

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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UB-04 FORM AND INSTRUCTIONS

The UB-04 claim form is required for billing Medicaid and is suitable for billing most third party payers (both government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicaid hospice claims. Items not listed need not be completed, although you may complete them when billing multiple payees.

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5 PATIENT NAME		6 PATIENT ADDRESS		7 STATEMENT COVERS PERIOD FROM		8 THROUGH	
9 BIRTHDATE		10 SEX		11 DATE		12	
13 ADMISSION		14 TYPE		15 SRC		16 EHR	
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UB-04 Instructions for Hospice Providers

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/Identification (ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	Required. Enter the appropriate 3-digit code as follows: <u>a. First digit-type facility</u> 8 = Special facility (hospice) <u>b. Second digit-classification</u> 1 = Hospice (Non-hospital based) 2 = Hospice (Hospital based) <u>c. Third digit-frequency</u> 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax Number	Optional.	

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Locator #	Description	Instructions	Alerts
6	Statement Covers Period (from and through dates of the period covered by this bill)	<p>Required. Enter the beginning and ending service dates.</p> <p>Note: Do not show days before the patient's entitlement began.</p> <p>Note: A claim may not span more than one month of service at a time.</p>	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, and middle initial.	
9a-e	Patient's Address (Street, City, State, and 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 Birth Date	Required. Enter the patient's date of birth using six 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>	

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Locator #	Description	Instructions	Alerts
12	Admission Date	<p>Required. Enter the admission date in MMDDYY format, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the "From" date in the Statement Covers Period (Form Locator 6).</p> <p>The date of admission may not precede the physician's certification by more than two calendar days.</p> <p>Note: If the Notice of Election (NOE) form and the Certification of Terminal Illness (CTI) are not received within ten calendar days, the date of admission (election) will be the date BHSF receives the proper documentation.</p>	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

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Locator #	Description	Instructions	Alerts
17	Patient Status	<p>Required. Enter the patient's two digit status code as of the "Through" date of the billing period (Form Locator 6).</p> <p><u>Valid Codes</u> 01 = Discharged to home or self-care (routine discharge) 30 = Still patient or expected to return for outpatient services. 40 = Expired at home. 41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice. 42 = Expired – place unknown</p>	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	<p>Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MMDDYY). If there are more occurrences than there are spaces on the form, use Form Locators 35 and 36 (occurrence spans) to record additional occurrences and dates.</p> <p>Use the following codes where appropriate:</p> <p>27 = Date of Hospice Certification. Code indicates the date of written certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.</p>	

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Locator #	Description	Instructions	Alerts
31-34 (cont'd)	Occurrence Codes/Dates (cont'd)	<p>This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject.</p> <p>Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date.</p> <p>42 = Termination date. Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)</p>	
35-36	Occurrence Spans (Code and Dates)	<p>Situational. If a specific event relating to this billing period should be indicated, then enter the code(s) and associated beginning and ending date(s). Event codes are two alphanumeric characters, and dates are shown numerically as MMDDYY. Use the following code when appropriate:</p> <p>M2 = Dates of Inpatient Respite Care. Code indicates From/Through dates of a period of inpatient respite care for hospice patients.</p>	
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p>Required. Enter the appropriate value code(s).</p> <p>Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state codes for each service are required for correct claim payment.</p> <p>Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of "a" codes is used before entering information in "b" codes.) Enter value code 61 in the "code" section of the field; the MSA code/rural state code in the dollar portion of the "amount" section of the field; and double zeros (00) in the "cents" portion of the "amount" section of the field.</p> <p>Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Form Locators 42 and 45.)</p> <p>Note: Medicaid will continue to reimburse based on MSA Codes and will not use the Core Based Statistical Area (CSBA) Codes that Medicare has implemented. Please use the appropriate MSA codes.</p>	<p>Covered days are now reported with Value Code 80. Entry of covered days is not required on your claim form for Medicaid Services.</p> <p>If your system is programmed to enter Covered Days, they must be entered AFTER the MSA Value Codes.</p>
42	Revenue Code	<p>Required. Enter a revenue code for each service. Revenue codes must be listed vertically in ascending order. If</p>	

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Locator #	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	<p>there is more than one occurrence of any hospice service during the billing period, list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.)</p> <p>Example:</p> <p>651 Routine Home Care 07/01/05 651 Routine Home Care 07/08/05 652 Continuous Home Care 07/06/05 656 General Inpatient Care 07/31/05</p> <p>Use these revenue codes to bill Medicaid:</p> <p>651 = Routine Home Care (RTN Home)</p> <p>652 = Continuous Home Care (CTNS Home – a minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.)</p> <p>655 = Inpatient Respite Care (IP Respite)</p> <p>656 = General Inpatient Care (GNP IP)</p> <p>657 = Physician Services (PHY Ser. – must be accompanied by a physician procedure code)</p> <p>659 = Service Intensity Add-On (payment will be reimbursable for a visit by an RN or a social worker, when provided during routine home care in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate.)</p> <p>NOTE: Revenue code 001 (Total Charges) MUST always be the final revenue code.</p>	<p>659: Effective 01/01/2016</p> <p>HR659 may only be billed during the last seven days of a patient's life and must be billed on the same claim as routine home care services.</p>
43	Revenue Description	Required. Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	

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Locator #	Description	Instructions	Alerts
44	Healthcare Common Procedure Coding System (HCPCS)/Rates Health Insurance Prospective Payment System (HIPPS) Code	<p>Situational. Revenue code 657 (physician services), entry of appropriate procedure code(s) is required.</p> <p>Procedure codes should be obtained from the physician providing the service in order for the intermediary to make reasonable charge determinations when paying for physician services.</p> <p>Revenue Code 659 (service intensity add-on), entry of appropriate procedure code(s) is required.</p>	<p>G0299 = (registered nurse visit)</p> <p>G0155 = (medical social worker visit)</p>
45	Service Date	<p>Required. Enter the appropriate service date (MMDDYY) for each service. The service date must be the first date that a service began.</p> <p>Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42).</p> <p>For example: Routine care is provided beginning the first day of the month of service for five days; then the patient has continuous care beginning the sixth day of the month for two days, followed by routine care again for the eighth day through the 30th day of the month. The revenue code for routine care must be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eighth day of the</p>	

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Locator #	Description	Instructions	Alerts
45 (cont'd)	Service Date (cont'd)	month. 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.
46	Units of Service	Required. Enter the number of units of service for each type of service on the line adjacent to the revenue code, description, and service date. RC 651 is measured in DAYS. RC 652 is measured in HOURS. (Remember that a minimum of 8 hours – not necessarily consecutive – in a 24-hour period is required. Less than 8 hours is considered routine care.) RC 655 is measured in DAYS. RC656 is measured in DAYS. RC 657 is measured in NUMBER OF PROCEDURES. RC 659 is measured in units. 1 unit = 15 minutes. The maximum number of reimbursable units per day is 16 units PLEASE BE SURE THAT THE UNITS AND DATES BILLED FOR EACH OCCURRENCE CORRESPOND.	The seven day maximum number of reimbursable units is 112 units.
47	Total Charges	Required. Enter the charges pertaining to the related revenue codes. Must be numeric. (Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue Code 001 in Form Locator 42.)	
48	Non-Covered Charges	Leave blank.	
49	Unlabeled Field (National)	Leave blank.	

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Locator #	Description	Instructions	Alerts
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>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 Identification (ID)	<p>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.</p>	
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Cert. Ind.	Optional.	
54-A,B,C	Prior Payments	<p>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.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.</p>	
55-A,B,C	Estimated Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI.	The 10-digit NPI must be entered here.
57	Other Provider Identification (ID)	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58-A,B,C	Insured's Name	Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A.	

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Locator #	Description	Instructions	Alerts
58-A,B,C (cont'd)	Insured's Name (cont'd)	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	<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 = Patient is insured 02 = Spouse 03 = Natural child/insured has financial responsibility 04 = Natural child/ insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/nephew 15 = Injured plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent</p>	
60-A,B,C	Insured's Unique Identification (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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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 Number (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter on lines 62A, 62B 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	Leave blank.	
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, a separate UB-04 form is required for each claim line since each line has a different internal control number.

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

Locator #	Description	Instructions	Alerts
65-A,B,C	Employer Name	Situational. If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	Diagnosis and Procedure Code Qualifier DX Version Qualifier	Required. Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Codes	Required. Enter the ICD code for the principal diagnosis for the terminal illness. Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim. NOTE: ICD 9- Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code. ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service 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).
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting diagnosis code for the terminal illness.	Refer to field locator 67.
70	Patient Reason for Visit	Leave blank.	
71	Prospective Payment System (PPS) Code	Leave blank.	

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

Locator #	Description	Instructions	Alerts
72 A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a - e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and NPI of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.	<p>This field must be completed.</p> <p>The attending provider name and NPI cannot be the billing provider.</p> <p>The individual attending provider information must be entered in this field.</p> <p>The attending provider must be enrolled with LA Medicaid.</p>
77	Operating	Leave blank.	
78	Other	Required. Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Form Locator 76 is an employee of the hospice agency. If the attending physician volunteers for the hospice, he or she is considered an employee.	<p>ONLY ENTER "EMPLOYEE" OR "NON-EMPLOYEE" IN THIS FIELD.</p> <p>DO NOT ENTER PROVIDER NUMBERS OR NPI(s).</p>
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.

A hospice representative must verify that the required physicians' certification and a signed hospice election statement are in the records.

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 HOSPICE CARES		2		3a PAT. CHL. # 1111111		4 TYPE OF BILL 813	
987 CORN ST.				5 MED. REG. # 111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET					
b ANYWHERE		c LA		d 71111		e	
10 BIRTHDATE MMDDYY M 080515		11 SEX F		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SNF 16 DHR 17 STAT 30		18 19 20 21	
22 23 24 25 26 27 28 29 ACCT STATE		30		31 OCCURRENCE CODE		32 OCCURRENCE DATE	
33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH	
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869		870		871			

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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SAMPLE HOSPICE CLAIM FORM

WITH AN ATTENDING PROVIDER ONLY

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

1 HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111		2		3a PRI. CNTL. # 111111 b. MED. REG. # 111111111111 5 FED. TAX NO.		4 TYPE OF BILL 814	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS b. ANYWHERE		10 1235 ANYSTREET			
10 BIRTHDATE MMDDYY M 080515		11 SEX M		12 DATE OF ADMISSION 13 HPI 14 TYPE 15 SPIC 16 DHR 40		17 STAT 18 19 20 21	
18 19 20 21		17 STAT 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	
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815 CODE		816 CODE		817 CODE		818 CODE	
819 CODE		820 CODE		821 CODE			

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CHL. # 11111111 3b MED. REC. # 111111111111 3c FED. TAX NO.		4 TYPE OF BILL 817	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		6 STATEMENT COVERS PERIOD FROM 091315		7 THROUGH 091315	
10 BIRTHDATE MMDDYY 080515		11 SEX M		12 DATE OF ADMISSION 13 HH 14 TYPE 080515		15 SFC	
16 DHR		17 STAT		18		19	
20		21		22		23	
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SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 122815 TOTALS 2000.00

50 PRIOR NAME MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS TPL PAYMENT IF APPLICABLE		53 EST. AMOUNT DUE 1234567890	
54 INSURED'S NAME DOE, JOHN		55 INSURED'S UNIQUE ID 1234567890123		56 GROUP NAME TPL CARRIER CODE IF APPLICABLE		57 INSURANCE GROUP NO.	
58 TREATMENT AUTHORIZATION CODES		59 DOCUMENT CONTROL NUMBER A 5274198798700 02		60 EMPLOYER NAME			
61 ADMIT DX 5172		62 PATIENT REASON DX		63 OTHER PROCEDURE CODE DATE		64 OTHER PROCEDURE CODE DATE	
65 OTHER PROCEDURE CODE DATE		66 OTHER PROCEDURE CODE DATE		67 OTHER PROCEDURE CODE DATE		68 OTHER PROCEDURE CODE DATE	
69 REMARKS		70 CC a b c d		71 ATTENDING NP 1298765432 LAST ADAMS FIRST JANE		72 OPERATING NP LAST EMPLOYEE FIRST	
73 OTHER NP LAST FIRST		74 OTHER NP LAST FIRST		75 OTHER NP LAST FIRST		76 OTHER NP LAST FIRST	

UB-04 CMS-1450 APPROVED CMS NO. 0008-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

1 HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CHIT. # 111111 3b MED. REG. # 111111111111 3c FED. TAX NO.		4 TYPE OF BILL 817	
5 PATIENT NAME a DOE, JOHN		6 PATIENT ADDRESS a 1235 ANYSTREET		7 STATEMENT COVERS PERIOD FROM 102015 THROUGH 102015		7	
8b		8c ANYWHERE		8d LA 71111		8e	
10 BIRTH DATE MMDDYY M 080515		11 SEX F		12 DATE OF ADMISSION 10/15/15		13 TYPE 14	
15 SEC 16 DHR 17 STAT 30		18		19		20	
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865		866		867		868	

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APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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UB04 Instructions for LTC Providers

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/Identification (ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	<p>Required. Enter the appropriate 3-digit code as follows:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>1st Digit - Type of Facility</u> 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF Technology Dependent Care) (LOC = SNF Infectious Disease) (LOC = NF Rehab) (LOC = NF Complex Care)</p> <p>Skilled Nursing/ Intermediate Care (LOC = Case Mix)</p> <p><u>2nd Digit - Classification</u> 1 = Skilled Nursing – Inpatient</p>	<p>2nd Digit “7” when used with 1st Digit “2” is reserved for assignment by NUBC.</p>

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Locator #	Description	Instructions	Alerts
		<p>FOR ICF/ID PROVIDERS:</p> <p><u>1st Digit - Type of Facility</u> 6 = Intermediate Care (LOC = ICF/ID)</p> <p><u>2nd Digit - Classification</u> 5 = Intermediate Care Level I 6 = Intermediate Care Level II</p> <p>FOR NURSING FACILITY and ICF/ID PROVIDERS:</p> <p><u>3rd Digit – Frequency Definition</u></p> <p>1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient.</p> <p>2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment.</p> <p>3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted.</p> <p>4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death.</p> <p>7 = Adjustment/Replacement of Prior Claim. Use this code to correct a previously submitted</p>	<p>Use 2nd Digit “1” instead.</p>

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Locator #	Description	Instructions	Alerts
		and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	
5	Federal Tax Number	Optional.	
6	Statement Covers Period (from and through dates of the period covered by this bill.)	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	Required. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip code 9e = Zip plus	
10	Patient's Birth Date	Required. Enter the patient's date of birth using 6 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	Required. Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	Leave blank.	

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Locator #	Description	Instructions	Alerts
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	
17	Patient Status	<p>Required. This code indicates the patient's status as of the "Through" date of the billing period (Field 6).</p> <p>Code Structure</p> <p>01 = Discharged to home or self-care (routine discharge)</p> <p>02 = Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF)</p> <p>04 = Discharged/transferred to another type of institution for inpatient care</p> <p>06 = Discharged/transferred to home under care of home health services organization</p> <p>07 = Left against medical advice or discontinued care</p> <p>09 = Admitted as inpatient to a hospital</p> <p>20 = Expired/discharged due to death</p> <p>30 = Still a patient</p> <p>61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed</p> <p>62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p>	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	

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Locator #	Description	Instructions	Alerts
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	Leave blank.	
35-36	Occurrence Spans (Code and Dates)	Leave blank.	
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>*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)</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>Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.</p> <p>Value Codes 81, 82, and 83 are not used for straight Medicaid billing.</p>
42	Revenue Code	<p>Required. Enter the applicable revenue code(s) which identifies the service provided.</p> <p>Bill a level of care (LOC) revenue code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill Louisiana Medicaid:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>Revenue Code & Description</u></p>	

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Locator #	Description	Instructions	Alerts
		<p><u>(Corresponding Level of Care)</u></p> <p>022 = Skilled Nursing Facility Prospective Payment System (RUGS) (88 = Case Mix -- Formerly LOC 20,21, 22)</p> <p>118 = Room & Board-Private Subacute Rehabilitation (31 = NF Rehabilitation 20 = SNF/Hospice in Nursing Facility 21 = ICF I/Hospice in Nursing Facility 22 = ICF II)</p> <p>193 = Subacute Care Level III (Complex Care) (32 = NF Complex Care)</p> <p>194 = Subacute Care Level IV (28 = SNF Technology Dependent Care)</p> <p>199 = Other Subacute Care (30 = SNF Infectious Disease)</p> <p>FOR ICF-DD PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39) 191 = Limited Level of Care (ICAP Score 40-69) 190 = Intermittent Level of Care (ICAP Score 70-99)</p> <p>NOTE: Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP</p>	

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Locator #	Description	Instructions	Alerts
		<p>Assessment on file.</p> <p><i>FOR NURSING FACILITY and ICF/DD:</i></p> <p><u>Revenue Code & Description</u> <u>Leave of Absence</u></p> <p>183 = Leave of Absence - Subcategory Therapeutic (for Home Leave)</p> <p>185 = Leave of Absence - Subcategory Nursing Home (for Hospitalization)</p>	
43	Revenue Description	Required. Enter the narrative description of the corresponding revenue code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Leave blank.	
45	Service Date	<p>Required. Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided.</p> <p>Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31.</p> <p>Example 2: If the recipient is on hospital leave (Revenue Code 185) from March 6 – 12, the service date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).</p>	

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Locator #	Description	Instructions	Alerts
		<p>Note: The claim must reflect the total number of days billed at a particular level of care (LOC) corresponding to the revenue code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate revenue code for that LOC and the correct number of days indicated for that LOC for the month of service.</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>	
46	Units of Service	<p>Required. Enter in DAYS the number of units of service for each level of care type on the line adjacent to the level of care revenue code, description, and service date.</p> <p>Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194.</p> <p>Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the "from and to" days in Form Locator 45.</p> <p>Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank.</p>	
47	Total Charges	Leave blank.	
48	Non-Covered Charges	Leave blank.	

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Locator #	Description	Instructions	Alerts
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>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	<p>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.</p>	
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Certification Indicator	Optional.	
54-A,B,C	Prior Payments	<p>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.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.</p>	
55-A,B,C	Estimated Amount Due	Optional.	
56	National Provider Identifier (NPI) FIELD	Required. Enter the provider's National Provider Identifier	The 10-digit National Provider Identifier (NPI) must be entered here.
57	Other Provider Identification (ID)	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	

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Locator #	Description	Instructions	Alerts
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: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent</p>	
60-A,B,C	Insured's Unique Identification (ID)	<p>Required. Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.</p>	

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Locator #	Description	Instructions	Alerts
		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 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	Leave blank.	
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	

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Locator #	Description	Instructions	Alerts
		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	
65-A,B,C	Employer Name	Situational. If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	Diagnosis and Procedure Code Qualifier DX Version Qualifier	Required. Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Code	Required. Enter the ICD code for the principal diagnosis. Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim. NOTE: ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code. ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	<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 before 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>

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APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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Locator #	Description	Instructions	Alerts
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting diagnosis code.	Refer to field locator 67.
70	Patient Reason for Visit	Leave blank.	
71	Prospective Payment System (PPS) Code	Leave blank.	
72 A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a - e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name <u>and</u> NPI number of the physician ordering the plan of care.	<p>This field must be completed.</p> <p>The attending provider name and NPI <u>cannot</u> be the billing provider. The individual attending provider information must be entered in this field.</p> <p>The attending provider must be enrolled with LA Medicaid.</p>
77	Operating	Leave blank.	
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>The referring provider cannot be the billing provider. The individual referring provider</p>

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Locator #	Description	Instructions	Alerts
			information should be entered in this field. If entered, the referring provider must be enrolled with Louisiana Medicaid.
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.

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APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 HAPPY HOME NURSING HOME		2 987 CORN ST. ANYWHERE, LA 71111		3a PAT. CNTL. # 11111111 b. MED. REG. # 111111111111 c. FED. TAX NO. 090115		4 TYPE OF BILL 212	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS b. 1235 ANY STREET		c. LA d. 71111		e.	
10 BIRTH DATE MMDDYY M 090115		11 SEX M		12 DATE OF ADMISSION 090115		13 TYPE 14 SPEC 15	
16 DHR 17 STAT 30		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	
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CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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

[illegible]

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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

1 HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONTL # 111111 b MED. RES. # 1111111111		4 TYPE OF BILL 214					
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS b 1235 ANYSTREET		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090116 THROUGH 091516					
10 BIRTHDATE MMDDYY M 090116		11 SEX M		12 DATE OF ADMISSION 13 14 TYPE 15 SPC 1		16 DHR 17 STAT 20					
18 19 20 21		22 23 24 25 26 27 28 29 ACOT STATE 30		31 OCCURRENCE DATE CODE 32 OCCURRENCE DATE CODE 33 OCCURRENCE DATE CODE 34 OCCURRENCE DATE CODE 35 OCCURRENCE DATE CODE 36 OCCURRENCE DATE CODE 37 OCCURRENCE DATE CODE 38 OCCURRENCE DATE CODE 39 OCCURRENCE DATE CODE 40 OCCURRENCE DATE CODE 41 OCCURRENCE DATE CODE 42 OCCURRENCE DATE CODE 43 OCCURRENCE DATE CODE 44 OCCURRENCE DATE CODE 45 OCCURRENCE DATE CODE 46 OCCURRENCE DATE CODE 47 OCCURRENCE DATE CODE 48 OCCURRENCE DATE CODE 49 OCCURRENCE DATE CODE 50 OCCURRENCE DATE CODE 51 OCCURRENCE DATE CODE 52 OCCURRENCE DATE CODE 53 OCCURRENCE DATE CODE 54 OCCURRENCE DATE CODE 55 OCCURRENCE DATE CODE 56 OCCURRENCE DATE CODE 57 OCCURRENCE DATE CODE 58 OCCURRENCE DATE CODE 59 OCCURRENCE DATE CODE 60 OCCURRENCE DATE CODE 61 OCCURRENCE DATE CODE 62 OCCURRENCE DATE CODE 63 OCCURRENCE DATE CODE 64 OCCURRENCE DATE CODE 65 OCCURRENCE DATE CODE 66 OCCURRENCE DATE CODE 67 OCCURRENCE DATE CODE 68 OCCURRENCE DATE CODE 69 OCCURRENCE DATE CODE 70 OCCURRENCE DATE CODE 71 OCCURRENCE DATE CODE 72 OCCURRENCE DATE CODE 73 OCCURRENCE DATE CODE 74 OCCURRENCE DATE CODE 75 OCCURRENCE DATE CODE 76 OCCURRENCE DATE CODE 77 OCCURRENCE DATE CODE 78 OCCURRENCE DATE CODE 79 OCCURRENCE DATE CODE 80 OCCURRENCE DATE CODE 81 OCCURRENCE DATE CODE 82 OCCURRENCE DATE CODE 83 OCCURRENCE DATE CODE 84 OCCURRENCE DATE CODE 85 OCCURRENCE DATE CODE 86 OCCURRENCE DATE CODE 87 OCCURRENCE DATE CODE 88 OCCURRENCE DATE CODE 89 OCCURRENCE DATE CODE 90 OCCURRENCE DATE CODE 91 OCCURRENCE DATE CODE 92 OCCURRENCE DATE CODE 93 OCCURRENCE DATE CODE 94 OCCURRENCE DATE CODE 95 OCCURRENCE DATE CODE 96 OCCURRENCE DATE CODE 97 OCCURRENCE DATE CODE 98 OCCURRENCE DATE CODE 99 OCCURRENCE DATE CODE		39 CODE VALUE CODES AMOUNT 80 15.00		40 CODE VALUE CODES AMOUNT		41 CODE VALUE CODES AMOUNT	
42 REV. CD. 022		43 DESCRIPTION CASE MIX		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE 01-15					
46 SERV. UNITS 15		47 TOTAL CHARGES		48 NON COVERED CHARGES		49					
PAGE 1 OF 1		CREATION DATE 110515		TOTALS							
50 PRIOR NAME MEDICAID		51 HEALTH PLAN ID		52 REL. INFO		53 PRIOR PAYMENTS TPL ...					
54 PRIOR PAYMENTS TPL ...		55 EST. AMOUNT DUE		56 NPI 1234567890		57 1234567					
58 INSURED'S NAME DOE, JOHN		59 REL. 60 INSURED'S UNIQUE ID 1234567890123		61 GROUP NAME TPL CARRIER CODE IF APPLICABLE		62 INSURANCE GROUP NO.					
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME							
66 Z471 F0281		67		68		69					
70 ADMIT CODE		71 PATIENT REASON FOR ADMISSION		72 ICD-10 CODE		73					
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI 1298765432		77 QUAL. FIRST JANE					
78 LAST ADAMS		79 OPERATING NPI		80 QUAL. FIRST		81					
82 LAST		83 OTHER DN NPI 1589999999		84 QUAL. FIRST		85					
86 LAST DOE		87 NPI		88 QUAL. FIRST		89					
90 LAST		91 NPI		92 QUAL. FIRST		93					
94 LAST		95 NPI		96 QUAL. FIRST		97					
98 LAST		99 NPI		100 QUAL. FIRST		101					

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 HAPPY HOME NURSING HOME		2 987 CORN ST. ANYWHERE, LA 71111		3a PAY ORTL # 1111111		4 TYPE OF BILL 217	
b MED. REC. # 11111111111111		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015		7	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA d 71111		e	
10 BIRTH DATE		11 SEX M		12 DATE OF BIRTH 090115		13 ADMISSION 13 HR 14 TYPE 15 SPEC 16 DHR 17 STAT 30	
18		19		20		21	
22		23		24		25	
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CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 HAPPY HOME NURSING HOME		2		3a PRV. OUTL. # 1111111		4 TYPE OF BILL 217	
987 CORN ST.				5 MED. REC. # 1111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET					
b ANYWHERE				c LA d 71111		e	
10 BIRTH DATE		11 SEX M		12 DATE OF BIRTH 090115		13 ADMISSION 13 HR 14 TYPE 15 SPC 16 DHR 17 STAT 01	
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 CODE		40 VALUE CODES AMOUNT		41 CODE		42 VALUE CODES AMOUNT	
a 80		19.00		b		c	
d				e		f	
43 REV. CD.		44 DESCRIPTION		45 HCPCS / RATE / HIPPS CODE		46 SERV. DATE	
022		CASE MIX				01-20	
185		HOSPITAL LEAVE				05-08	
183		HOME LEAVE				17-19	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
50 PRV. NAME		51 HEALTH PLAN ID		52 PBL INFO		53 PRIOR PAYMENTS	
MEDICAID						54 EST. AMOUNT DUE	
55 NPI 1234567890		56 NPI 1234567		57 OTHER PRV ID			
58 INSURED'S NAME		59 INSURED'S UNIQUE ID		60 GROUP NAME		61 INSURANCE GROUP NO.	
DOE, JOHN		1234567890123		TPL CARRIER CODE IF APPLICABLE			
62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER		64 EMPLOYER NAME			
A		A		5278198798700		02	
65 Z471		F0281		66			
67 ADMIT CD		68 PATIENT REASON CD		69 PRV CODE		70 ECI	
71 PRINCIPAL PROCEDURE DATE		72 OTHER PROCEDURE DATE		73 OTHER PROCEDURE DATE		74 OTHER PROCEDURE DATE	
75		76 ATTENDING NPI 1298765432		77 QUAL		78 FIRST JANE	
79 LAST ADAMS		80 NPI		81 QUAL		82 FIRST	
83 LAST		84 NPI		85 QUAL		86 FIRST	
87 LAST		88 NPI		89 QUAL		90 FIRST	
91 LAST		92 NPI		93 QUAL		94 FIRST	
95 LAST		96 NPI		97 QUAL		98 FIRST	
99 LAST		100 NPI		101 QUAL		102 FIRST	

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 122815 TOTALS

UB-04 CMS-1450 APPROVED OMB NO. 0968-0097 NUB THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

[illegible]

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a. ICF CMTL # 11111111		4 TYPE OF BILL 654	
5 MED. REC. # 11111111111111		6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015		7			
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET					
b. ANYWHERE		c. LA		d. 71111		e.	
10 BIRTHDATE MMDDYY 080115		11 SEX M		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SEC 16 DHR		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
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CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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

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CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

SAMPLE ICF/DD FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY (WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111										2										3a. PRV. CMTL # 111111 b. MED. REC. # 111111111111 5 FED. TAX NO.										4 TYPE OF BILL 657									
8 PATIENT NAME a. DOE, JOHN										9 PATIENT ADDRESS b. 1235 ANYSTREET										c. LA d. 71111 e.																			
10 BIRTHDATE 11 SEX M 12 DATE 080115										13 ADMISSION 13 HR 14 TYPE 15 SPG 16 DHR 17 STAT 30										18 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 DATE 38 CODE										39 VALUE CODES AMOUNT 40 CODE 41 VALUE CODES AMOUNT 42 CODE 43 VALUE CODES AMOUNT																													
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49																																							
1 193 CASE MIX										01-30										30																			
2 185 HOSPITAL LEAVE										04-07																													
3 183 HOME LEAVE										10-13																													
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PAGE 1 OF 1										CREATION DATE 122815										TOTALS																			
50 PRV. NAME MEDICAID										51 HEALTH PLAN ID										52 PRIOR PAYMENTS TPL : PAYMENT IF APPLICABLE										53 EST. AMOUNT DUE 1234567890									
54 INSURED'S NAME DOE, JOHN										55 INSURED'S UNIQUE ID 1234567890123										56 GROUP NAME TPL CARRIER CODE IF APPLICABLE										57 INSURANCE GROUP NO. 1234567									
58 TREATMENT AUTHORIZATION CODES										59 DOCUMENT CONTROL NUMBER A 5276198798700 02										60 EMPLOYER NAME																			
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UB-04 CMS-1450

APPROVED CMB NO. 0008-0997

NUBC

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

CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 43

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

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONT. # 11111111		4 TYPE OF BILL 657	
5 PATIENT NAME DOE, JOHN		6 PATIENT ADDRESS 1235 ANYSTREET		7 STATEMENT COVERS PERIOD FROM 100115		8 STATEMENT COVERS PERIOD THROUGH 102015	
9 PATIENT NAME DOE, JOHN		10 PATIENT ADDRESS ANYWHERE		11 LA		12 71111	
13 MMDYY M 080115		14 SEX M		15 DATE OF BIRTH 080115		16 DHR	
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