
CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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
- 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; and
http://www.lamedicaid.com/provweb1/fee_schedules/Out_Amb_FS_Rural_State.pdf.

The **pre-certification** forms listed below can be obtained from the Louisiana Medicaid web site at: <http://www.lamedicaid.com/provweb1/Forms/PCforms.htm>.

- PCF01 – PCF06
- PCF0A
- Acute Long Term Hospital Length of Stay Criteria
- Hospital-Based Alcoholism and Drug Treatment Units
- Psychiatric Unit Admission/Extension Criteria for Adults
- Psychiatric Unit Admission/Extension Criteria for Children
- Rehabilitation Hospital Length of Stay Criteria
- BHSF Form 142-C and Instructions (Hospital Admission Form)

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

CHAPTER 25: HOSPITALS SERVICES

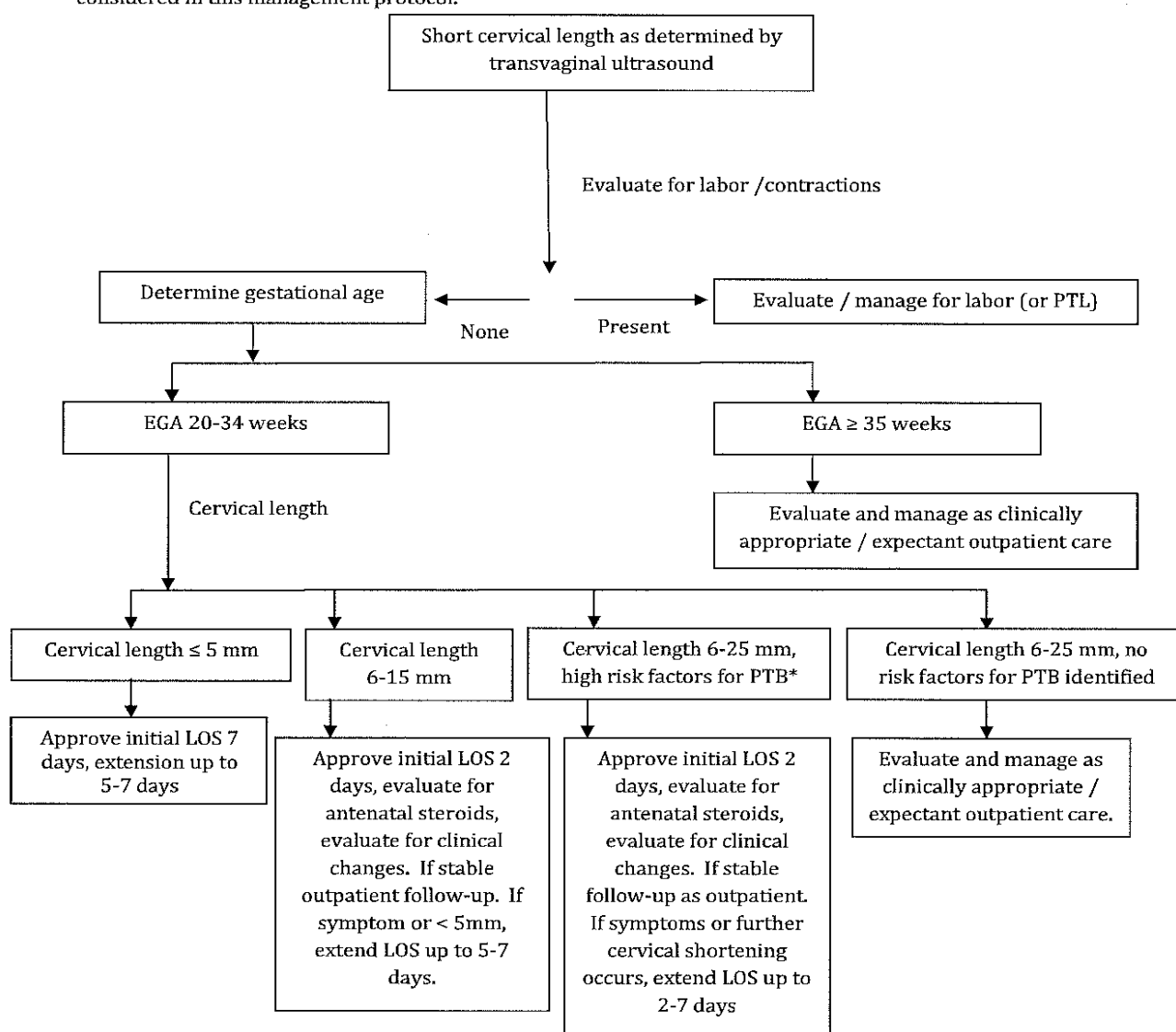
APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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 #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone No.	Required. Enter the name and address of the facility	
2	Pay to Name/Address/ID	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	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 No.	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 & 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>	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
5	Federal Tax No.	Optional.	
6	Statement Covers Period (From and Through Dates) dates of the period covered by this bill.	Required. Enter the beginning and ending service dates	
7	Unlabeled	<p>Optional. State Assigned.</p> <p>Note: Hospitals billing for services associated with moderate to high level emergency physician care (99283, 99284, and 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 8 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>	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
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.	
13	Admission Hour	Required for Hospital Services. Enter the 2-digit code which corresponds to the hour the patient was admitted for care as: <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	
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	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions			Alerts
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. The point of origin is the <u>direct</u> 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. <u>NOTE:</u> Newborn codes are at the end of this listing.
		NOTE: Newborn codes are at the end of the listing.			
		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 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.			

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions			Alerts
		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.	
		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.	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions			Alerts
		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 or enrolled in a Hospice Program.	Inpatient: The patient was admitted to this facility as a transfer from hospice.	
			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 2-digit code which corresponds to the hour the patient was discharged. See Form Locator 13.			

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
17	Patient Status	<p>Required for Hospital Services. Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are:</p> <p>01 = Discharged (routine) 02 = Discharged to another short-term general hospital 03 = Discharged to Skilled Nursing Facility 04 = Discharged to Intermediate Care Facility 05 = Discharged to another type of institution 06 = Discharged/transferred to home under care of home health service organization 07 = Left against medical advice 20 = Expired 30 = Still Patient</p>	<p>Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.</p>
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>	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
18-28 (cont'd)	Condition Codes (cont'd)	<u>Accommodations</u> 38 = Semi-private room not available 39 = Private room medically necessary 40 = Same day transfer <u>Special Program Indicators</u> A1 = EPSDT/CHAP A2 = Physically Handicapped Children's Program A4 = Family Planning	
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	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
35-36	Occurrence Spans (Code and Dates)	<p>Situational. Enter, if applicable, a code and related dates that identify 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.	
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. 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.</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>

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
39-41 (cont'd)	Value Codes and Amounts (cont'd)	<p>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</p> <p>*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.</p>	<p>Please read the instructions carefully for entering the new number of days information in the Value Code fields.</p> <p>The dollars/cents data must be entered accurately to prevent claim denials.</p>
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>

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
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 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 three 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. The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.</p> <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>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> <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>

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
43 (cont'd)	Revenue Description (cont'd)	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.	
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 HCPCS code that corresponds with the NDC entered in FL 43 must be entered in FL 44.</p> <p>EXCEPTION: HR 258 no longer requires the entry of a HCPCS code and/or NDC.</p> <p>Modifiers are recognized on paper claims when required by Medicaid policy. Modifiers should be entered ONLY in such cases.</p>
45	Service Date	<p>Required for outpatient services. Enter the appropriate service date (MMDDYY) on each line indicating a Revenue Code.</p> <p>Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	<p>The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).</p>

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
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	<p>Situational. Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is required.</p> <p>If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan ID	Situational. Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is required .	
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Cert. Ind.	Optional.	
54-A,B,C	Prior Payments	Situational. Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
54-A,B,C (cont'd)	Prior Payments (cont'd)	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.	
55-A,B,C	Estimated Amt. Due	Optional.	
56	NPI	Required. Enter the provider's National Provider Identifier	The 10-digit National Provider Identifier (NPI) must be entered here.
57	Other Provider ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	The 7-digit Medicaid provider number must be entered here.
58-A,B,C	Insured's Name	Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A. Situational: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the 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)	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
59-A,B,C (cont'd)	Patient's Relationship Insured (cont'd)	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.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE
62-A,B,C	Insured's Group No. (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
63-A,B,C	Treatment Auth. 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	<p>Situational. If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error</p> <p><u>Adjustments (Continued)</u> 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	To adjust or void more than one claim line 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	<p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p>	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
67	Principal Diagnosis Codes	Required. Enter the ICD-9-CM/ ICD-10-CM code for the principal diagnosis.	The most specific diagnosis codes must be used. General codes are not acceptable.
67 A-Q	Other Diagnosis Code	<p>Situational. Enter the ICD-9-CM/ ICD-10-CM code or codes for all other applicable diagnoses for this claim.</p> <p>Use the most specific and accurate Diagnosis Code. A code is invalid if it has not been coded to the full number of digits required for that code.</p> <p>Note: ICD-9-CM Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</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>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 10/1/15 forward.</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 field locator 67.
70	Patient Reason for Visit	Optional. Enter the appropriate Diagnosis Code indicating the patient’s presenting symptom.	Refer to field locator 67.
71	PPS Code	Leave blank.	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

Locator #	Description	Instructions	Alerts
72 A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Situational. Enter a valid current ICD-9-PCS / ICD-10-PCS procedure code when an inpatient procedure is performed.	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 10/1/15 forward. 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).
74 a - e	Other Procedure Code / Date	Situational. Enter valid current ICD-9-PCS / ICD-10-PCS procedure codes as appropriate for multiple inpatient procedures.	
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and/or number of the attending physician.	This field must be completed.
77	Operating	Situational. If applicable, enter the name and/or number of the operating physician. Note: For sterilization procedures, the surgeon's name must appear in Form Locator 77.	
78	Other	Situational. If applicable, enter the name and/or number of any other physician.	
79	Other	Situational. If applicable, enter the name and/or 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.

PAGE(S) 30

ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000		2		3a PRV CNTRL # b. MED REC #		111111111		4 TYPE OF BILL		131	
9 PATIENT NAME		a		DOE, JANE		9 PATIENT ADDRESS		a		1235 R. STREET, BATON ROUGE LA 70000	
b		10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 ICD 9 14 TYPE 15 SPD		16 DHR	
17 STAT		18		19		20		21		CONDITION CODES 22 23 24 25 26 27 28	
29 ACCT STATE		30		31		32		33		34	
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PAGE(S) 30

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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000		2		3a PAT. CNTL. # b MED. REC. # c		4 TYPE OF BILL 137	
5 PATIENT NAME a DOE, JANE		6 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000		7		8 STATEMENT COVERS PERIOD FROM 093015 THROUGH 093015	
10 BIRTHDATE **/**/**		11 SEX F		12 DATE 15 1 18		13 ADMISSION 14 TYPE 15 SPC 16 DHR 17 STAT 18 01	
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

SAMPLE OUTPATIENT HOSPITAL CLAIM FORM ADJUSTMENT 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. OUTL. # 11111111 3b MED. REC. # 3c 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		13 ADMISSION 13 HPI 14 TYPE 15 SPC 16 DHR	
17 STAT 01		18		19		20	
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25		26		27		28	
29 ACCT STATE		30		31		32	
33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE	
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

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

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000										2										3a PAT. CONT. # b. MED. REC. # 5 FED. TAX NO.										4 TYPE OF BILL 112																																																																																																																																																																																																																																															
8 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000										6 STATEMENT COVERS PERIOD FROM 093015 THROUGH 093015										7																																																																																																																																																																																																																																															
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0097

DATE 10/1/15

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

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000										2										3a PRI. CNTL. # 11111111 b. MED. REC. # 5 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										6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100315										7																																																																																																																																																																																			
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42 REV. CD 112										43 DESCRIPTION Room and Board										44 HCPCS / RATE / HPPS CODE 1000.00										45 SERV. DATE										46 SERV. UNITS 2										47 TOTAL CHARGES 2000.00										48 NON-COVERED CHARGES										49																																																																																																																																											
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0097

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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 ICD-10 DIAGNOSIS CODE
(WITH 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. REG. # 111111111		4 TYPE OF BILL 111	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 093015		7 THROUGH 100315			
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000					
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10 BIRTHDATE **/**/****		11 SEX F		12 DATE 093015		13 HR 23	
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990		991		992		993	

CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

SAMPLE INPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000		2		3a PAT. QNTL # b. MED. REC. # c. FED. TAX NO.		111111111		4 TYPE OF BILL 117																																	
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 HR 23		14 TYPE 1		15 SFC 2		16 DHR 15		17 STAT 30		18 CI		19		20		21		22		23		24		25		26		27		28		29 ACOT STATE		30	
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			
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CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

PAGE(S) 30

SAMPLE INPATIENT HOSPITAL CLAIM FORM 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 3b MED. REC. # 3c FED. TAX NO.										4 TYPE OF BILL 117																																																																																																																																																																																																																																															
8 PATIENT NAME a DOE, JANE										9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000										c										d																																																																																																																																																																																																																																															
10 BIRTHDATE **/**/****										11 SEX F										12 DATE OF ADMISSION 093015										13 ICD-10 CODE 23										14 ICD-10 CODE 1										15 ICD-10 CODE 2										16 DHR 15										17 STAT 01										18 CI										19										20										21										22										23										24										25										26										27										28										29 ACCT STATE										30																																																																					
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE										35 OCCURRENCE DATE										36 OCCURRENCE DATE										37 OCCURRENCE DATE										38										39										40										41										42										43										44										45										46										47										48										49																																																																																									
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42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPIS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON COVERED CHARGES										49																																																																																																																																																																																																							
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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																																																																																																																																																																																																																											
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305										Lab Hematology																														5										80.86																																																																																																																																																																																																																											
370										Anesthesia																														1										759.00																																																																																																																																																																																																																											
636										Drugs																														8										619.85																																																																																																																																																																																																																											
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50 PAYER NAME Medicaid										51 HEALTH PLAN ID										52 PAYER INFO										53 PRIOR PAYMENTS										54 EST. AMOUNT DUE										55 NPI 1234567890										56 NPI 1234567																																																																																																																																																																																																																	
58 INSURED'S NAME DOE, JANE										59 P. REL.										60 INSURED'S UNIQUE ID 0123456789012										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																																																																																																																																																																																					
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER A										65 EMPLOYER NAME																																																																																																																																																																																																																																																									
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74 PRINCIPAL PROCEDURE CODE 00UG0ZZ										75 OTHER PROCEDURE CODE 100114										76 ATTENDING NPI 1987654322										77 QUAL 1765432																																																																																																																																																																																																																																															
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UB-04 CMS-1400

APPROVED OMB NO. 0908-0097

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 DAYS X PER DIEM CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000		2		3a PRV. CONTR. # 111111111		4 TYPE OF BILL 121	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 101515		7 THROUGH 101915			
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000					
10 BIRTH DATE **/****		11 SEX F		12 DATE 093015		13 ADMISSION 14 TYPE 15 SPC 16 DHR 17 STAT 18 C1	
19		20		21		22	
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31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
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871							