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.

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	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									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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14									14
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17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX										68

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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

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: a. First digit-type facility 8 = Special facility (hospice) b. Second digit-classification 1 = Hospice (Non-hospital based) 2 = Hospice (Hospital based) c. Third digit-frequency 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.**	

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.**

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). Valid Codes 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.**

Locator #	Description	Instructions	Alerts
		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. Use the following codes where appropriate: **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. 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. 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. **42 = Termination date**. Enter code to indicate the date on	

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)	**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: **M2 = Dates of Inpatient Respite Care**. Code indicates From/Through dates of a period of inpatient respite care for hospice patients.	**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	**Required.** Enter the appropriate Value Code(s). 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. Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field	**Covered days are now reported with Value Code 80. Entry of covered days is not required on your claim form for Medicaid Services.** **If your system is programmed to enter Covered Days, they must be entered AFTER the MSA Value Codes.** **Value Code 80 must be entered in the Code portion of the field and the Number of Days in the**

Locator #	Description	Instructions	Alerts
		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. 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.) **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.**	**"Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.**
42	Revenue Code	**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.) Example:	

Locator #	Description	Instructions	Alerts
		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 Use these revenue codes to bill Medicaid: 651 = Routine Home Care (RTN Home) 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.) 655 = Inpatient Respite Care (IP Respite) 656 = General Inpatient Care (GNP IP) 657 = Physician Services (PHY Ser – must be accompanied by a physician procedure code) **NOTE:** Revenue code 001 (Total Charges) MUST always be the final revenue code.	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	

Locator #	Description	Instructions	Alerts
44	HCPCS/Rates HIPPS Code	**Situational.** When using Revenue Code 657 (Physician Services), entry of appropriate Procedure Code(s) is **required**. 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.	
45	Service Date	**Required.** Enter the appropriate service date (MMDDYY) for each service. The service date must be the first date that a service began. 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	

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

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	**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**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan 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	

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	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = 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	

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.	

Locator #	Description	Instructions	Alerts
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 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	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	

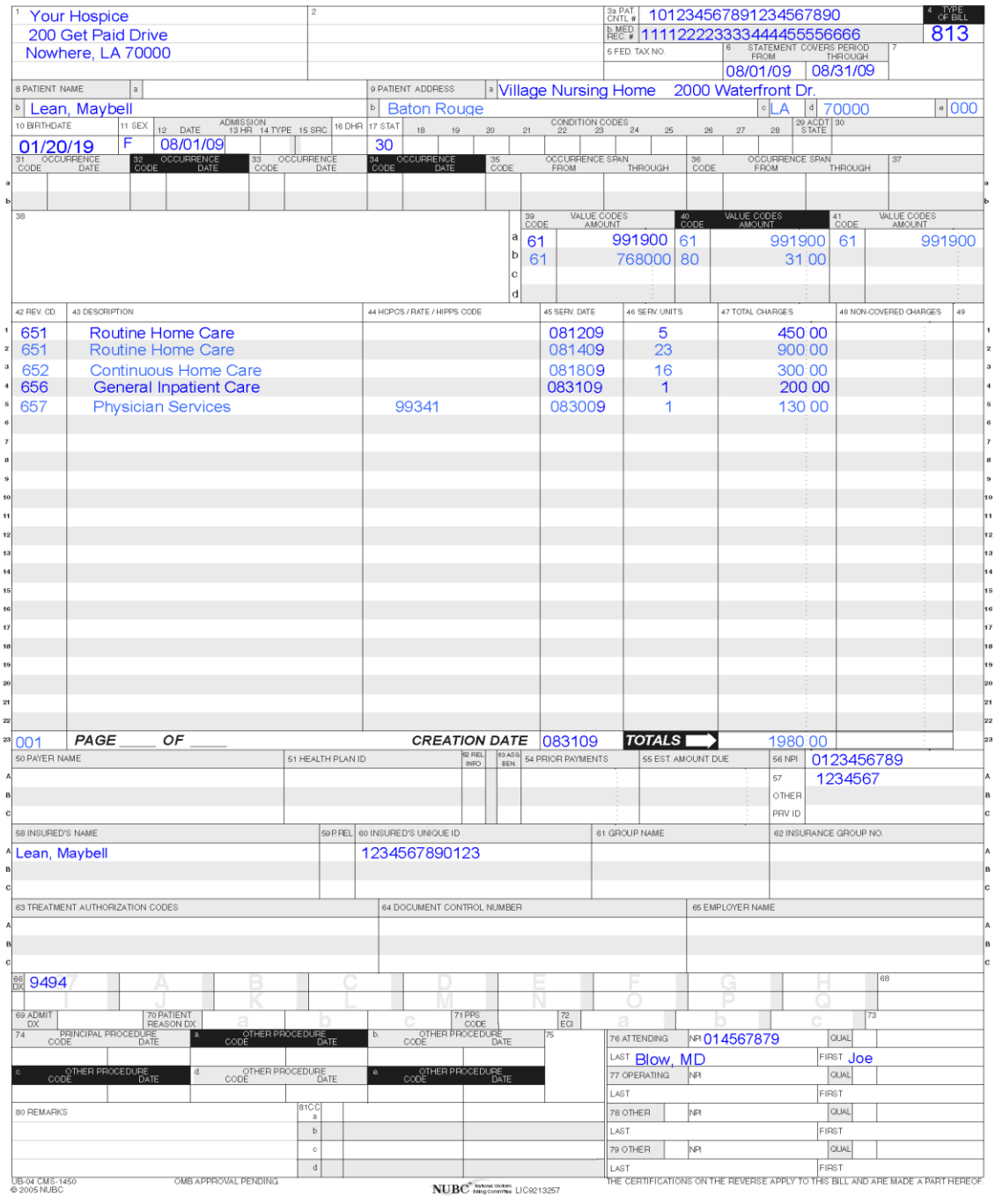
Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Codes	**Required.** Enter the ICD-9-CM code for the principal diagnosis for the terminal illness. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **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.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
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 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	

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	**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. **Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **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.**
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.

UB04 Sample for Hospice



1 Your Hospice
200 Get Paid Drive
Nowhere, LA 70000

2

3a PAT. CNTL # 10123456789123456789
b MED REC. # 11112222333344445555666
4 TYPE OF BILL 813
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/01/09 THROUGH 08/31/09
7

8 PATIENT NAME a
b Lean, Maybell
9 PATIENT ADDRESS a Village Nursing Home 2000 Waterfront Dr.
b Baton Rouge c LA d 70000 e 000

10 BIRTHDATE 01/20/19
11 SEX F
12 ADMISSION DATE 08/01/09
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT 30
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	991900	61	991900	61	991900
b	61	768000	80	31 00		
c						
d						

	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	651	Routine Home Care		081209	5	450 00		
2	651	Routine Home Care		081409	23	900 00		
3	652	Continuous Home Care		081809	16	300 00		
4	656	General Inpatient Care		083109	1	200 00		
5	657	Physician Services	99341	083009	1	130 00		
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50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 0123456789
57 OTHER 1234567
PRV ID

58 INSURED'S NAME
A Lean, Maybell
59 P REL
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9494
67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

80 REMARKS
81CC a b c d

76 ATTENDING NPI 014567879 QUAL
LAST Blow, MD FIRST Joe
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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	**Required.** Enter the appropriate 3-digit code as follows: ***FOR NURSING FACILITY PROVIDERS:*** *1st Digit - Type of Facility* 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) Skilled Nursing/ Intermediate	

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

Locator #	Description	Instructions	Alerts
		for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment. 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. 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. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	
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).	

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.**	

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required.** This code indicates the patient's status as of the "Through" date of the billing period (Field 6). **Code Structure** 01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital	**Formerly entered in UB-92 Form Locator 22.** **Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**

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	**Required**. Enter the appropriate Value Code (listed below). *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) *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. ***No other value codes are required for processing LTC claims.**	**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.** **Please read the instructions carefully for entering the new number of days information in the Value Code fields.**

Locator #	Description	Instructions	Alerts
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. 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: **FOR ALL PROVIDERS (Excluding ADHC Providers):** <u>Revenue Code & Description Leave of Absence</u> 183 = Leave of Absence – Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence – Subcategory Nursing Home (for Hospitalization) **FOR NURSING FACILITY PROVIDERS**: <u>Revenue Code & Description *(Corresponding Level of Care)*</u> 022 = Skilled Nursing Facility Prospective Payment System (RUGS) *(88 = Case Mix -- Formerly LOC 20,*	

Locator #	Description	Instructions	Alerts
		21, 22) 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)* 193 = Sub-acute Care Level III (Complex Care) *(32 = NF Complex Care)* 194 = Sub-acute Care Level IV *(28 = SNF Technology Dependent Care)* 199 = Other Sub-acute Care *(30 = SNF Infectious Disease)* **FOR ICF/DD PROVIDERS**: Revenue Code & Description *(Corresponding Level of Care)* **ICAP Revenue codes to be used for dates of service October 1, 2005 and forward:** 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	

Locator #	Description	Instructions	Alerts
		Care (ICAP Score 70-99) **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. **FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:** <u>Revenue Code & Description</u> <u>*(Corresponding Level of Care)*</u> 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
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	**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. Example 1: If SNF TDC care (Revenue Code 194) is	

Locator #	Description	Instructions	Alerts
		provided for the entire month of March, the Service Date should be entered 01-31. 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).** **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.** **Required**. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of	

Locator #	Description	Instructions	Alerts
		Care revenue code, description, and service date. Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194. **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.** Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank. **Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided.**	
47	Total Charges	**Leave blank.**	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of	

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	

Locator #	Description	Instructions	Alerts
		recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = 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	

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, 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 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.**

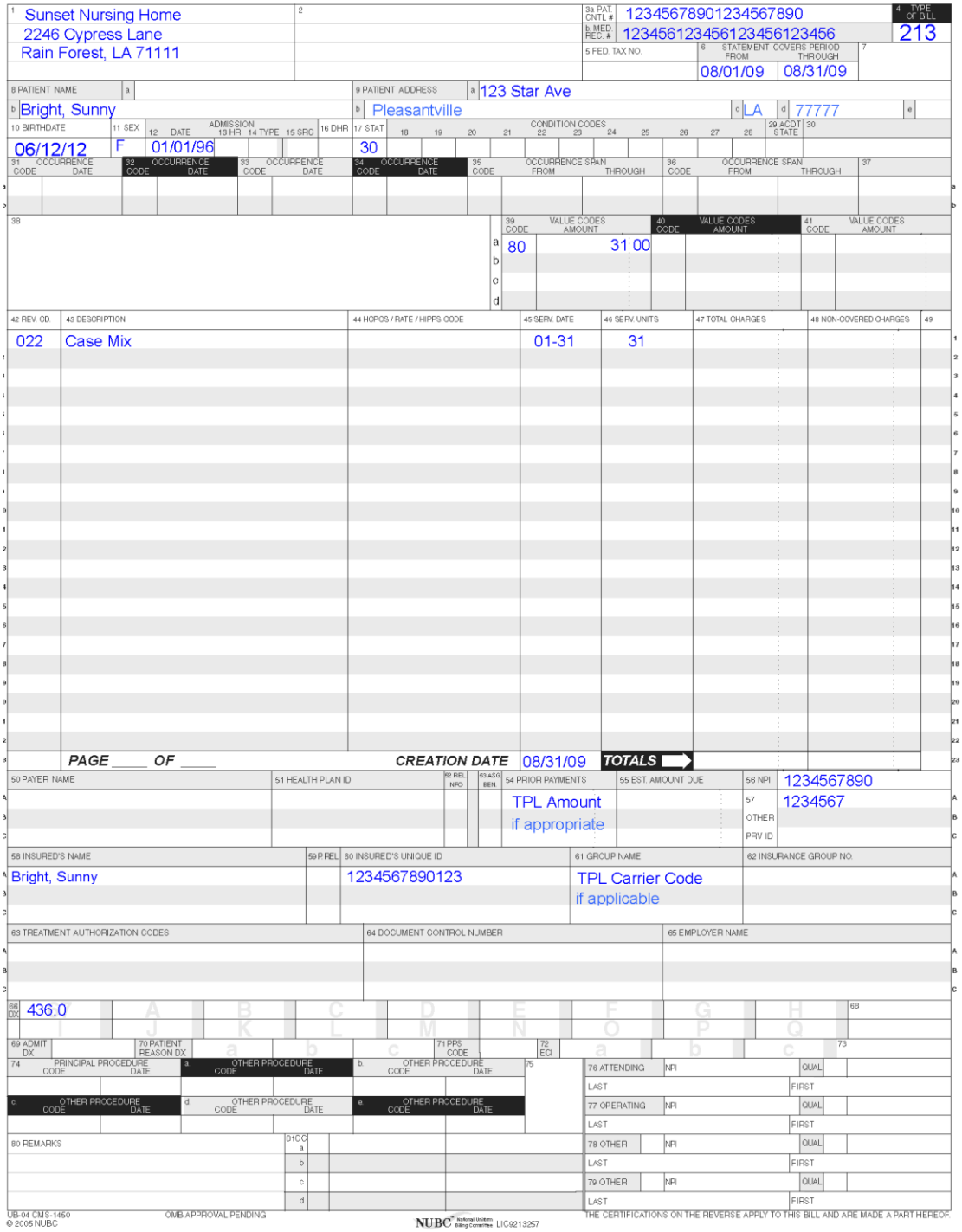
Locator #	Description	Instructions	Alerts
		64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability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

Locator #	Description	Instructions	Alerts
		CM code or codes for all other applicable diagnoses for this claim. **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.**	
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 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	
75	Unlabeled	**Leave blank.**	
76	Attending	**Leave blank.**	

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.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **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.**
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

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



Intermediate Care Facilities