OCCURRENCE SPAN THROUGH FROM											
DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000						VALUE CODES AMOUNT 80 300						VALUE CODES AMOUNT 40						VALUE CODES AMOUNT 41						VALUE CODES AMOUNT 42																	
REV. CD.						DESCRIPTION						HCP/CB / RATE / HIPPS CODE						SERV. DATE						SERV. UNITS						TOTAL CHARGES						NON COVERED CHARGES					
112 Room and Board						1000.00												3						3000.00																	
250 Pharmacy																		22						570.89																	
270 Medical/Surgical Supply																		14						618.00																	
272 Sterile Supply																		2						142.57																	
300 Laboratory- Gen Classific																		3						270.00																	
302 Lab/ Immunology																		1						50.00																	
305 Lab Hematology																		5						80.86																	
370 Anesthesia																		1						759.00																	
636 Drugs																		8						619.85																	
710 Recovery Room																		116						2589.00																	
720 Labor/Delivery																		11						4563.00																	
PAGE 1 OF 1						CREATION DATE						122815						TOTALS						13263.17																	
PRIMER NAME Medicaid						HEALTH PLAN ID						PRIOR PAYMENTS TPL : PAYMENT IF APPLICABLE						EST. AMOUNT DUE 57 1234567						INSURANCE GROUP NO. 1234567																	
INSURED'S NAME DOE, JANE						INSURED'S UNIQUE ID 0123456789012						GROUP NAME TPL CARRIER CODE IF APPLICABLE						INSURANCE GROUP NO.																							
TREATMENT AUTHORIZATION CODES						DOCUMENT CONTROL NUMBER A 5309198798700 02						EMPLOYER NAME																													
O10013 Y Z370 N O714 N O701 N Z23 N																																									
ADMIT DK						PATIENT REASON DX						PPS CODE						ECI																							
74 PRINCIPAL PROCEDURE DATE 0UQG0ZZ 100114						OTHER PROCEDURE CODE a						OTHER PROCEDURE DATE b						75 ATTENDING NPJ LAST WALKER FIRST J																							
c OTHER PROCEDURE DATE						d OTHER PROCEDURE CODE						e OTHER PROCEDURE DATE						77 OPERATING NPJ LAST FIRST																							
REMARKS						BICC a b c d						78 OTHER NPJ LAST FIRST						79 OTHER NPJ LAST FIRST																							

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

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**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		2		3a PAY. CHITL # b MED. REC. # c		111111111		4 TYPE OF BILL 121	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 101515		7 THROUGH 101915	
10 BIRTHDATE 11 SEX 12 DATE 13 PR. 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21		22 CONDITION CODES 23 24 25 26 27 28 29 ACCT STATE 30		31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37		38		39 VALUE CODES 40 CODE 41 VALUE CODES 42 CODE 43 VALUE CODES 44 CODE 45	
38 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000		39 80 400		40 400		41 400		42 400	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPS CODE		45 SERV. DATE		46 SERV. UNITS	
112		Room and Board		1000.00				4	
250		Pharmacy						5	
260		IV Therapy						7	
270		Med-Surg Supplies						2	
300		Laboratory- Gen Classific						3	
320		Radiology- Diagnostic						3	
410		Respiratory						5	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		4000: 00		478: 00	
618: 00		142: 57		270: 00		71: 00		500: 00	
SAMPLE		EXAMPLE OF ICD 10		WITH AN ATTENDING PROVIDER ONLY					
PAGE 1 OF 1		CREATION DATE		100715		TOTALS		6079: 57	
50 PAYER NAME Medicare Medicaid		51 HEALTH PLAN ID 19000		52 PRIOR PAYMENTS 2079: 57		53 EST. AMOUNT DUE		54 NPI 1234567890	
55 INSURED'S NAME DOE, JANE		56 INSURED'S UNIQUE ID 0123456789012		57 GROUP NAME TPL carrier code if applicable		58 INSURANCE GROUP NO.		59 OTHER PRV ID 1234567	
60 TREATMENT AUTHORIZATION CODES		61 DOCUMENT CONTROL NUMBER		62 EMPLOYER NAME					
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