

CHAPTER 24: HOSPICE

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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.

CHAPTER 24: HOSPICE**APPENDIX E: UB-04 FORM AND INSTRUCTIONS****PAGE(S) 37****UB-04 Instructions for Hospice Providers**

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	Required. Enter the name and address of the facility	
2	Pay to Name/Address/ID	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	Expanded to 20 characters from 16 characters.
3b	Medical Record #	Optional. Enter patient's medical record number (up to 24 characters)	Expanded to 24 characters from 16 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 No.	Optional.	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	Required. Enter the beginning and ending service dates. Note: Do not show days before the patient's entitlement began.	

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Locator #	Description	Instructions	Alerts
		Note: A claim may not span more than one month of service at a time.	
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.	Formerly entered in UB-92 Form Locator 12.
9a-e	Patient's Address (Street, City, State, and 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	Formerly entered in UB-92 Form Locator 13.
10	Patient's Birth Date	Required. Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	Formerly entered in UB-92 Form Locator 14.
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	Formerly entered in UB-92 Form Locator 15.
12	Admission Date	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). The date of admission may not	Formerly entered in UB-92 Form Locator 17.

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Locator #	Description	Instructions	Alerts
		precede the physician's certification by more than two calendar days. Note: If the Notice of Election form and the Certification of Terminal Illness are not received within 10 calendar days, the date of admission (election) will be the date the Hospice Manager receives the proper documentation.	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	
17	Patient Status	Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). <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	Formerly entered in UB-92 Form Locator 22.
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are	Formerly entered in UB-92 Form Locators 32-35.

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Locator #	Description	Instructions	Alerts
		<p>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 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.</p> <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</p>	

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Locator #	Description	Instructions	Alerts
		which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)	
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>	Formerly entered in UB-92 Form Locators 36.
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	
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</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> <p>Value Code 80 must be entered in the Code portion of the field and the Number of Days in the</p>

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Locator #	Description	Instructions	Alerts
		<p>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>“Dollar” portion of the “Amount” section of the field. Enter “00” in the “Cents” portion of the “Amount” section of the field.</p>
42	Revenue Code	<p>Required. Enter a revenue code for each service. Revenue codes must be listed vertically in ascending order. If there is more than one (1) 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>	

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Locator #	Description	Instructions	Alerts
		<p>651 Routine Home Care 07/01/05</p> <p>651 Routine Home Care 07/08/05</p> <p>652 Continuous Home Care 07/06/05</p> <p>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</p> <p>(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>NOTE: Revenue code 001 (Total Charges) MUST always be the final revenue code.</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	HCPCS/Rates HIPPS Code	<p>Situational. When using 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>	
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). 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</p>	

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Locator #	Description	Instructions	Alerts
		<p>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 month.</p> <p>Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	<p>The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).</p>
46	Units of Service	<p>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.</p> <p>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.</p> <p>PLEASE BE SURE THAT THE UNITS AND DATES BILLED FOR EACH OCCURRENCE CORRESPOND.</p>	
47	Total Charges	<p>Required. Enter the charges pertaining to the related Revenue Codes. Must be numeric.</p>	

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Locator #	Description	Instructions	Alerts
		(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.	
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>	The 7-digit Medicaid ID number is now located in Form Locator 57.
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</p>	

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Locator #	Description	Instructions	Alerts
		insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	Optional.	
56	NPI FIELD	Required. Enter the provider's National Provider Identifier.	The 10-digit National Provider Identifier (NPI) must be entered here.
57	Other Provider ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 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	Pt'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</p>	

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Locator #	Description	Instructions	Alerts
		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	
60-A,B,C	Insured's Unique ID	Required. Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. Situational. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (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.	

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Locator #	Description	Instructions	Alerts
63-A,B,C	Treatment Auth. Code	Leave blank.	
64-A,B,C	Document Control Number	<p>Situational. If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.</p> <p>To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.</p>
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	Leave blank.	

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Locator #	Description	Instructions	Alerts
67	Principal Diagnosis Codes	Required. Enter the ICD-9-CM code for the principal diagnosis for the terminal illness.	The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.
67 A-Q	Other Diagnosis Codes	<p>Situational. Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim.</p> <p>Note: Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</p>	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting Diagnosis Code for the terminal illness.	
70	Patient Reason for Visit	Leave blank.	
71	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		

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Locator #	Description	Instructions	Alerts
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and/or the 7-digit Medicaid Provider identification number of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.	Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.
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.	Formerly entered in UB-92 Form Locator 83.
79	Other	Leave blank.	
80	Remarks	<p>Required. Enter the signature of the appropriate person at the facility who is authorized to submit Medicaid claims (stamped signatures must be initialed). A hospice representative verifies that the required physician's certification and a signed hospice election statement are in the records before signing the form.</p> <p>Situational. Enter explanations for special handling of claims.</p>	<p>Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.</p> <p>Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.</p>
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.

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UB04 Sample for Hospice

1 Your Hospice 200 Get Paid Drive Nowhere, LA 70000		2		3a PAT CNTL # 101234567891234567890		4 TYPE OF BILL 813	
b 1 Lean, Maybell		c 2 Baton Rouge		d 3 LA		e 4 70000	
f 5 01/20/19		g 6 F		h 7 08/01/09		i 8 30	
j 9 01/20/19		k 10 F		l 11 08/01/09		m 12 30	
n 13 01/20/19		o 14 F		p 15 08/01/09		q 16 30	
r 17 01/20/19		s 18 F		t 19 08/01/09		u 20 30	
v 21 01/20/19		w 22 F		x 23 08/01/09		y 24 30	
z 25 01/20/19		aa 26 F		ab 27 08/01/09		ac 28 30	
ad 29 01/20/19		ae 30 F		af 31 08/01/09		ag 32 30	
ah 33 01/20/19		ai 34 F		aj 35 08/01/09		ak 36 30	
al 37 01/20/19		am 38 F		an 39 08/01/09		ao 40 30	
ap 41 01/20/19		aq 42 F		ar 43 08/01/09		as 44 30	
at 45 01/20/19		au 46 F		av 47 08/01/09		aw 48 30	
ax 49 01/20/19		ay 50 F		az 51 08/01/09		ba 52 30	
bc 53 01/20/19		bd 54 F		be 55 08/01/09		bf 56 30	
bg 57 01/20/19		bh 58 F		bi 59 08/01/09		bj 60 30	
bk 61 01/20/19		bl 62 F		bm 63 08/01/09		bn 64 30	
bo 65 01/20/19		bp 66 F		bq 67 08/01/09		br 68 30	
bs 69 01/20/19		bt 70 F		bu 71 08/01/09		bv 72 30	
bw 73 01/20/19		bx 74 F		by 75 08/01/09		bz 76 30	
ca 77 01/20/19		cb 78 F		cc 79 08/01/09		cd 80 30	
ce 81 01/20/19		cf 82 F		cg 83 08/01/09		ch 84 30	
ci 85 01/20/19		cj 86 F		ck 87 08/01/09		cl 88 30	
cm 89 01/20/19		cn 90 F		co 91 08/01/09		cp 92 30	
cq 93 01/20/19		cr 94 F		cs 95 08/01/09		ct 96 30	
cu 97 01/20/19		cv 98 F		cw 99 08/01/09		cx 100 30	
cy 101 01/20/19		cz 102 F		ca 103 08/01/09		cb 104 30	
cc 105 01/20/19		cd 106 F		ce 107 08/01/09		cf 108 30	
ce 109 01/20/19		cf 110 F		cg 111 08/01/09		ch 112 30	
cg 113 01/20/19		ch 114 F		ci 115 08/01/09		cj 116 30	
ci 117 01/20/19		cj 118 F		ck 119 08/01/09		cl 120 30	
ck 121 01/20/19		cl 122 F		cm 123 08/01/09		cn 124 30	
cm 125 01/20/19		cn 126 F		co 127 08/01/09		cp 128 30	
co 129 01/20/19		cp 130 F		cq 131 08/01/09		cr 132 30	
cq 133 01/20/19		cr 134 F		cs 135 08/01/09		ct 136 30	
ct 137 01/20/19		cu 138 F		cv 139 08/01/09		cw 140 30	
cv 141 01/20/19		cw 142 F		cx 143 08/01/09		cy 144 30	
cy 145 01/20/19		cz 146 F		ca 147 08/01/09		cb 148 30	
ca 149 01/20/19		cb 150 F		cc 151 08/01/09		cd 152 30	
cd 153 01/20/19		cc 154 F		ce 155 08/01/09		cf 156 30	
ce 157 01/20/19		cd 158 F		cg 159 08/01/09		ch 160 30	
ch 161 01/20/19		ce 162 F		ci 163 08/01/09		cj 164 30	
ci 165 01/20/19		cf 166 F		ck 167 08/01/09		cl 168 30	
cl 169 01/20/19		cg 170 F		cm 171 08/01/09		cn 172 30	
cm 173 01/20/19		cn 174 F		co 175 08/01/09		cp 176 30	
co 177 01/20/19		cp 178 F		cq 179 08/01/09		cr 180 30	
cr 181 01/20/19		cq 182 F		cs 183 08/01/09		ct 184 30	
ct 185 01/20/19		cu 186 F		cv 187 08/01/09		cw 188 30	
cv 189 01/20/19		cw 190 F		cx 191 08/01/09		cy 192 30	
cy 193 01/20/19		cz 194 F		ca 195 08/01/09		cb 196 30	
ca 197 01/20/19		cb 198 F		cc 199 08/01/09		cd 200 30	
cd 201 01/20/19		cc 202 F		ce 203 08/01/09		cf 204 30	
ce 205 01/20/19		cd 206 F		cg 207 08/01/09		ch 208 30	
ch 209 01/20/19		ce 210 F		ci 211 08/01/09		cj 212 30	
ci 213 01/20/19		cf 214 F		ck 215 08/01/09		cl 216 30	
cl 217 01/20/19		cg 218 F		cm 219 08/01/09		cn 220 30	
cn 221 01/20/19		ch 222 F		co 223 08/01/09		cp 224 30	
co 225 01/20/19		ch 226 F		ci 227 08/01/09		cj 228 30	
ci 229 01/20/19		cl 230 F		ck 231 08/01/09		cl 232 30	
cl 233 01/20/19		cm 234 F		cm 235 08/01/09		cm 236 30	
cm 237 01/20/19		cn 238 F		cn 239 08/01/09		cn 240 30	
cn 241 01/20/19		co 242 F		co 243 08/01/09		co 244 30	
co 245 01/20/19		cp 246 F		cp 247 08/01/09		cp 248 30	
cp 249 01/20/19		cq 250 F		cq 251 08/01/09		cq 252 30	
cq 253 01/20/19		cr 254 F		cr 255 08/01/09		cr 256 30	
cr 257 01/20/19		cs 258 F		cs 259 08/01/09		cs 260 30	
cs 261 01/20/19		ct 262 F		ct 263 08/01/09		ct 264 30	
ct 265 01/20/19		cu 266 F		cu 267 08/01/09		cu 268 30	
cu 269 01/20/19		cv 270 F		cv 271 08/01/09		cv 272 30	
cv 273 01/20/19		cw 274 F		cw 275 08/01/09		cw 276 30	
cw 277 01/20/19		cx 278 F		cx 279 08/01/09		cx 280 30	
cx 281 01/20/19		cy 282 F		cy 283 08/01/09		cy 284 30	
cy 285 01/20/19		cz 286 F		ca 287 08/01/09		ca 288 30	
ca 289 01/20/19		cb 290 F		cb 291 08/01/09		cb 292 30	
cb 293 01/20/19		cc 294 F		cc 295 08/01/09		cc 296 30	
cc 297 01/20/19		cd 298 F		cd 299 08/01/09		cd 300 30	
cd 301 01/20/19		ce 302 F		ce 303 08/01/09		ce 304 30	
ce 305 01/20/19		cf 306 F		cf 307 08/01/09		cf 308 30	
cf 309 01/20/19		cg 310 F		cg 311 08/01/09		cg 312 30	
cg 313 01/20/19		ch 314 F		ch 315 08/01/09		ch 316 30	
ch 317 01/20/19		ci 318 F		ci 319 08/01/09		ci 320 30	
ci 321 01/20/19		cj 322 F		cj 323 08/01/09		cj 324 30	
cj 325 01/20/19		ck 326 F		ck 327 08/01/09		ck 328 30	
ck 329 01/20/19		cl 330 F		cl 331 08/01/09		cl 332 30	
cl 333 01/20/19		cm 334 F		cm 335 08/01/09		cm 336 30	
cm 337 01/20/19		cn 338 F		cn 339 08/01/09		cn 340 30	
cn 341 01/20/19		co 342 F		co 343 08/01/09		co 344 30	
co 345 01/20/19		cp 346 F		cp 347 08/01/09		cp 348 30	
cp 349 01/20/19		cq 350 F		cq 351 08/01/09		cq 352 30	
cq 353 01/20/19		cr 354 F		cr 355 08/01/09		cr 356 30	
cr 357 01/20/19		cs 358 F		cs 359 08/01/09		cs 360 30	
cs 361 01/20/19		ct 362 F		ct 363 08/01/09		ct 364 30	
ct 365 01/20/19		cu 366 F		cu 367 08/01/09		cu 368 30	
cu 369 01/20/19		cv 370 F		cv 371 08/01/09		cv 372 30	
cv 373 01/20/19		cw 374 F		cw 375 08/01/09		cw 376 30	
cw 377 01/20/19		cx 378 F		cx 379 08/01/09		cx 380 30	
cx 381 01/20/19		cy 382 F		cy 383 08/01/09		cy 384 30	
cy 385 01/20/19		cz 386 F		ca 387 08/01/09		ca 388 30	
ca 389 01/20/19		cb 390 F		cb 391 08/01/09		cb 392 30	
cb 393 01/20/19		cc 394 F		cc 395 08/01/09		cc 396 30	
cc 397 01/20/19		cd 398 F		cd 399 08/01/09		cd 400 30	
cd 401 01/20/19		ce 402 F		ce 403 08/01/09		ce 404 30	
ce 405 01/20/19		cf 406 F		cf 407 08/01/09		cf 408 30	
cf 409 01/20/19		cg 410 F		cg 411 08/01/09		cg 412 30	
cg 413 01/20/19		ch 414 F		ch 415 08/01/09		ch 416 30	
ch 417 01/20/19		ci 418 F		ci 419 08/01/09		ci 420 30	
ci 421 01/20/19		cj 422 F		cj 423 08/01/09		cj 424 30	
cj 425 01/20/19		ck 426 F		ck 427 08/01/09		ck 428 30	
ck 429 01/20/19		cl 430 F		cl 431 08/01/09		cl 432 30	
cl 433 01/20/19		cm 434 F		cm 435 08/01/09		cm 436 30	
cm 437 01/20/19		cn 438 F		cn 439 08/01/09		cn 440 30	
cn 441 01/20/19		co 442 F		co 443 08/01/09		co 444 30	
co 445 01/20/19		cp 446 F		cp 447 08/01/09		cp 448 30	
cp 449 01/20/19		cq 450 F		cq 451 08/01/09		cq 452 30	
cq 453 01/20/19		cr 454 F		cr 455 08/01/09		cr 456 30	
cr 457 01/20/19		cs 458 F		cs 459 08/01/09		cs 460 30	
cs 461 01/20/19		ct 462 F		ct 463 08/01/09		ct 464 30	
ct 465 01/20/19		cu 466 F		cu 467 08/01/09		cu 468 30	
cu 469 01/20/19		cv 470 F		cv 471 08/01/09		cv 472 30	
cv 473 01/20/19		cw 474 F		cw 475 08/01/09		cw 476 30	
cw 477 01/20/19		cx 478 F		cx 479 08/01/09		cx 480 30	
cx 481 01/20/19		cy 482 F		cy 483 08/01/09		cy 484 30	
cy 485 01/20/19		cz 486 F		ca 487 08/01/09		ca 488 30	
ca 489 01/20/19		cb 490 F		cb 491 08/01/09		cb 492 30	
cb 493 01/20/19		cc 494 F		cc 495 08/01/09		cc 496 30	
cc 497 01/20/19		cd 498 F		cd 499 08/01/09		cd 500 30	
cd 501 01/20/19		ce 502 F		ce 503 08/01/09		ce 504 30	
ce 505 01/20/19		cf 506 F		cf 507 08/01/09		cf 508 30	
cf 509 01/20/19		cg 510 F		cg 511 08/01/09		cg 512 30	
cg 513 01/20/19		ch 514 F		ch 515 08/01/09		ch 516 30	
ch 517 01/20/19		ci 518 F		ci 519 08/01/09		ci 520 30	
ci 521 01/20/19		cj 522 F		cj 523 08/01/09		cj 524 30	
cj 525 01/20/19		ck 526 F		ck 527 08/01/09		ck 528 30	
ck 529 01/20/19		cl 530 F		cl 531 08/01/09		cl 532 30	
cl 533 01/20/19		cm 534 F		cm 535 08/01/09		cm 536 30	
cm 537 01/20/19		cn 538 F		cn 539 08/01/09		cn 540 30	
cn 541 01/20/19		co 542 F		co 543 08/01/09		co 544 30	
co 545 01/20/19		cp 546 F		cp 547 08/01/09		cp 548 30	
cp 549 01/20/19		cq 550 F		cq 551 08/01/09		cq 552 30	
cq 553 01/20/19		cr 554 F		cr 555 08/01/09		cr 556 30	
cr 557 01/20/19		cs 558 F		cs 559 08/01/09		cs 560 30	
cs 561 01/20/19		ct 562 F		ct 563 08/01/09		ct 564 30	
ct 565 01/20/19		cu 566 F		cu 567 08/01/09		cu 568 30	
cu 569 01/20/19		cv 570 F		cv 571 08/01/09		cv 572 30	
cv 573 01/20/19		cw 574 F		cw 575 08/01/09		cw 576 30	
cw 577 01/20/19		cx 578 F		cx 579 08/01/09		cx 580 30	
cx 581 01/20/19		cy 582 F		cy 583 08/01/09		cy 584 30	
cy 585 01/20/19		cz 586 F		ca 587 08/01/09		ca 588 30	
ca 589 01/20/19		cb 590 F		cb 591 08/01/09		cb 592 30	
cb 593 01/20/19		cc 594 F		cc 595 08/01/09		cc 596 30	
cc 597 01/20/19		cd 598 F		cd 599 08/01/09		cd 600 30	
cd 601 01/20/19		ce 602 F		ce 603 08/01/09		ce 604 30	
ce 605 01/20/19		cf 606 F		cf 607 08/01/09		cf 608 30	
cf 609 01/20/19		cg 610 F		cg 611 08/01/09		cg 612 30	
cg 613 01/20/19		ch 614 F		ch 615 08/01/09		ch 616 30	
ch 617 01/20/19		ci 618 F		ci 619 08/01/09		ci 620 30	
ci 621 01/20/1							

CHAPTER 24: HOSPICE**APPENDIX E: UB-04 FORM AND INSTRUCTIONS****PAGE(S) 37****Ub04 Instructions for LTC Providers**

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ID	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	Expanded to 20 characters from 16 characters.
3b	Medical Record #	Optional. Enter patient's medical record number (up to 24 characters)	Expanded to 24 characters from 16 characters.
4	Type of Bill	<p>Required. Enter the appropriate 3-digit code as follows:</p> <p><i>FOR NURSING FACILITY PROVIDERS:</i></p> <p><u>1st Digit - Type of Facility</u></p> <p>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</p>	

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Locator #	Description	Instructions	Alerts
		<p>Care (LOC = Case Mix)</p> <p><u>2nd Digit – Classification</u> 1 = Skilled Nursing – Inpatient</p> <p>FOR ICF/DD PROVIDERS:</p> <p><u>1st Digit - Type of Facility</u> 6 = Intermediate Care (LOC = ICF/DD)</p> <p><u>2nd Digit - Classification</u> 5 = Intermediate Care Level I 6 = Intermediate Care Level II</p> <p>FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:</p> <p><u>1st Digit - Type of Facility</u> 8 = Special Facility (LOC = Adult Day Health Care)</p> <p><u>2nd Digit - Classification</u> 9 = Other (Adult Day Health Care - ADHC)</p> <p>FOR NURSING FACILITY, ICF/DD, AND ADHC PROVIDERS:</p> <p><u>3rd Digit – Frequency Definition</u> 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment</p>	<p>2nd Digit “7” when used with 1st Digit “2” is reserved for assignment by NUBC. Use 2nd Digit “1” instead.</p>

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Locator #	Description	Instructions	Alerts
		<p>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 and paid claim.</p> <p>8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.</p>	
5	Federal Tax No.	Optional.	
6	Statement Covers Period (From & Through Dates) dates of the period	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	

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Locator #	Description	Instructions	Alerts
	covered by this bill.		
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.	Formerly entered in UB-92 Form Locator 12.
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	Formerly entered in UB-92 Form Locator 13.
10	Patient's Birth Date	Required. Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	Formerly entered in UB-92 Form Locator 14.
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	Formerly entered in UB-92 Form Locator 15.
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.	Formerly entered in UB-92 Form Locator 17.
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. 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>Formerly entered in UB-92 Form Locator 22.</p> <p>Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.</p>

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Locator #	Description	Instructions	Alerts
		63 = Discharged/transferred to a long term care hospital	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
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>*No other value codes are required for processing LTC claims.</p>	<p>Formerly entered in Form Locator 7 of the UB-92. Covered Days is now reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.</p> <p>Please read the instructions carefully for entering the new number of days information in the Value Code fields.</p>

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Locator #	Description	Instructions	Alerts
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 LA Medicaid:</p> <p>FOR ALL PROVIDERS (Excluding ADHC Providers):</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> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>022 = Skilled Nursing Facility Prospective Payment System (RUGS) (88 = Case Mix -- Formerly LOC 20,</p>	

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Locator #	Description	Instructions	Alerts
		<p style="text-align: center;">21, 22)</p> <p>118 = Room & Board-Private Sub-acute Rehabilitation (31 = NF Rehabilitation 20 = SNF/Hospice in Nursing Facility 21 = ICF I/Hospice in Nursing Facility 22 = ICF II)</p> <p>193 = Sub-acute Care Level III (Complex Care) (32 = NF Complex Care)</p> <p>194 = Sub-acute Care Level IV (28 = SNF Technology Dependent Care)</p> <p>199 = Other Sub-acute 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>ICAP Revenue codes to be used for dates of service October 1, 2005 and forward:</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</p>	

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Locator #	Description	Instructions	Alerts
		<p>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 Assessment on file.</p> <p>FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:</p> <p><u>Revenue Code & Description</u> (<i>Corresponding Level of Care</i>)</p> <p>932 = Medical Rehabilitation Day Program- Subcategory 2 – Full Day (27 = <i>Adult Day Health Care</i>)</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</p>	

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Locator #	Description	Instructions	Alerts
		<p>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> <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>	<p>The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).</p>
46	Units of Service	Required. Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of	

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Locator #	Description	Instructions	Alerts
		<p>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> <p>Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.</p>	
47	Total Charges	Leave blank.	
48	Non-Covered Charges	Leave blank.	
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</p>	

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Locator #	Description	Instructions	Alerts
		the spend-down eligibility period.	
51-A,B,C	Health Plan ID	Situational. Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is required .	The 7-digit Medicaid ID number is now located in Form Locator 57.
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Cert. Ind.	Optional.	
54-A,B,C	Prior Payments	Situational. Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	Optional.	
56	NPI FIELD	Required. Enter the provider's National Provider Identifier	The 10-digit National Provider Identifier (NPI) must be entered here.
57	Other Provider ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.
58-A,B,C	Insured's Name	Required. Enter the	

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Locator #	Description	Instructions	Alerts
		<p>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	Pt'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</p>	

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Locator #	Description	Instructions	Alerts
		minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	Required. Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. Situational. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (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 Auth. 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	Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.

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Locator #	Description	Instructions	Alerts
		<p>64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u></p> <p>01 = Third Party Liability Recovery</p> <p>02 = Provider Correction</p> <p>03 = Fiscal Agent Error</p> <p>90 = State Office Use Only – Recovery</p> <p>99 = Other</p> <p><u>Voids</u></p> <p>10 = Claim Paid for Wrong Recipient</p> <p>11 = Claim Paid for Wrong Provider</p> <p>00 = Other</p>	<p>To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.</p>
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	Leave blank.	
67	Principal Diagnosis Codes	Required. Enter the ICD-9-CM code for the principal diagnosis.	The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.
67 A-Q	Other Diagnosis Code	Situational. Enter the ICD-9-	

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Locator #	Description	Instructions	Alerts
		<p>CM code or codes for all other applicable diagnoses for this claim.</p> <p>Note: Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</p>	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	Leave blank.	
71	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	Leave blank.	

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Locator #	Description	Instructions	Alerts
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	Situational. Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.	<p>Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.</p> <p>Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.</p>
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.

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UB-04 Samples Long Term Care (LTC) Providers
Nursing Facility

1 Sunset Nursing Home 2246 Cypress Lane Rain Forest, LA 71111		2		3a PAT CNTL # 12345678901234567890		4 TYPE OF BILL 213	
3b MED REC # 123456123456123456123456		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 08/01/09 THROUGH 08/31/09		7	
8 PATIENT NAME a		9 PATIENT ADDRESS a 123 Star Ave		c LA		d 77777	
10 BIRTHDATE 06/12/12		11 SEX F		12 DATE 01/01/96		13 HRT 14 TYPE 15 SRC 16 DHR 17 STAT 30	
18		19		20		21	
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CHAPTER 24: HOSPICE

APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 37

Intermediate Care Facilities

1 Weeping Willow Nursing Home 2246 Cypress Lane Rain Forest, LA 71111										2										3a PAT CNTL # 1234567890 b MED REC # 9876543 5 FED TAX NO.										4 TYPE OF BILL 653																																																																																																																																																					
8 PATIENT NAME a Bright, Sunny										9 PATIENT ADDRESS a 123 Anywhere Street										c LA d 71111 e																																																																																																																																																															
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42 REV CD 193										43 DESCRIPTION Pervasive Level of Care										44 HCPCS / RATE / HIPPS CODE										45 SERV DATE 01-30										46 SERV UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																													
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58 INSURED'S NAME Bright, Sunny										59 PREL										60 INSURED'S UNIQUE ID 1234567890123										61 GROUP NAME										62 INSURANCE GROUP NO.										63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																																																													
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