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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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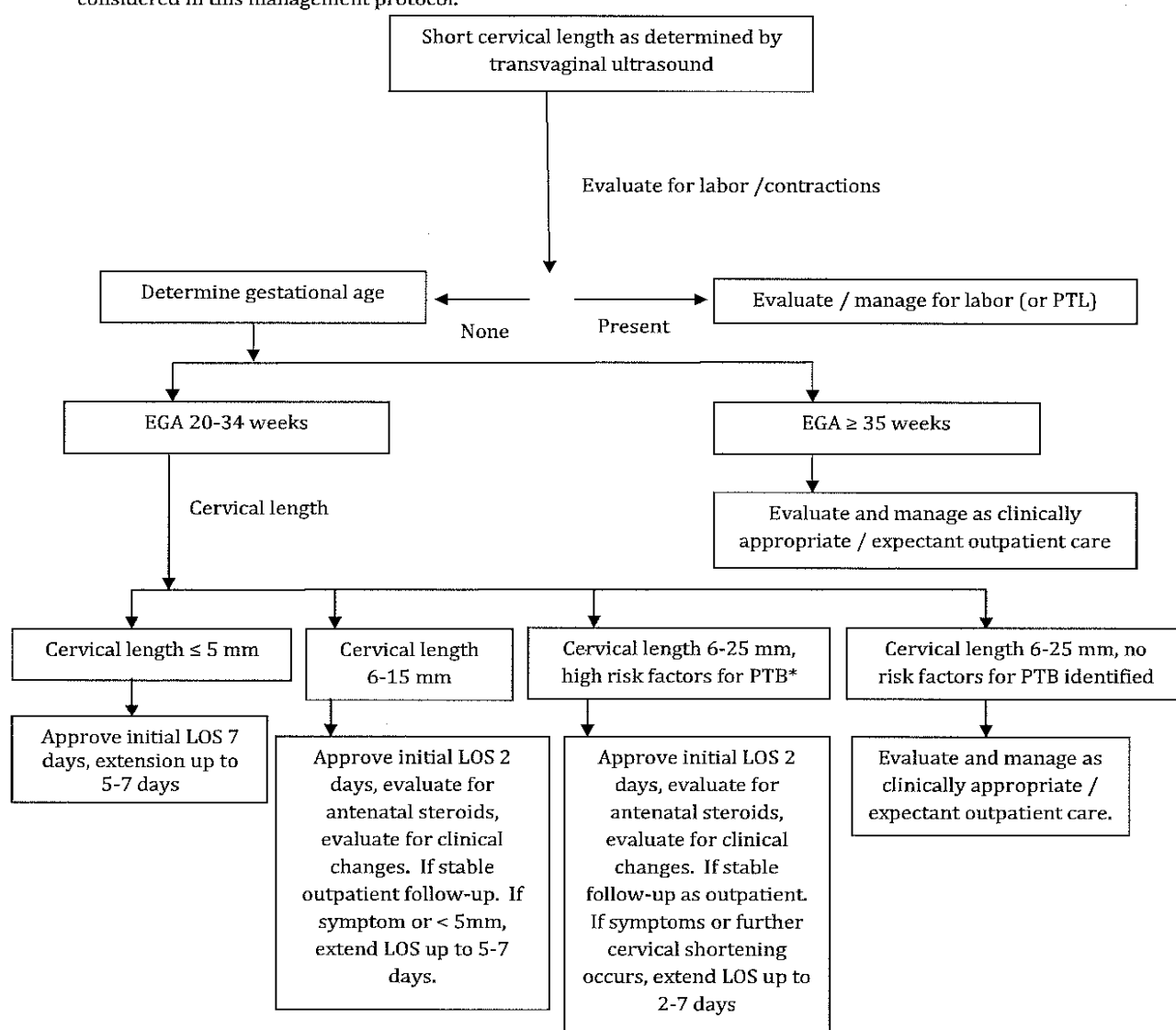
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Short Cervix Guide

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</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)		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	Required for hospital services. Enter C1 in Form Locator 18 for inpatient claims. <u>PRO Approval</u> C1 Approved as billed. Optional. Must be a valid code if entered. Valid codes are listed as follows: <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			
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			

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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. 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)**

1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000										2										3a PAT. CNTL. # 111111111										4 TYPE OF BILL 131																																																																																																																																																																									
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0197

NUBC

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

CHAPTER 25: HOSPITALS SERVICES

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

[illegible]

CHAPTER 25: HOSPITALS SERVICES

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

[illegible]

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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 b. 1235 R. STREET, BATON ROUGE LA 70000					
10 BIRTHDATE **/**/**	11 SEX F	12 DATE	13 ADMISSION 15 15	14 TYPE 1	15 SPC 1	16 DHR 18	17 STAT 01
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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										2										3a PAT. CNTRL.# b. MED. REC.#										4 TYPE OF BILL																																																	
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ANYTOWN, LA 70000																				5 FED. TAX NO.										6 STATEMENT COVERS PERIOD FROM 102015 THROUGH 102015										7																																							
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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)**

[illegible]

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. # 5 FED. TAX NO.		c 111111111		4 TYPE OF BILL 114	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS b 1235 R. STREET, BATON ROUGE LA 70000		c		d		e	
10 BIRTHDATE 11 SEX 12 DATE 13 ADMISSION 14 TYPE 15 SPC 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 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 OCCURRENCE DATE 36 OCCURRENCE DATE 37		38		39	
38 DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000		39 a 80 b c d		40 a 2300 b c d		41 a b c d		42 a b c d	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV. DATE		46 SERV. UNITS	
1 112		Room and Board		1000.00				2	
2 250		Pharmacy						22	
3 270		Medical/Surgical Supply						14	
4 272		Sterile Supply						2	
5 300		Laboratory- Gen Classific						3	
6 302		Lab/ Immunology						1	
7 305		Lab Hematology						5	
8 370		Anesthesia						1	
9 636		Drugs						8	
10 710		Recovery Room						116	
11 720		Labor/Delivery						11	
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PAGE 1 OF 1		CREATION DATE		100715		TOTALS		12263 : 17	
50 PAYER NAME A Medicaid		51 HEALTH PLAN ID		52 FILL INFO 53 AND BIN		54 PRIOR PAYMENTS TPL : .. PAYMENT IF APPLICABLE		55 EST. AMOUNT DUE 56 NPI 1234567890 57 1234567 58 OTHER PRV ID	
59 INSURED'S NAME A DOE, JANE		60 INSURED'S UNIQUE ID 0123456789012		61 GROUP NAME TPL CARRIER CODE IF APPLICABLE		62 INSURANCE GROUP NO.			
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					
66 OI0013 Y Z370 N O714 N O701 N Z23 N		67		68		69		70	
71 ADMIT DX		72 PATIENT REASON DX		73 PPS CODE		74 ECI		75	
76 PRINCIPAL PROCEDURE CODE 0UQG0ZZ		77 OTHER PROCEDURE DATE 100114		78 OTHER PROCEDURE CODE 0UQG0ZZ		79 OTHER PROCEDURE DATE 100114		80	
81 ATTENDING NPI 1987654322		82 QUAL J		83 FIRST WALKER		84 LAST WALKER		85	
86 OPERATING NPI		87 QUAL		88 FIRST		89 LAST		90	
91 OTHER NPI		92 QUAL		93 FIRST		94 LAST		95	
96 OTHER NPI		97 QUAL		98 FIRST		99 LAST		100	
101 REMARKS		102		103		104		105	
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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

PAGE(S) 30

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 **/**/**** F 093015		11 SEX F		12 DATE 093015		13 ADMISSION 13 HPI 14 TYPE 15 SPC 1 2 15	
16 DHR 17 STAT 01 C1		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACCT 30 STATE		31		32		33	
34		35		36		37	
38		39		40		41	
38 DOE, JANE 1235 R. STREET BATON ROUGE LA 70000		39 CODE 80		40 VALUE CODES AMOUNT 3.00		41 CODE 80	
42		43		44		45	
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		47		48		49	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
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					
PAGE 1 OF 1		CREATION DATE		100715		TOTALS	
13263.17							
50 PRV. NAME Medicaid		51 HEALTH PLAN ID		52 PHL INO		53 PRIOR PAYMENTS	
						54 EST. AMOUNT DUE	
						55 NPI	
						1234567890	
56 INSURED'S NAME DOE, JANE		57 PRIOR PAYMENTS		58 EST. AMOUNT DUE		59 NPI	
						1234567	
60 INSURED'S UNIQUE ID 0123456789012		61 GROUP NAME TPL carrier		62 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		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73 PRINCIPAL PROCEDURE CODE 0UQG0ZZ		74 OTHER PROCEDURE DATE 100114		75 OTHER PROCEDURE DATE		76 ATTENDING NPI 1987654322	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		80 QUAL 1765432	
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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. # 111111111 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 HPI 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																													
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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																																							
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6 302 Lab/ Immunology																																							
7 305 Lab Hematology																																							
8 370 Anesthesia																																							
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SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

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 PAYER ID 1234567

56 INSURED'S NAME DOE, JANE 57 INSURED'S UNIQUE ID 0123456789012 58 GROUP NAME TPL carrier code if applicable 59 INSURANCE GROUP NO.

60 TREATMENT AUTHORIZATION CODES 61 DOCUMENT CONTROL NUMBER 62 EMPLOYER NAME

63 OI0013 Y Z370 N O714 N O701 N Z23 N 64

65 ADMIT DX 66 PATIENT REASON DX 67 OTHER PROCEDURE CODE 68 OTHER PROCEDURE DATE 69 OTHER PROCEDURE CODE 70 OTHER PROCEDURE DATE 71 OTHER PROCEDURE CODE 72 OTHER PROCEDURE DATE 73 OTHER PROCEDURE CODE 74 OTHER PROCEDURE DATE 75 OTHER PROCEDURE CODE 76 OTHER PROCEDURE DATE 77 OTHER PROCEDURE CODE 78 OTHER PROCEDURE DATE 79 OTHER PROCEDURE CODE 80 OTHER PROCEDURE DATE 81 OTHER PROCEDURE CODE 82 OTHER PROCEDURE DATE 83 OTHER PROCEDURE CODE 84 OTHER PROCEDURE DATE 85 OTHER PROCEDURE CODE 86 OTHER PROCEDURE DATE 87 OTHER PROCEDURE CODE 88 OTHER PROCEDURE DATE 89 OTHER PROCEDURE CODE 90 OTHER PROCEDURE DATE 91 OTHER PROCEDURE CODE 92 OTHER PROCEDURE DATE 93 OTHER PROCEDURE CODE 94 OTHER PROCEDURE DATE 95 OTHER PROCEDURE CODE 96 OTHER PROCEDURE DATE 97 OTHER PROCEDURE CODE 98 OTHER PROCEDURE DATE 99 OTHER PROCEDURE CODE 100 OTHER PROCEDURE DATE

76 ATTENDING NPI 1987654322 QUAL 1765432
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77 OPERATING NPI QUAL
LAST DOE FIRST APRIL
78 OTHER DN NPI 15899999999 QUAL
LAST DOE FIRST APRIL
79 OTHER NPI QUAL
LAST DOE FIRST APRIL

80 REMARKS 81 CC a 82 CC b 83 CC c 84 CC d

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. CNTL. # b. MED. RESC. # 111111111		4 TYPE OF BILL 117	
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 093015 THROUGH 093015	
10 BIRTHDATE **/**/**** F 093015		11 SEX F		12 DATE 093015		13 ADMISSION 13 ICL 14 TYPE 15 SPC 16 DHR 17 STAT C1	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE		38 CODE	
39 VALUE CODES AMOUNT		40 CODE		41 VALUE CODES AMOUNT		42 CODE	
43 VALUE CODES AMOUNT		44 CODE		45 VALUE CODES AMOUNT		46 CODE	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
112 Room and Board		1000.00		1		1000.00	
250 Pharmacy				3		80.60	
						570.89	
PAGE 1 OF 1		CREATION DATE 100715		TOTALS		1651.49	
50 PAYER NAME Medicaid		51 HEALTH PLAN ID		52 RPL INFO		53 PRIOR PAYMENTS	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57	
58 INSURED'S NAME DOE, JANE		59 INSURE D'S UNIQUE ID 0123456789012		60 GROUP NAME TPL CARRIER		61 INSURANCE GROUP NO.	
62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER A 5250198798700 02		64 EMPLOYER NAME			
65 ADMIT DATE		66 PATIENT REASON/DX		67 CODE		68	
69 PRINCIPAL PROCEDURE DATE		70 OTHER PROCEDURE DATE		71 OTHER PROCEDURE DATE		72	
73 ATTENDING NPI 1987654322		74 QUAL		75 FIRST		76	
77 OPERATING NPI		78 QUAL		79 FIRST		80	
81 OTHER NPI		82 QUAL		83 FIRST		84	
85 OTHER NPI		86 QUAL		87 FIRST		88	
89 OTHER NPI		90 QUAL		91 FIRST		92	
93 OTHER NPI		94 QUAL		95 FIRST		96	
97 OTHER NPI		98 QUAL		99 FIRST		100	

LB-04 CMS-1400

APPROVED OMB NO. 0908-0097

NUBC

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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-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. # c										4 TYPE OF BILL 117																																																																					
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 100115 THROUGH 100415										7																																																											
10 BIRTHDATE b										11 SEX F										12 DATE 093015										13 ADMISSION 13 HR 14 TYPE 15 SPC 16 DHR										17 STAT 01 C1										18 CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE																																																	
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE										35 OCCURRENCE DATE										36 OCCURRENCE DATE										37																																							
38 DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000										39 CODE a 80 b c d										40 VALUE CODES AMOUNT 3.00										41 CODE a b c d										42 VALUE CODES AMOUNT										43 CODE a b c d										44 VALUE CODES AMOUNT																																							
45 REV. CD.										46 DESCRIPTION										47 HCPCS / RATE / HIPS CODE										48 SERV. DATE										49 SERV. UNITS										50 TOTAL CHARGES										51 NON-COVERED CHARGES										52																													
112										Room and Board										1000.00																				3										3000.00																				1																													
250										Pharmacy																														22										570.89																				2																													
270										Medical/Surgical Supply																														14										618.00																				3																													
272										Sterile Supply																														2										142.57																				4																													
300										Laboratory- Gen Classific																														3										270.00																				5																													
302										Lab/ Immunology																														1										50.00																				6																													
305										Lab Hematology																														5										80.86																				7																													
370										Anesthesia																														1										759.00																				8																													
636										Drugs																														8										619.85																				9																													
710										Recovery Room																														116										2589.00																				10																													
720										Labor/Delivery																														11										4563.00																				11																													
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PAGE 1 OF 1										CREATION DATE										122815										TOTALS										13263.17																				24																																							
53 PRIOR NAME Medicaid										54 HEALTH PLAN ID										55 PRIOR PAYMENTS TPL										56 EST. AMOUNT DUE 1234567890										57 NPI 1234567										58																																																	
59 INSURED'S NAME DOE, JANE										60 INSURED'S UNIQUE ID 0123456789012										61 GROUP NAME TPL CARRIER CODE IF APPLICABLE										62 INSURANCE GROUP NO.										63																																																											
64 TREATMENT AUTHORIZATION CODES A										65 DOCUMENT CONTROL NUMBER 5309198798700										66 EMPLOYER NAME										67										68																																																											
69 ADMIT DX										70 PATIENT REASON										71 ICD-10 CODE										72 ECG										73										74																																																	
74 PRINCIPAL PROCEDURE CODE 0UQG0ZZ										75 OTHER PROCEDURE CODE 100114										76 ATTENDING NPI 1987654322										77 QUAL 1765432										78																																																											
77 OPERATING CODE										78 OTHER CODE										79 LAST WALKER										80 FIRST J										81																																																											
80 REMARKS										81 CC a										82 LAST WALKER										83 FIRST J										84																																																											
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0097

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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 **/**/**** F 093015		11 SEX F		12 DATE 093015		13 ADMISSION 13 PR 14 TYPE 15 SPC 1 2		16 DHR 15	
17 STAT 01		18 CI		19		20		21	
22		23		24		25		26	
27		28		29		30		31	
32		33		34		35		36	
37		38		39		40		41	
39 CODE 80		40 CODE 4300		41 CODE		42 CODE		43 CODE	
44		45		46		47		48	
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54		55		56		57		58	
59		60		61		62		63	
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109		110		111		112		113	
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759		760		761		762		763	
764		765		766		767		768	
769		770		771		772		773	
774		775		776		777		778	
779		780		781		782		783	
784		785		786		787		788	
789		790		791		792		793	
794		795		796		797		798	
799		800		801		802		803	
804		805		806		807		808	
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814		815		816		817		818	
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824		825		826		827		828	
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834		835		836		837		838	
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849		850		851		852		853	
854		855		856		857		858	
859		860		861		862		863	
864		865		866		867		868	
869		870		871		872		873	
874		875		876		877		878	
879		880		881		882		883	
884		885		886		887		88	