

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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## UB-04 FORM AND INSTRUCTIONS

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

1		2		3a PAT CMTL # 3b MISC REC #		4 TYPE OF BILL	
5 PATIENT NAME		6 PATIENT ADDRESS		7 STATEMENT COVERS PERIOD FROM		8 THROUGH	
9 BIRTHDATE		10 SEX		11 DATE		12	
13 ADMISSION		14 TYPE		15 SRC		16 DHR	
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## UB-04 Instructions for Hospice Providers

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	<b>Required.</b> Enter the name and address of the facility	
2	Pay to Name/Address/ID	<b>Situational.</b> Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	<b>Optional.</b> Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	<b>Optional.</b> Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	<b>Required.</b> 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.	<b>Optional.</b>	

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Locator #	Description	Instructions	Alerts
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	<p><b>Required.</b> Enter the beginning and ending service dates.</p> <p><b>Note: Do not show days before the patient's entitlement began.</b></p> <p><b>Note: A claim may not span more than one month of service at a time.</b></p>	
7	Unlabeled	<b>Leave blank.</b>	
8	Patient's Name	<b>Required.</b> Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, and middle initial.	
9a-e	Patient's Address (Street, City, State, and Zip)	<p><b>Required.</b> Enter patient's permanent address appropriately in Form Locator 9a-e.</p> <p>9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus</p>	
10	Patient's Birth Date	<b>Required.</b> Enter the patient's date of birth using six digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	<p><b>Required.</b> Enter sex of the patient as:</p> <p>M = Male F = Female U = Unknown</p>	

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Locator #	Description	Instructions	Alerts
12	Admission Date	<p><b>Required.</b> Enter the admission date in MMDDYY format, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the From date in the Statement Covers Period (Form Locator 6).</p> <p>The date of admission may not precede the physician's certification by more than two calendar days.</p> <p><b>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.</b></p>	
13	Admission Hour	<b>Leave blank.</b>	
14	Type Admission	<b>Leave blank.</b>	
15	Source of Admission	<b>Leave blank.</b>	
16	Discharge Hour	<b>Leave blank.</b>	

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

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Locator #	Description	Instructions	Alerts
		<p>the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.</p> <p>This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-certification of an individual, the claim will reject.</p> <p>Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date.</p> <p><b>42 = Termination date.</b> Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)</p>	
35-36	Occurrence Spans (Code and Dates)	<b>Situational.</b> If a specific event relating to this billing period should be indicated, then enter the code(s) and associated beginning and ending date(s).	

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Locator #	Description	Instructions	Alerts
		<p>Event codes are two alphanumeric characters, and dates are shown numerically as MMDDYY. Use the following code when appropriate:</p> <p><b>M2 = Dates of Inpatient Respite Care.</b> Code indicates From/Through dates of a period of inpatient respite care for hospice patients.</p>	
37	Unlabeled	<b>Leave blank.</b>	
38	Responsible Party Name and Address	<b>Optional.</b>	
39-41	Value Codes and Amounts	<p><b>Required.</b> Enter the appropriate Value Code(s).</p> <p>Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Metropolitan Statistical Area (MSA) code/rural state codes for each service are required for correct claim payment.</p> <p>Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of “a” codes is used before entering information in “b” codes.) Enter value code 61 in the “code” section of the field; the MSA code/rural state code in the dollar portion of the</p>	<p><b>Covered days are now reported with Value Code 80. Entry of covered days is not required on your claim form for Medicaid Services.</b></p> <p><b>If your system is programmed to enter Covered Days, they must be entered AFTER the MSA Value Codes.</b></p>

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Locator #	Description	Instructions	Alerts
		<p>“amount” section of the field; and double zeros (00) in the “cents” portion of the “amount” section of the field.</p> <p>Multiple Occurrences of the Same Service: Enter the value codes/MSAs multiple times if there are multiple occurrences of the same service during the same month. (See further explanation under Form Locators 42 and 45.)</p> <p><b>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.</b></p>	
42	Revenue Code	<p><b>Required.</b> 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.)</p> <p>Example:</p> <p>651 Routine Home Care 07/01/05</p> <p>651 Routine Home Care 07/08/05</p> <p>652 Continuous Home Care 07/06/05</p> <p>656 General Inpatient Care 07/31/05</p>	



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Locator #	Description	Instructions	Alerts
		<p>Use these revenue codes to bill Medicaid:</p> <p>651 = Routine Home Care (RTN Home)</p> <p>652 = Continuous Home Care (CTNS Home – a minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.)</p> <p>655 = Inpatient Respite Care (IP Respite)</p> <p>656 = General Inpatient Care (GNP IP)</p> <p>657 = Physician Services (PHY Ser – must be accompanied by a physician procedure code)</p> <p><b>NOTE:</b> Revenue code 001 (Total Charges) <b>MUST</b> always be the final revenue code.</p>	
43	Revenue Description	<b>Required.</b> Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	<p><b>Situational.</b> When using Revenue Code 657 (Physician Services), entry of appropriate Procedure Code(s) is <b>required</b>.</p> <p>Procedure Codes should be obtained from the physician</p>	

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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	<p><b>Required.</b> Enter the appropriate service date (MMDDYY) for each service. The service date must be the first date that a service began.</p> <p>Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service – not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42). For example: Routine care is provided beginning the first day of the month of service for five days; then the patient has continuous care beginning the sixth day of the month for two days, followed by routine care again for the eighth day through the 30th day of the month. The revenue code for routine care must be indicated twice – one entry with a service date of the first day of the month and one entry with a service date of the eighth day of the month.</p>	

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Locator #	Description	Instructions	Alerts
		<b>Required.</b> 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.	<b>The CREATION DATE replaces the Date of Provider Representative Signature.</b>
46	Units of Service	<p><b>Required.</b> Enter the number of units of service for each type of service on the line adjacent to the Revenue Code, Description, and Service Date.</p> <p>RC 651 is measured in DAYS. RC 652 is measured in HOURS. (Remember that a minimum of 8 hours – not necessarily consecutive – in a 24-hour period is required. Less than 8 hours is considered routine care.)</p> <p>RC 655 is measured in DAYS. RC656 is measured in DAYS. RC 657 is measured in NUMBER OF PROCEDURES.</p> <p><b>PLEASE BE SURE THAT THE UNITS AND DATES BILLED FOR EACH OCCURRENCE CORRESPOND.</b></p>	
47	Total Charges	<p><b>Required.</b> Enter the charges pertaining to the related Revenue Codes. Must be numeric.</p> <p>(Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue</p>	

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Locator #	Description	Instructions	Alerts
		Code 001 in Form Locator 42.)	
48	Non-Covered Charges	<b>Leave blank.</b>	
49	Unlabeled Field (National)	<b>Leave Blank.</b>	
50-A,B,C	Payer Name	<p><b>Situational.</b> 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 <b>required</b>.</p> <p>The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan ID	<p><b>Situational.</b> 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 <b>required</b>.</p>	
52-A,B,C	Release of Information	<b>Optional.</b>	
53-A,B,C	Assignment of Benefits Cert. Ind.	<b>Optional.</b>	
54-A,B,C	Prior Payments	<p><b>Situational.</b> Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.</p> <p>If private insurance was available, but no private insurance payment was made,</p>	

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		then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	<b>Optional.</b>	
56	NPI FIELD	<b>Required.</b> Enter the provider's National Provider Identifier.	<b>The 10-digit National Provider Identifier (NPI) must be entered here.</b>
57	Other Provider ID	<b>Required.</b> Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	<b>The 7-digit Medicaid provider number must be entered here.</b>
58-A,B,C	Insured's Name	<p><b>Required.</b> Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p><b>Situational:</b> If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	
59-A,B,C	Patient's Relationship Insured	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C.</p> <p>Acceptable codes are as follows:            01 = Patient is insured            02 = Spouse            03 = Natural child/Insured has financial responsibility            04 = Natural child/ Insured does not have financial responsibility            05 = Step child</p>	

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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	<b>Required.</b> Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.  <b>Situational.</b> 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)	<b>Situational.</b> 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.	<b>ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.</b>  <b>DO NOT enter dashes, hyphens, or the word TPL in the field.</b>  <b>NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE</b>
62-A,B,C	Insured's Group No. (Medicaid not	<b>Situational.</b> If insurance coverage other than Medicaid	

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

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	<b>Leave blank.</b>	
64-A,B,C	Document Control Number	<p><b>Situational.</b> If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u>  01 = Third Party Liability Recovery  02 = Provider Correction  03 = Fiscal Agent Error  90 = State Office Use Only – Recovery  99 = Other</p> <p><u>Voids</u>  10 = Claim Paid for Wrong Recipient  11 = Claim Paid for Wrong Provider  00 = Other</p>	<b>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.</b>
65-A,B,C	Employer Name	<b>Situational.</b> If insurance coverage other than Medicaid	

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

Locator #	Description	Instructions	Alerts
		applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	<b>Required.</b> 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	Principal Diagnosis Codes	<b>Required.</b> Enter the ICD code for the principal diagnosis for the terminal illness.	<b>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</b>  <b>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</b>  <b>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 (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>).</b>
67 A-Q	Other Diagnosis Codes	<b>Situational.</b> Enter the ICD code or codes for all other applicable diagnoses for this claim.  <b>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.</b>  <b>Note: Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</b>	
68	Unlabeled	<b>Leave blank.</b>	
69	Admitting Diagnosis	<b>Optional.</b> Enter the admitting Diagnosis Code for the terminal illness.	<b>Refer to field locator 67.</b>
70	Patient Reason for Visit	<b>Leave blank.</b>	
71	PPS Code	<b>Leave blank.</b>	



## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

Locator #	Description	Instructions	Alerts
72 A B C	ECI (External Cause of Injury)	<b>Leave blank.</b>	
73	Unlabeled.	<b>Leave blank.</b>	
74	Principal Procedure Code / Date	<b>Leave blank.</b>	
74 a - e	Other Procedure Code / Date		
75	Unlabeled	<b>Leave blank.</b>	
76	Attending	<b>Required.</b> 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.	<b>This field must be completed.</b>
77	Operating	<b>Leave blank.</b>	
78	Other	<b>Required.</b> 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	<b>Leave blank.</b>	
80	Remarks	<b>Required.</b> 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	

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

Locator #	Description	Instructions	Alerts
		required physician's certification and a signed hospice election statement are in the records before signing the form.  <b>Situational.</b> Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	<b>Leave blank.</b>	

**Signature is not required on the UB-04.**

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

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

**PAGE(S) 46**

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

[illegible]

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

**PAGE(S) 46**

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

[illegible]

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

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

1 HOSPICE CARES 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CNTL. # 111111 b. MED. REC. # 1111111111		4 TYPE OF BILL 817	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET		b. ANYWHERE		c. LA d. 71111 e.	
10 BIRTHDATE MMDDYY M 080515		11 SEX M		12 DATE OF ADMISSION 13 HPI 14 TYPE 15 SPD 16 DHR 17 STAT 30		18 19 20 21 22 23 24 25 26 27 28 29 ACOT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38 CODE	
39 CODE		40 CODE		41 CODE		42 CODE	
43 CODE		44 CODE		45 CODE		46 CODE	
47 CODE		48 CODE		49 CODE		50 CODE	
51 CODE		52 CODE		53 CODE		54 CODE	
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59 CODE		60 CODE		61 CODE		62 CODE	
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823 CODE		824 CODE		825 CODE		826 CODE	

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

# **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		2		3a PAT. CNTL. # b. MED. REC. # c. FED. TAX NO.		4 TYPE OF BILL 817	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET		c. LA d. 71111		e.	
10 BIRTH DATE MMDDYY M 080515		11 SEX M		12 DATE ADMISSION 13 HPI 14 TYPE 15 SPO 16 DHR 17 STAT 30		18	
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267		268		269		270	
271		272		273		274	
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739		740		741		742	
743		744		745		746	
747		748		749		750	
751		752		753		754	
755		756		757		758	
759		760		761		762	
763		764		765		766	
767		768		769		770	
771		772		773		774	
775		776		777		778	
779		780		781		782	
783		784		785		786	
787		788		789		790	
791		792		793		794	
795		796		797		798	
799		800		801		802	
803		804		805		806	
807		808		809		810	
811		812		813		814	
815		816		817		818	
819		820		821		822	
823		824		825		826	
827		828		829		830	
831		832		833		834	
835		836		837		838	
839		840		841		842	
843		844		845		846	
847		848		849		850	
851		852		853		854	
855		856		857		858	
859		860		861		862	
863		864		865		866	
867		868		869		870	
871		872		873		874	
8							

## CHAPTER 24: HOSPICE

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## UB04 Instructions for LTC Providers

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

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## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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



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Locator #	Description	Instructions	Alerts
		<p>entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient.</p> <p>2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment.</p> <p>3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted.</p> <p>4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death.</p> <p>7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim.</p> <p>8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.</p>	
5	Federal Tax No.	<b>Optional.</b>	
6	Statement Covers Period (From &	<b>Required.</b> Enter the beginning and ending service	

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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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	<b>Leave blank.</b>	
8	Patient's Name	<b>Required.</b> 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)	<b>Required.</b> 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	<b>Required.</b> 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	<b>Required.</b> Enter sex of the patient as:  M = Male F = Female U = Unknown	
12	Admission Date	<b>Required.</b> Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	<b>Leave blank.</b>	
14	Type Admission	<b>Leave blank.</b>	

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

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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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	<b>Leave blank.</b>	
29	Accident State	<b>Leave blank.</b>	
30	Unlabeled Field	<b>Leave blank.</b>	
31-34	Occurrence Codes/Dates	<b>Leave blank.</b>	
35-36	Occurrence Spans (Code and Dates)	<b>Leave blank.</b>	
37	Unlabeled	<b>Leave blank.</b>	
38	Responsible Party Name and Address	<b>Optional.</b>	
39-41	Value Codes and Amounts	<p><b>Required.</b> Enter the appropriate Value Code (listed below).</p> <p>*80 = Covered days 81 = Non-covered days 82 = Co-insurance days (required only for Medicare crossover claims) 83 = Lifetime reserve days (required only for Medicare crossover claims)</p> <p>*Enter the appropriate Value Code in the code portion of the field and the Number of Days in the “Dollar” portion of the “Amount” section of the field. Enter “00” in the “Cents”</p>	<p><b>Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.</b></p> <p><b>Value Codes 81, 82, and 83 are not used for straight Medicaid billing.</b></p>

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Locator #	Description	Instructions	Alerts
		<p>portion of the "Amount" section of the field.</p> <p><b>*No other value codes are required for processing LTC claims.</b></p>	
42	Revenue Code	<p><b>Required.</b> Enter the applicable revenue code(s) which identifies the service provided.</p> <p>Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid:</p> <p><b>FOR ALL PROVIDERS (Excluding ADHC Providers):</b></p> <p><u>Revenue Code &amp; Description</u> <u>Leave of Absence</u></p> <p>183 = Leave of Absence – Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence – Subcategory Nursing Home (for Hospitalization)</p> <p><b>FOR NURSING FACILITY PROVIDERS:</b></p>	

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Locator #	Description	Instructions	Alerts
		<u>Revenue Code &amp; Description</u> <u>(Corresponding Level of Care)</u>  022 = Skilled Nursing Facility Prospective Payment System (RUGS) (88 = Case Mix -- <i>Formerly LOC 20,</i> <i>21, 22)</i>  118 = Room & Board-Private Sub-acute Rehabilitation (31 = NF Rehabilitation 20 = SNF/Hospice in <i>Nursing Facility</i> 21 = ICF I/Hospice in <i>Nursing Facility</i> 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)  <b>FOR ICF/DD PROVIDERS:</b>  <u>Revenue Code &amp; Description</u> <u>(Corresponding Level of Care)</u>  <b>ICAP Revenue codes to be            used for dates of service            October 1, 2005 and            forward:</b>	

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Locator #	Description	Instructions	Alerts
		<p>193 = Pervasive Level of Care (ICAP Score 1-19)  192 = Extensive Level of Care (ICAP Score 20-39)  191 = Limited Level of Care (ICAP Score 40-69)  190 = Intermittent Level of Care (ICAP Score 70-99)</p> <p><b>NOTE:</b> Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file.</p> <p><b>FOR ADULT DAY HEALTH CARE (ADHC) PROVIDERS:</b></p> <p><u>Revenue Code &amp; Description</u>  <i>(Corresponding Level of Care)</i></p> <p>932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day  (27 = Adult Day Health Care)</p>	
43	Revenue Description	<b>Required.</b> Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	<b>Leave blank.</b>	
45	Service Date	<b>Required.</b> Enter a beginning	

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Locator #	Description	Instructions	Alerts
		<p>and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided.</p> <p>Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31.</p> <p>Example 2: If the recipient is on Hospital Leave (Revenue Code 185) from March 6 – 12, the Service Date should be entered 07-12, -- <b>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).</b></p> <p><b>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.</b></p> <p><b>Required.</b> Enter the date the claim is submitted for payment</p>	



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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	<p><b>Required.</b> Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of Care revenue code, description, and service date.</p> <p>Example 1 above, Service Date 01-31 should indicate 31 units or days for Revenue Code 194.</p> <p><b>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.</b></p> <p>Example 2 above (Revenue Code 185), Service date 07-12, service units should be left blank.</p>	
47	Total Charges	<b>Leave blank.</b>	
48	Non-Covered Charges	<b>Leave blank.</b>	
49	Unlabeled Field (National)	<b>Leave Blank.</b>	
50-A,B,C	Payer Name	<b>Situational.</b> 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	

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Locator #	Description	Instructions	Alerts
		<p><b>required.</b></p> <p>The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan ID	<p><b>Situational.</b> 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 <b>required.</b></p>	
52-A,B,C	Release of Information	<b>Optional.</b>	
53-A,B,C	Assignment of Benefits Cert. Ind.	<b>Optional.</b>	
54-A,B,C	Prior Payments	<p><b>Situational.</b> Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.</p>	
55-A,B,C	Estimated Amt. Due	<b>Optional.</b>	
56	NPI FIELD	<b>Required.</b> Enter the provider's National Provider Identifier	<b>The 10-digit National Provider Identifier (NPI) must be entered here.</b>

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Locator #	Description	Instructions	Alerts
57	Other Provider ID	<b>Required.</b> Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	<b>The 7-digit Medicaid provider number must be entered here.</b>
58-A,B,C	Insured's Name	<p><b>Required.</b> Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p><b>Situational:</b> If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	
59-A,B,C	Pt's. Relationship Insured	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C.</p> <p>Acceptable codes are as follows:  01 = Patient is insured  02 = Spouse  03 = Natural child/Insured has financial responsibility  04 = Natural child/ Insured does not have financial responsibility  05 = Step child  06 = Foster child  07 = Ward of the court  08 = Employee  09 = Unknown  10 = Handicapped dependent</p>	

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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	<b>Required.</b> Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.  <b>Situational.</b> 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)	<b>Situational.</b> 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)	<b>Situational.</b> If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	

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Locator #	Description	Instructions	Alerts
63-A,B,C	Treatment Auth. Code	<b>Leave blank.</b>	
64-A,B,C	Document Control Number	<p><b>Situational.</b> If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u>  01 = Third Party Liability Recovery  02 = Provider Correction  03 = Fiscal Agent Error  90 = State Office Use Only – Recovery  99 = Other</p> <p><u>Voids</u>  10 = Claim Paid for Wrong Recipient  11 = Claim Paid for Wrong Provider  00 = Other</p>	
65-A,B,C	Employer Name	<b>Situational.</b> If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	

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Locator #	Description	Instructions	Alerts
66	DX Version Qualifier	Leave blank.	
67	Principal Diagnosis Codes	<b>Required.</b> Enter the ICD code for the principal diagnosis.	<b>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</b>  <b>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</b>  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 ( <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> ).
67 A-Q	Other Diagnosis Code	<b>Situational.</b> Enter the ICD code or codes for all other applicable diagnoses for this claim.  <b>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.</b>  <b>Note: ICD-9 Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</b>	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	<b>Optional.</b> Enter the admitting Diagnosis Code.	<b>Refer to field locator 67.</b>
70	Patient Reason for Visit	Leave blank.	
71	PPS Code	Leave blank.	
72 A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a - e	Other Procedure Code / Date		

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Locator #	Description	Instructions	Alerts
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	This field must be completed.
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	<b>Situational.</b> 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.**

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**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										2		3a PAT. CNTRL. # 11111111 3b MED. REG. # 111111111111 3c FED. TAX NO.										4 TYPE OF BILL 212									
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANYSTREET										c LA d 71111 e											
10 BIRTHDATE b MMDDYY M 090115										11 SEX 12 DATE OF BIRTH 13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACOT STATE 30										31 OCCURRENCE CODE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 OCCURRENCE DATE 36 OCCURRENCE SPAN FROM THROUGH 37 OCCURRENCE SPAN FROM THROUGH 38											
42 REV. CD. 1 022 CASE MIX 2 185 HOSPITAL LEAVE 3 183 HOME LEAVE 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23										44 HCPCS / RATE / HIPPS CODE										46 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49											
50 PRVYR. NAME A MEDICAID										51 HEALTH PLAN ID										52 PRIOR PAYMENTS TPL 53 EST. AMOUNT DUE 54 PRIOR PAYMENTS PAYMENT IF APPLICABLE											
58 INSURED'S NAME C DOE, JOHN										59 FEL. 60 INSURED'S UNIQUE ID 1234567890123										61 GROUP NAME TPL CARRIER CODE IF APPLICABLE 62 INSURANCE GROUP NO.											
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME											
66 V5481 29411										67										68											
69 ADMIT DX 70 PATIENT REASON DX										71 FPS CODE										72 ECI											
74 PRINCIPAL PROCEDURE CODE a										75 OTHER PROCEDURE CODE b										76 ATTENDING NPI 1298765432 QUAL FIRST JANE											
77 OPERATING NPI										78 OTHER NPI										79 OTHER NPI											
80 REMARKS										81 CC a b c d										82											



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## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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# **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		2		3a PAY. ONLY # b. MED. REC. # c. FED. TAX NO.		1111111 1111111111111 100115		4 TYPE OF BILL 214		5 STATEMENT COVERS PERIOD FROM 100115		7 THROUGH 102015	
8 PATIENT NAME a. DOE, JOHN				9 PATIENT ADDRESS a. 1235 ANYSTREET b. ANYWHERE c. LA d. 71111 e.									
10 BIRTHDATE MMDDYY M 090115		11 SEX M		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SEC 1 01		16 DHR 17 STAT 18 19 20 21		22 CONDITION CODES 23 24 25 26 27 28 29 ACCT STATE 30		31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE		39 VALUE CODES 40 CODE 41 CODE 42 CODE	
43 REV. CD. 022 185 183		44 DESCRIPTION CASE MIX HOSPITAL LEAVE HOME LEAVE		45 HCPCS / RATE / HIPPS CODE		46 SERV. DATE 01-20 05-08 18-19		47 SERV. UNITS 19		48 TOTAL CHARGES		49 NON-COVERED CHARGES	
<p><b>SAMPLE</b></p> <p><b>EXAMPLE OF ICD 10</b></p>													
PAGE 1 OF 1				CREATION DATE 110515		TOTALS							
50 PAYER NAME MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS TPL : PAYMENT IF APPLICABLE		53 EST. AMOUNT DUE		54 NPI 1234567890		55 OTHER PRV ID 1234567		56 INSURANCE GROUP NO.	
57 INSURED'S NAME DOE, JOHN		58 PRIOR 1234567890123		59 GROUP NAME TPL CARRIER CODE IF APPLICABLE		60 INSURANCE GROUP NO.							
61 TREATMENT AUTHORIZATION CODES				62 DOCUMENT CONTROL NUMBER				63 EMPLOYER NAME					
64 Z471		F0281		65		66		67		68		69	
70 ADMIT DATE		71 PATIENT REASON		72 ICD-9 CODE		73 ICD-10 CODE		74 ATTENDING NPI 1298765432 LAST ADAMS FIRST JANE		75 OPERATING NPI LAST FIRST		76 OTHER NPI LAST FIRST	
77 REMARKS		78 ICD-9 CODE		79 ICD-10 CODE		80 ICD-9 CODE		81 ICD-10 CODE		82 ICD-9 CODE		83 ICD-10 CODE	

UB-04 CMS-1450

APPROVED OMB NO. 0908-0097

NUBC

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

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## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

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

1 HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONT. # 1111111 b. MED. REC. # 111111111111 5 FED. TAX NO.		4 TYPE OF BILL 217	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS b. 1235 ANYSTREET		c. LA d. 71111		e.	
10 BIRTHDATE MMDDYY M 090115		11 SEX M		12 DATE OF ADMISSION 090115		13 TYPE 14	
15 SPO 16 DHR 17 STAT 30		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACOT STATE		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

SAMPLE  
EXAMPLE OF ICD 9

UB-04 CMS-1400

APPROVED: OMB NO. 0908-0097

NUBC

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

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

**PAGE(S) 46**

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

[illegible]

## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

# **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		2		3a PAT. CNTRL. # 11111111 3b MED. REC. # 111111111111 5 FED. TAX NO. 090115		4 TYPE OF BILL 653	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET b ANYWHERE c LA d 71111		6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015		7	
10 BIRTHDATE MMDDYY M 080115		11 SEX M		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SPEC 16 DHR 17 STAT 30		18 CONDITION CODES 22 23 24 25 26 27 28 29 ACOT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
39		40		41		42	
43		44		45		46	
47		48		49		50	
51		52		53		54	
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59		60		61		62	
63		64		65		66	
67		68		69		70	
71		72		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		100		101		102	

**SAMPLE  
EXAMPLE OF ICD 9**

PAGE 1 OF 1 CREATION DATE 100315 TOTALS

50 PRVYR NAME  
MEDICAID

51 HEALTH PLAN ID

52 REL. INQ.

53 PRIOR PAYMENTS

54 TPL. PAYMENT IF APPLICABLE

55 EST. AMOUNT DUE

56 NPI 1234567890

57 OTHER PRV ID 1234567

58 INSURED'S NAME  
DOE, JOHN

59 REL. 60 INSURED'S UNIQUE ID  
1234567890123

61 GROUP NAME  
TPL CARRIER CODE IF APPLICABLE

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66

67 3180

68

69 ADMIT DATE

70 PATIENT REASON FOR ADMISSION

71 PRV CODE

72 ICD

73

74 PRINCIPAL PROCEDURE CODE

75 OTHER PROCEDURE CODE

76 ATTENDING NPI 1298765432

77 OPERATING NPI

78 OTHER NPI

79 OTHER NPI

80 REMARKS

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## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

# **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										2										3a PAT. CNTRL. # 11111111 3b MED. REC. # 1111111111 5 FED. TAX NO. 100115 6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015										4 TYPE OF BILL 654																																																											
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANY STREET										c LA d 71111 e																																																																					
10 BIRTHDATE MMDDYY M 080115										11 SEX M										12 DATE OF ADMISSION 13 HH 14 TYPE 15 SPC 16 DHR 17 STAT 18 19 20 21										CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30																																																											
31 OCCURRENCE CODE										32 OCCURRENCE DATE										33 OCCURRENCE CODE										34 OCCURRENCE DATE										35 CODE										OCCURRENCE SPAN FROM THROUGH										36 CODE										OCCURRENCE SPAN FROM THROUGH										37									
38										39 CODE										VALUE CODES AMOUNT										40 CODE										VALUE CODES AMOUNT										41 CODE										VALUE CODES AMOUNT																													
42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																			
1 193										CASE MIX																				01-20										19																																																	
2 185										HOSPITAL LEAVE																				03-05																																																											
3 183										HOME LEAVE																				12-15																																																											
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## CHAPTER 24: HOSPICE

## APPENDIX E: UB-04 FORM AND INSTRUCTIONS

PAGE(S) 46

**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		2		3a PAT. CHL. # 1111111111 3 MED. REC. # 111111111111 5 FED. TAX NO.		4 TYPE OF BILL 657	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS b ANYWHERE		c LA		d 71111	
10 BIRTH DATE MMDDYY M 080115		11 SEX M		12 DATE ADMISSION 13 HPI 14 TYPE 15 SPC 080115		16 DHR 30	
17 STAT 30		18		19		20	
21		22		23		24	
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53		54		55		56	
57		58		59		60	
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121		122		123		124	
125		126		127		128	
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