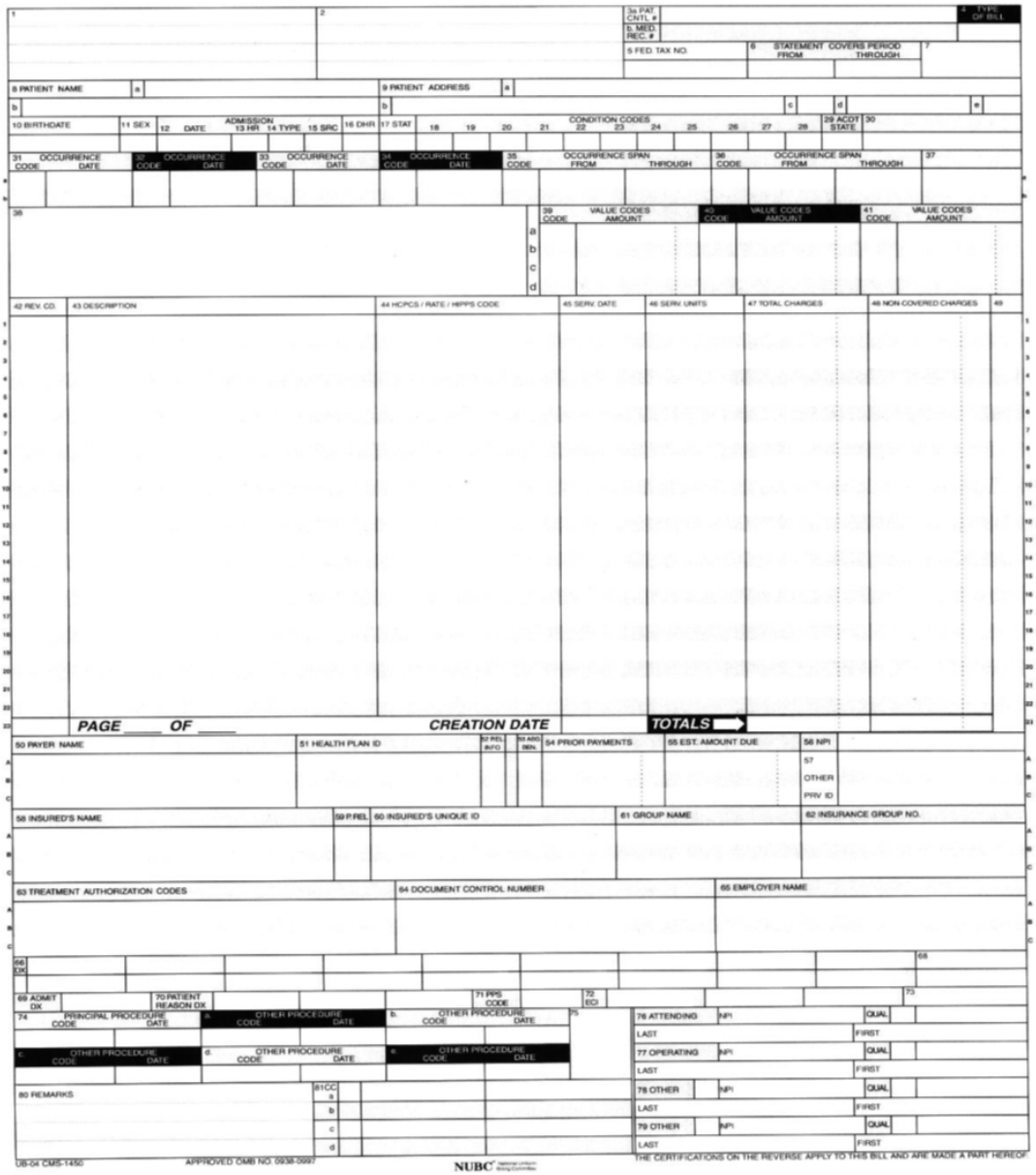
UB-04 FORM AND INSTRUCTIONS

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.



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.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: <u>a. First digit-type facility</u> 8 = Special facility (hospice) <u>b. Second digit-classification</u> 1 = Hospice (Non-hospital based) 2 = Hospice (Hospital based) <u>c. Third digit-frequency</u> 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	

Locator #	Description	Instructions	Alerts
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.** **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.	
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	
10	Patient's Birth Date	**Required.** Enter the patient's date of birth using six digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	

Locator #	Description	Instructions	Alerts
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 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.**	

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required.** Enter the patient's two 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	
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 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	

Locator #	Description	Instructions	Alerts
		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 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).	

Locator #	Description	Instructions	Alerts
		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.	
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 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	**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.**

Locator #	Description	Instructions	Alerts
		"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.**	
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 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: 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	

Locator #	Description	Instructions	Alerts
		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.	
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	

Locator #	Description	Instructions	Alerts
		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 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.	

Locator #	Description	Instructions	Alerts
		Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature.**
46	Units of Service	**Required.** Enter the number of units of service for each type of service on the line adjacent to the Revenue Code, Description, and Service Date. RC 651 is measured in DAYS. RC 652 is measured in HOURS. (Remember that a minimum of 8 hours – not necessarily consecutive – in a 24-hour period is required. Less than 8 hours is considered routine care.) RC 655 is measured in DAYS. RC656 is measured in DAYS. RC 657 is measured in NUMBER OF PROCEDURES. **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. (Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue	

Locator #	Description	Instructions	Alerts
		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**.	
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,	

Locator #	Description	Instructions	Alerts
		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 must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Patient's Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child	

Locator #	Description	Instructions	Alerts
		06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	**ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE**
62-A,B,C	Insured's Group No. (Medicaid not	**Situational.** If insurance coverage other than Medicaid	

Locator #	Description	Instructions	Alerts
	Primary)	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 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid	

Locator #	Description	Instructions	Alerts
		applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Required.** Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Codes	**Required.** Enter the ICD code for the principal diagnosis for the terminal illness. **Situational.** Enter the ICD code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate Diagnosis Code. A code is invalid if it has not been coded to the full number of digits required for that code.** **Note: Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.** **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** **Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code for the terminal illness.	Refer to field locator 67.
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	

Locator #	Description	Instructions	Alerts
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	**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.	**This field must be completed.**
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.	
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	

Locator #	Description	Instructions	Alerts
		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.	
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.

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

1 HOSPICE CARES
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 813
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY
11 SEX M
ADMISSION 12 DATE 080515
17 STAT 30

39/40/41 VALUE CODES

	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT
a	61	3880 00	61	3880 00	61	3880 00
b	61	3880 00	61	3880 00		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	651	ROUTINE HOME CARE		090115	10	800 00	
2	651	ROUTINE HOME CARE		091215	1	80 00	
3	652	CONTINUOUS HOME CARE		091315	18	1800 00	
4	656	GENERAL INPATIENT CARE		091515	5	625 00	
5	657	PHYSISICAN SERVCIES	99231	091815	1	75 00	
23	001	PAGE 1 OF 1	CREATION DATE	100315	TOTALS	3380 00	

SAMPLE

EXAMPLE OF ICD 9

50 PAYER NAME: A MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME: A DOE, JOHN
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9 5172

76 ATTENDING NPI 1298765432
LAST ADAMS FIRST JANE

77 OPERATING NPI
78 OTHER NPI
79 OTHER NPI
80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE HOSPICE CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

Field	Entry
1	HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111
2	
3a PAT. CNTL #	1111111
b. MED. REC. #	11111111111
4 TYPE OF BILL	814
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	100115 / 102015
7	
8 PATIENT NAME	a DOE, JOHN
9 PATIENT ADDRESS	a 1235 ANYSTREET b ANYWHERE c LA d 71111 e
10 BIRTHDATE	MMDDYY
11 SEX	M
ADMISSION 12 DATE	080515
13 HR / 14 TYPE / 15 SRC / 16 DHR	
17 STAT	40
CONDITION CODES 18–28	
29 ACDT STATE / 30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	3880 00	61	3880 00	61	3880 00
b	61	3880 00	61	3880 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		100115	5	400 00		
2	651	ROUTINE HOME CARE		100815	1	80 00		
3	652	CONTINUOUS HOME CARE		102015	18	1800 00		
4	656	GENERAL INPATIENT CARE		101515	4	500 00		
5	657	PHYSISICAN SERVCIES	99231	101615	1	75 00		
23	001	PAGE 1 OF 1	CREATION DATE	110515	TOTALS	2855 00		

SAMPLE

EXAMPLE OF ICD 10

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	MEDICAID				TPL	
B					PAYMENT IF	
C					APPLICABLE	

56 NPI: 1234567890
57 OTHER PRV ID: 1234567

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN		1234567890123	TPL CARRIER	
B				CODE IF	
C				APPLICABLE	

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

66 DX: M3481

67, A–Q: (blank)

68:

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

74 PRINCIPAL PROCEDURE CODE / DATE; a.–e. OTHER PROCEDURE CODE / DATE: (blank)

75:

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

Field	Entry
1	HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111
2	
3a PAT. CNTL #	1111111
b. MED. REC. #	11111111111
4 TYPE OF BILL	817
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	091315
THROUGH	091315
7	
8 PATIENT NAME a	DOE, JOHN
9 PATIENT ADDRESS a	1235 ANYSTREET
b	ANYWHERE
c	LA
d	71111
10 BIRTHDATE	MMDDYY
11 SEX	M
ADMISSION 12 DATE	080515
13 HR / 14 TYPE / 15 SRC / 16 DHR	
17 STAT	30
18–28 CONDITION CODES	
29 ACDT STATE / 30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37 / 38	
39 VALUE CODES CODE / AMOUNT a	61 / 3880 00
40–41 VALUE CODES	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
652	CONTINUOUS HOME CARE		091315	20	2000 00		
	PAGE 1 OF 1	CREATION DATE	122815	TOTALS	2000 00		

SAMPLE

EXAMPLE OF ICD 9

Field	Entry
50 PAYER NAME A	MEDICAID
51 HEALTH PLAN ID / 52 REL. INFO / 53 ASG. BEN.	
54 PRIOR PAYMENTS	TPL PAYMENT IF APPLICABLE
55 EST. AMOUNT DUE	
56 NPI	1234567890
57 OTHER PRV ID	1234567
58 INSURED'S NAME A	DOE, JOHN
59 P. REL	
60 INSURED'S UNIQUE ID	1234567890123
61 GROUP NAME	TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	A 5274198798700 02
65 EMPLOYER NAME	
66 DX / 67	5172
68 / 69 ADMIT DX / 70 PATIENT REASON DX / 71 PPS CODE / 72 ECI / 73	
74 PRINCIPAL PROCEDURE / a–e OTHER PROCEDURE / 75	
76 ATTENDING NPI	1298765432
LAST / FIRST	ADAMS / JANE
77 OPERATING / 78 OTHER / 79 OTHER	
80 REMARKS / 81 CC	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

1 HOSPICE CARES
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL #: 1111111
b. MED. REC. #: 111111111111
4 TYPE OF BILL: 817
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 102015 THROUGH: 102015

8 PATIENT NAME a: DOE, JOHN
9 PATIENT ADDRESS a: 1235 ANYSTREET
b: ANYWHERE c: LA d: 71111

10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 080515
17 STAT: 30

39 VALUE CODES CODE a: 61 AMOUNT: 3880 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
652	CONTINUOUS HOME CARE		102015	20	2000 00		
	PAGE 1 OF 1	CREATION DATE	122815	TOTALS	2000 00		

SAMPLE

EXAMPLE OF ICD 10

50 PAYER NAME A: MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI: 1234567890
57 OTHER PRV ID: 1234567

58 INSURED'S NAME A: DOE, JOHN
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER: A 5309198798700 02
65 EMPLOYER NAME

66 DX: M3481

76 ATTENDING NPI: 1298765432
LAST: ADAMS FIRST: JANE

77 OPERATING NPI
78 OTHER NPI
79 OTHER NPI
80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC 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.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 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	**2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by NUBC. Use 2nd Digit "1" instead.**

Locator #	Description	Instructions	Alerts
		entire course of treatment 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 &	**Required.** Enter the beginning and ending service	

Locator #	Description	Instructions	Alerts
	Through Dates) dates of the period covered by this bill.	dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	

Locator #	Description	Instructions	Alerts
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	
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	

Locator #	Description	Instructions	Alerts
		62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 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"	**Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.** **Value Codes 81, 82, and 83 are not used for straight Medicaid billing.**

Locator #	Description	Instructions	Alerts
		portion of the "Amount" section of the field. ***No other value codes are required for processing LTC claims.**	
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**:	

Locator #	Description	Instructions	Alerts
		Revenue Code & Description *(Corresponding Level of Care)* 022 = Skilled Nursing Facility Prospective Payment System (RUGS) *(88 = Case Mix -- Formerly LOC 20, 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:**	

Locator #	Description	Instructions	Alerts
		193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39 191 = Limited Level of Care (ICAP Score 40-69) 190 = Intermittent Level of Care (ICAP Score 70-99) **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	

Locator #	Description	Instructions	Alerts
		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 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	

Locator #	Description	Instructions	Alerts
		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.	
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 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.	
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	

Locator #	Description	Instructions	Alerts
		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**.	
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.**

Locator #	Description	Instructions	Alerts
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	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	

Locator #	Description	Instructions	Alerts
		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, 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.	

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	
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.	

Locator #	Description	Instructions	Alerts
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis Code	**Required.** Enter the ICD code for the principal diagnosis. **Situational.** Enter the ICD code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate "A" Code. A code is invalid if it has not been coded to the full number of digits required for that code.** **Note: ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.** **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	**Refer to field locator 67.**
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	**Leave blank.**	**This field must be completed.**
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.	
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.

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

1 HAPPY HOME NURSING HOME
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 212
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY | 11 SEX M | 12 ADMISSION DATE 090115 | 17 STAT 30

39 VALUE CODES AMOUNT: a 80 30 00

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	022	CASE MIX		01-30	30		
2	185	HOSPITAL LEAVE		05-08			
3	183	HOME LEAVE		10-12			
23		PAGE 1 OF 1	CREATION DATE	100315	TOTALS		

SAMPLE

EXAMPLE OF ICD 9

50 PAYER NAME: A MEDICAID
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME: A DOE, JOHN
60 INSURED'S UNIQUE ID: 123456789012
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

66 DX: 9 V5481 | 67 A 29411

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

1 HAPPY HOME NURSING HOME
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 214
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY
11 SEX M
12 ADMISSION DATE 090115
13 HR 14 TYPE 15 SRC 1
16 DHR
17 STAT 01
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
a 80 19 00
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
022	CASE MIX		01-20	19			
185	HOSPITAL LEAVE		05-08				
183	HOME LEAVE		18-19				
	PAGE 1 OF 1		CREATION DATE	110515	TOTALS		

SAMPLE

EXAMPLE OF ICD 10

50 PAYER NAME
A MEDICAID
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
A TPL PAYMENT IF APPLICABLE
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME
A DOE, JOHN
59 P. REL
60 INSURED'S UNIQUE ID
A 123456789012 3
61 GROUP NAME
A TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 0
67 Z471
67 F0281
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
71 PPS CODE
72 ECI
73

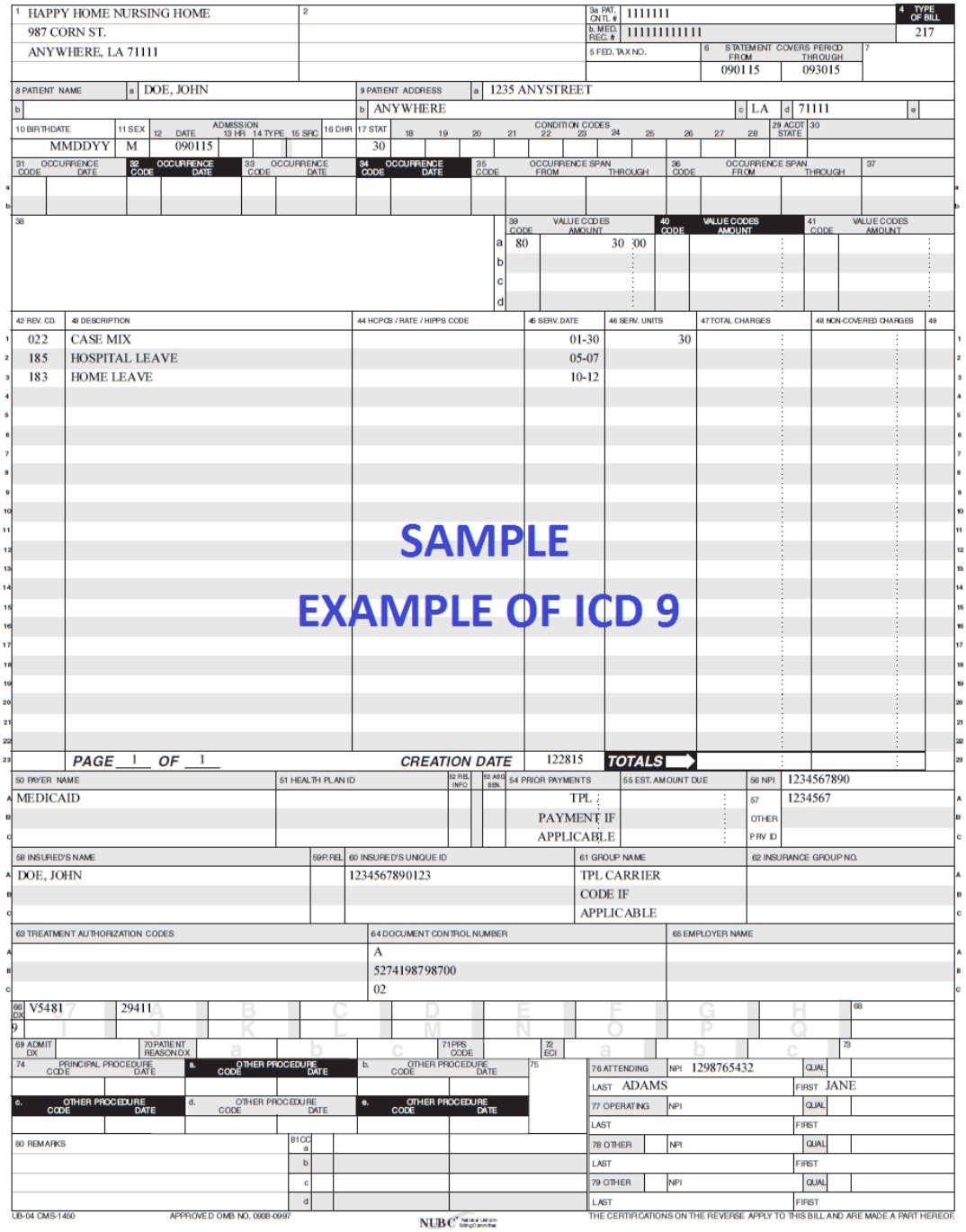
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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



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

1 HAPPY HOME NURSING HOME
987 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL #: 1111111
b. MED. REC. #: 111111111111
4 TYPE OF BILL: 217
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 100115 THROUGH: 102015

8 PATIENT NAME: a DOE, JOHN
9 PATIENT ADDRESS: a 1235 ANYSTREET; b ANYWHERE; c LA; d 71111
10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 090115
17 STAT: 01

39 VALUE CODES: a 80 — 19 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
022	CASE MIX		01-20	19		
185	HOSPITAL LEAVE		05-08			
183	HOME LEAVE		17-19			

PAGE 1 OF 1 CREATION DATE 122815 TOTALS

SAMPLE

EXAMPLE OF ICD 10

50 PAYER NAME: MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI: 1234567890
57 OTHER PRV ID: 1234567

58 INSURED'S NAME: DOE, JOHN
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

64 DOCUMENT CONTROL NUMBER: A 5278198798700 02

66 DX: Z471 F0281

76 ATTENDING NPI 1298765432
LAST ADAMS FIRST JANE

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 653
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY
11 SEX M
12 ADMISSION DATE 080115
17 STAT 30

39 VALUE CODES CODE a 80 AMOUNT 30 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		03-05			
183	HOME LEAVE		12-15			

SAMPLE

EXAMPLE OF ICD 9

PAGE 1 OF 1 CREATION DATE 100315 TOTALS

50 PAYER NAME A MEDICAID
54 PRIOR PAYMENTS TPL PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A DOE, JOHN
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

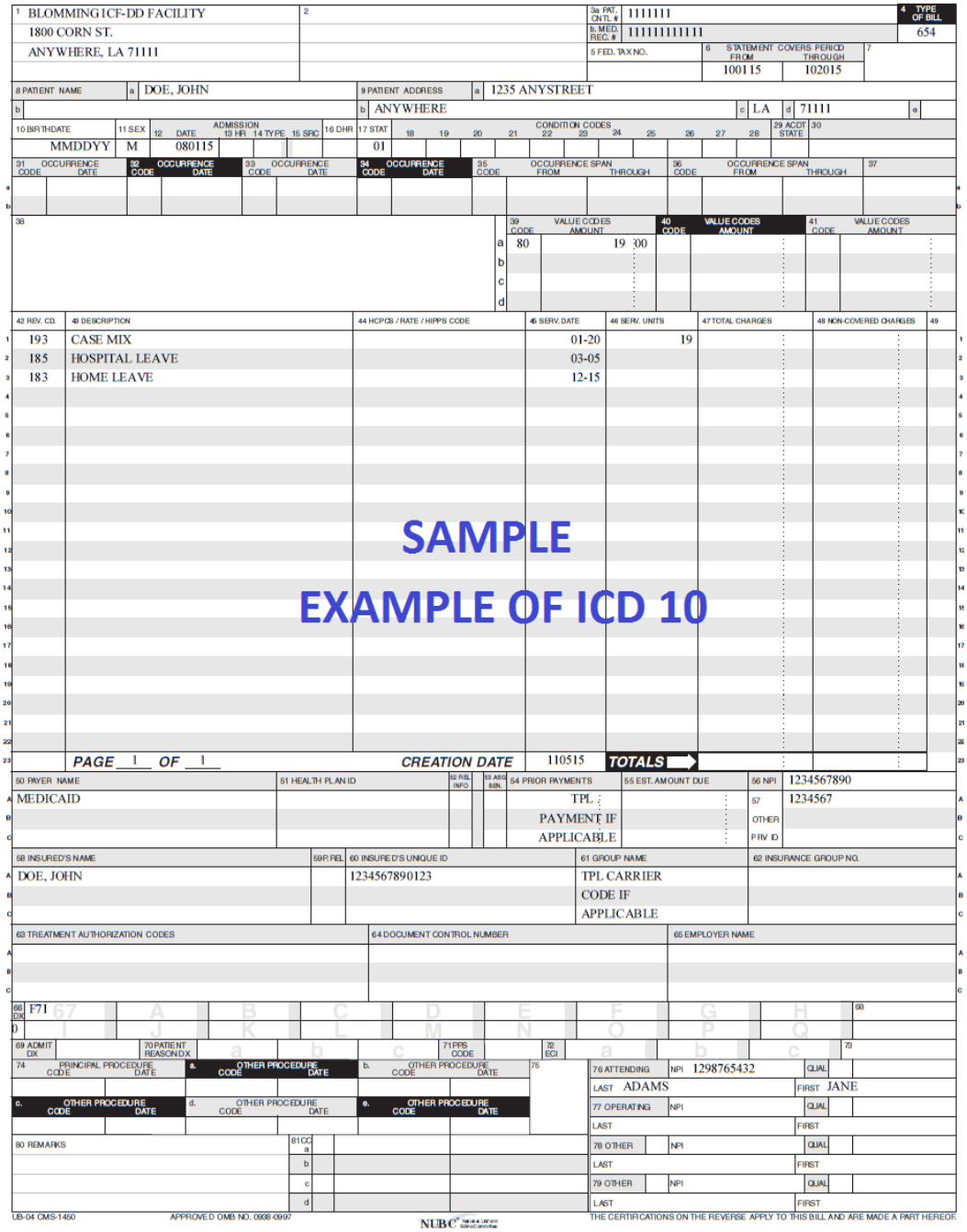
66 DX 9 67 3180

76 ATTENDING NPI 1298765432
LAST ADAMS FIRST JANE

77 OPERATING NPI
78 OTHER NPI
79 OTHER NPI
80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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



1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 654
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015

8 PATIENT NAME: DOE, JOHN
9 PATIENT ADDRESS: 1235 ANYSTREET
ANYWHERE LA 71111

10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 080115
17 STAT: 01

39 VALUE CODES a: 80 19 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-20	19		
185	HOSPITAL LEAVE		03-05			
183	HOME LEAVE		12-15			

SAMPLE

EXAMPLE OF ICD 10

PAGE 1 OF 1 CREATION DATE 110515 TOTALS

50 PAYER NAME: MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI: 1234567890
57 OTHER: 1234567

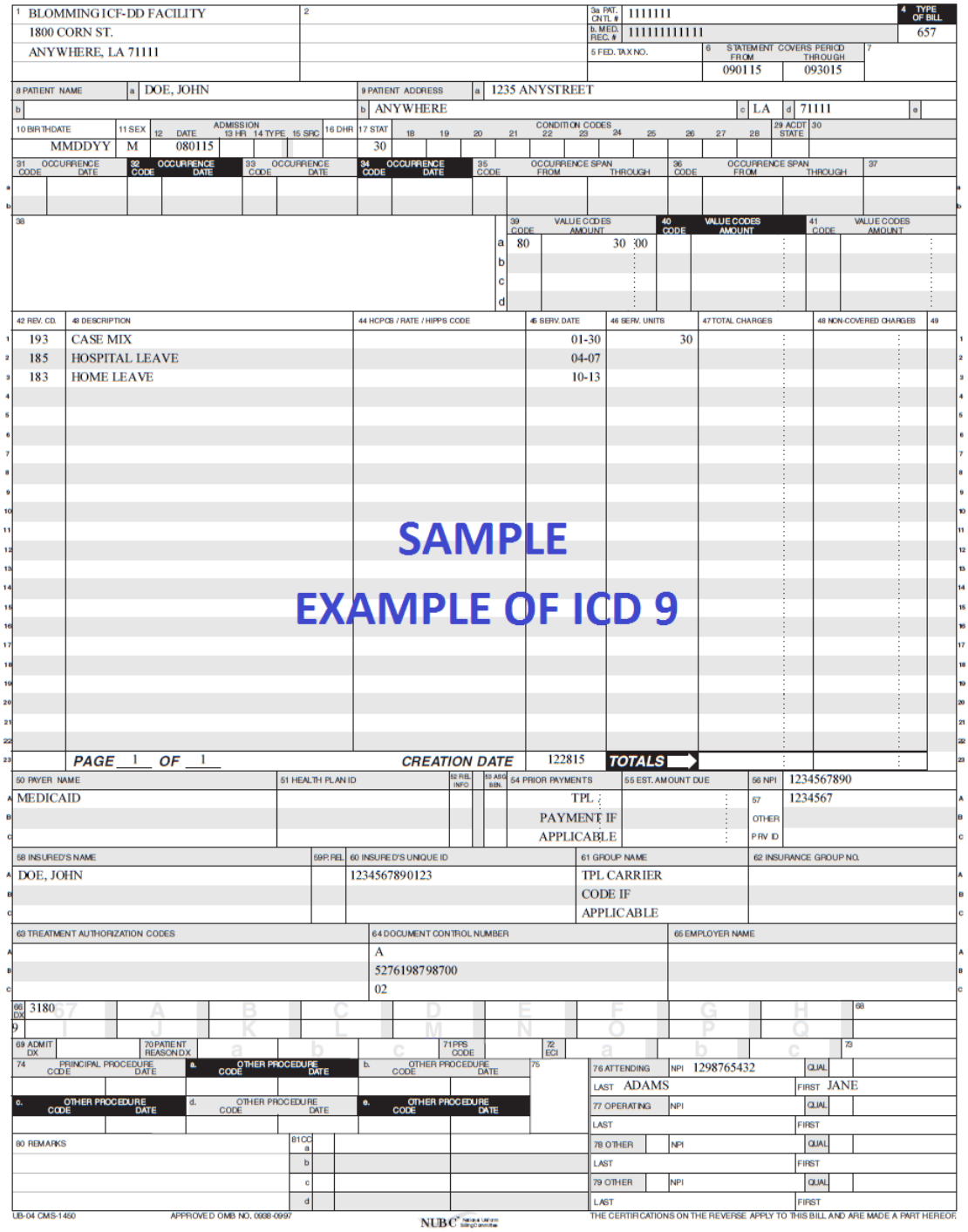
58 INSURED'S NAME: DOE, JOHN
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

66 DX: 0 F71

76 ATTENDING NPI 1298765432 LAST ADAMS FIRST JANE

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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



1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 657
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY | 11 SEX M | 12 ADMISSION DATE 080115 | 17 STAT 30

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		04-07			
183	HOME LEAVE		10-13			
	PAGE 1 OF 1	CREATION DATE	122815	TOTALS		

39 VALUE CODES a 80 AMOUNT 30 00

50 PAYER NAME A MEDICAID
51 HEALTH PLAN ID
54 PRIOR PAYMENTS TPL PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A DOE, JOHN
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

64 DOCUMENT CONTROL NUMBER A / 5276198798700 / 02

66 DX 9 3180

76 ATTENDING NPI 1298765432 LAST ADAMS FIRST JANE

SAMPLE

EXAMPLE OF ICD 9