CLAIMS FILING

The claims filing appendix includes the following information:

- Instructions for completing the UB 04 claim form; and
- Samples of a UB 04 claim form for ICF/ID routine billing.

Instructions for Completing the UB04 for ICF/ID Facility

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ Identification Number(ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	Required. Enter the appropriate 3-digit code as follows: *FOR NURSING FACILITY PROVIDERS:* First 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 Care (LOC = Case mix) Second Digit - Classification 1 = Skilled Nursing -Inpatient	2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by the National Uniform Billing Committee (NUBC). Use 2nd Digit "1" instead.

Locator #	Description	Instructions	Alerts
4 (cont'd)	Type of Bill (cont'd)	*FOR ICF/ID PROVIDERS:* *First digit - type of facility* 6 = Intermediate Care (LOC =ICF/ID) *Second digit - classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II *FOR NURSING FACILITY and ICF/ID:* *Third Digit – frequency definition* 1 = Admit through discharge claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 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 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 Number	Optional.	
6	Statement Covers Period (the from and through dates of the period covered by this bill)	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, middle initial.	

Locator #	Description	Instructions	Alerts
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 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	
12	Admission Date	Required for Hospital Services. 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.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

Locator #	Description	Instructions	Alerts
17	Patient Status	Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). Valid Codes 01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/discharged due to death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 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.	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	Required. Enter the appropriate value code. *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	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.
42	Revenue Code	Required. Enter the 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 Louisiana Medicaid: FOR NURSING FACILITY PROVIDERS: 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 and Board-Private Subacute Rehabilitation (31 = NF rehabilitation 20 = SNF/Hospice in nursing facility 21 = ICF I/Hospice in nursing facility 22 = ICF II) 193 = Subacute Care Level III (Complex Care) (32 = NF Complex Care) 194 = Subacute Care Level IV (28 = SNF technology dependent care) 199 = Other Subacute Care (30 = SNF infectious disease)	

Locator #	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	FOR ICF-ID PROVIDERS: Revenue Code & Description (Corresponding Level of Care) 193 = Pervasive level of care (Inventory for Client and Agency Planning (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 NURSING FACILITY & ICF/ID: Revenue Code & Description Leave of Absence 183 = Leave of Absence - Subcategory therapeutic (for home leave) 185 = Leave of Absence - Subcategory nursing home (for hospitalization)	
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.	

Locator #	Description	Instructions	Alerts
45	Service Date	Required. Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care (Revenue Code 194) is 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 06 -12, the service date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11). Note: The claim must reflect the total number of days billed at a particular level of care (LOC) corresponding to the revenue code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate revenue code for that LOC and the correct number of days indicated for that LOC for the month of service. Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	
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: 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: (Revenue Code 185), Service date 07-12, service units should be left blank.	
47	Total Charges	Leave Blank.	

Locator #	Description	Instructions	Alerts
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. If the patient is a Medically Needy Spend-Down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. 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 Identification (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 Certification Indicator	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 Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI.	The 10-digit NPI must be entered here.

Locator #	Description	Instructions	Alerts
57	Other Provider Identification (ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58- A,B,C	Insured's Name	Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A. 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 to Insured	Situational. If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	

Locator #	Description	Instructions	Alerts
60- A,B,C	Insured's Unique Identification (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 HMOs in this field. DO NOT enter dashes, hyphens or the word TPL in the field. NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE.
62- A,B,C	Insured's Group Number (Medicaid not Primary)	Situational If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Authorization Code	Leave blank.	

Locator #	Description	Instructions	Alerts
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.	
66	DX Version Qualifier (Diagnosis and Procedure Code 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	

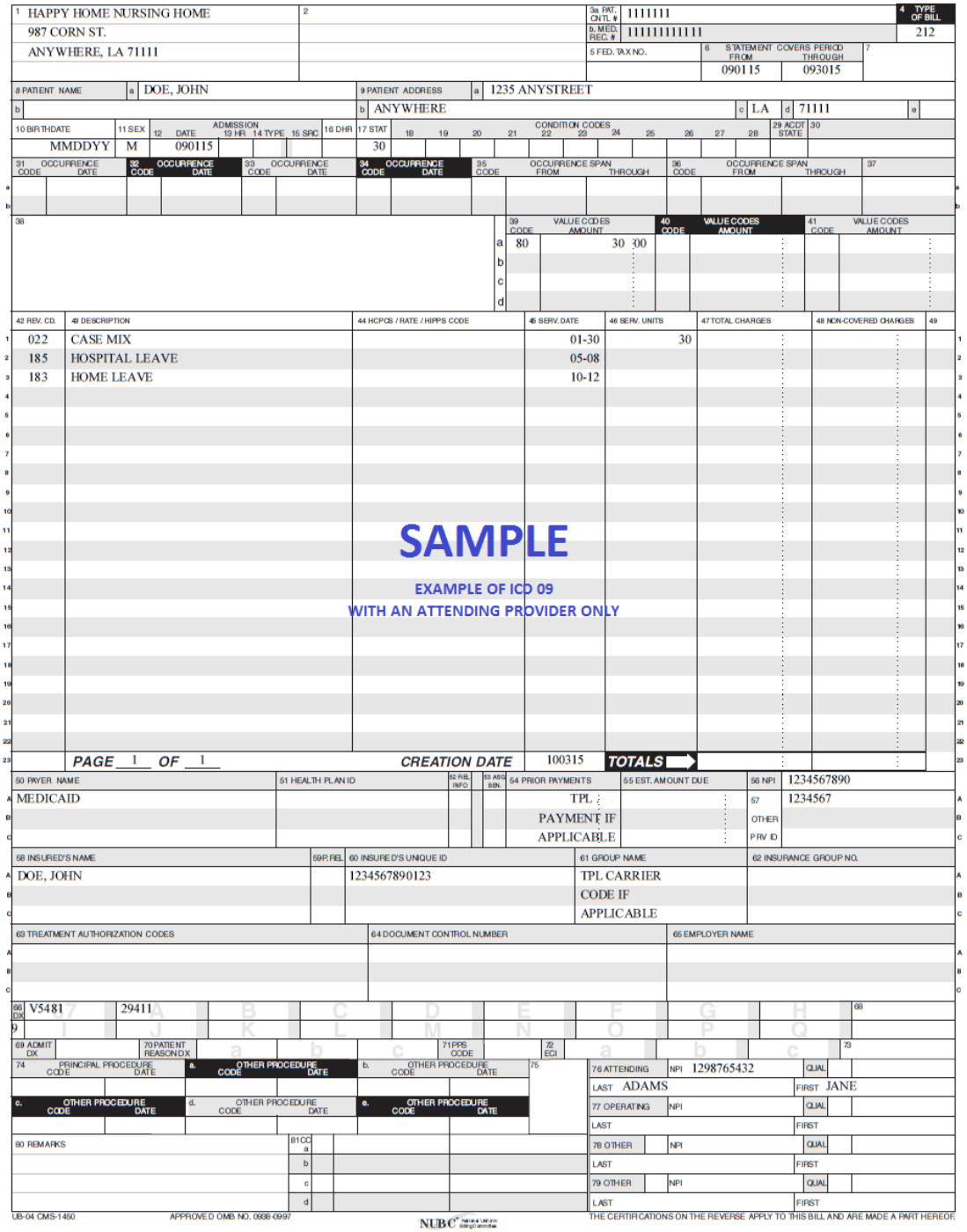
Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. Enter the most current ICD diagnosis code. Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim. NOTE: ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any diagnosis code. ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that 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 on or after 10/1/15. 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	Prospective Payment System (PPS) Code	Leave blank.	
72- A,B,C	ECI (External Cause of Injury)	Leave blank.	

Locator #	Description	Instructions	Alerts
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 NPI number of the physician ordering the plan of care.	This field must be completed. The attending provider name and NPI cannot be the billing provider. The individual attending provider information must be entered in this field. The attending provider must be enrolled with Louisiana Medicaid.
77	Operating	Leave blank.	

Locator #	Description	Instructions	Alerts
78	Other	Situational. If applicable, enter the name and NPI of the referring provider or other physician. Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.	A referring provider is NOT required on the claim. However, if a referring provider is entered on the claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider. The referring provider cannot be the billing provider. The individual referring provider information should be entered in this field. If entered, the referring provider must be enrolled with LA Medicaid.
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

SIGNATURE IS NOT REQUIRED ON THE UB-04.

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



1 HAPPY HOME NURSING HOME
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: DOE, JOHN
9 PATIENT ADDRESS: 1235 ANYSTREET; ANYWHERE; LA; 71111
10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 090115
17 STAT: 30

39 VALUE CODES: 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
022	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		05-08			
183	HOME LEAVE		10-12			
	PAGE 1 OF 1		CREATION DATE 100315		TOTALS	

SAMPLE
EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

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

66 DX 9: V5481
44: 29411

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

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

2

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 214
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015
7

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

10 BIRTHDATE MMDDYY | 11 SEX M | ADMISSION 12 DATE 090115 | 13 HR | 14 TYPE | 15 SRC 1 | 16 DHR | 17 STAT 01 | 18–28 CONDITION CODES | 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
WITH AN ATTENDING PROVIDER ONLY

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 | 65 EMPLOYER NAME

66 DX Z471 F0281 | 67 A B C D E F G H I J K L M N O P Q | 68

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

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

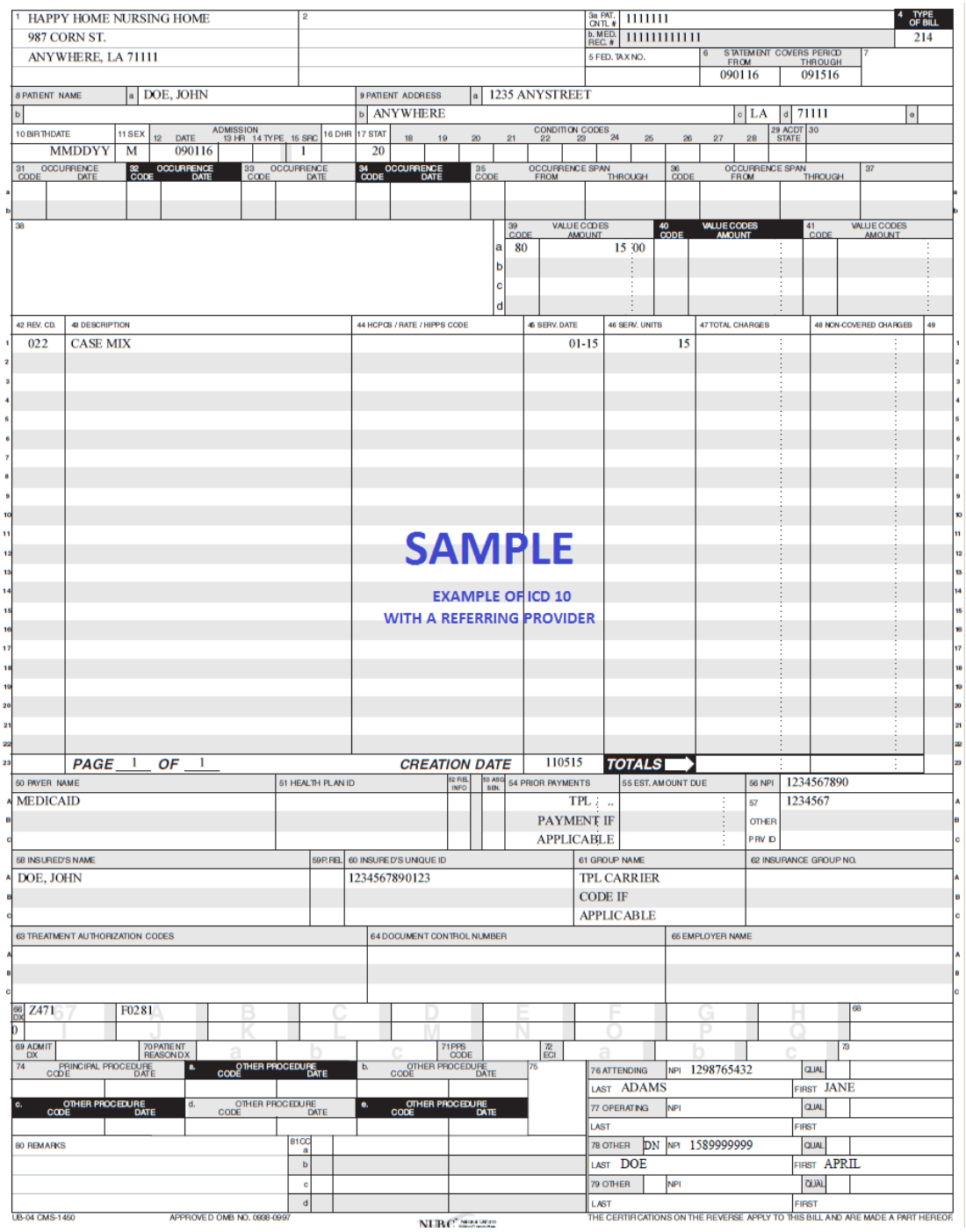
76 ATTENDING NPI 1298765432 QUAL LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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 NURSING FACILITY CLAIM FORM WITH A REFERRING PROVIDER

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



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

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

2

3a PAT. CNTL. # 1111111
b. MED. REC. # 111111111111

4 TYPE OF BILL 217

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

7

8 PATIENT NAME a DOE, JOHN

9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY

11 SEX M

12 ADMISSION DATE 090115

13 HR 14 TYPE 15 SRC 16 DHR

17 STAT 30

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 80	30 00				
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	CASE MIX		01-30	30			
2	185	HOSPITAL LEAVE		05-07				
3	183	HOME LEAVE		10-12				
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	122815	TOTALS			

SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

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

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

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A	
B		5274198798700	
C		02	

66 DX 9: V5481 29411

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

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

80 REMARKS

81 CC a b c d

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE

77 OPERATING NPI QUAL
LAST FIRST

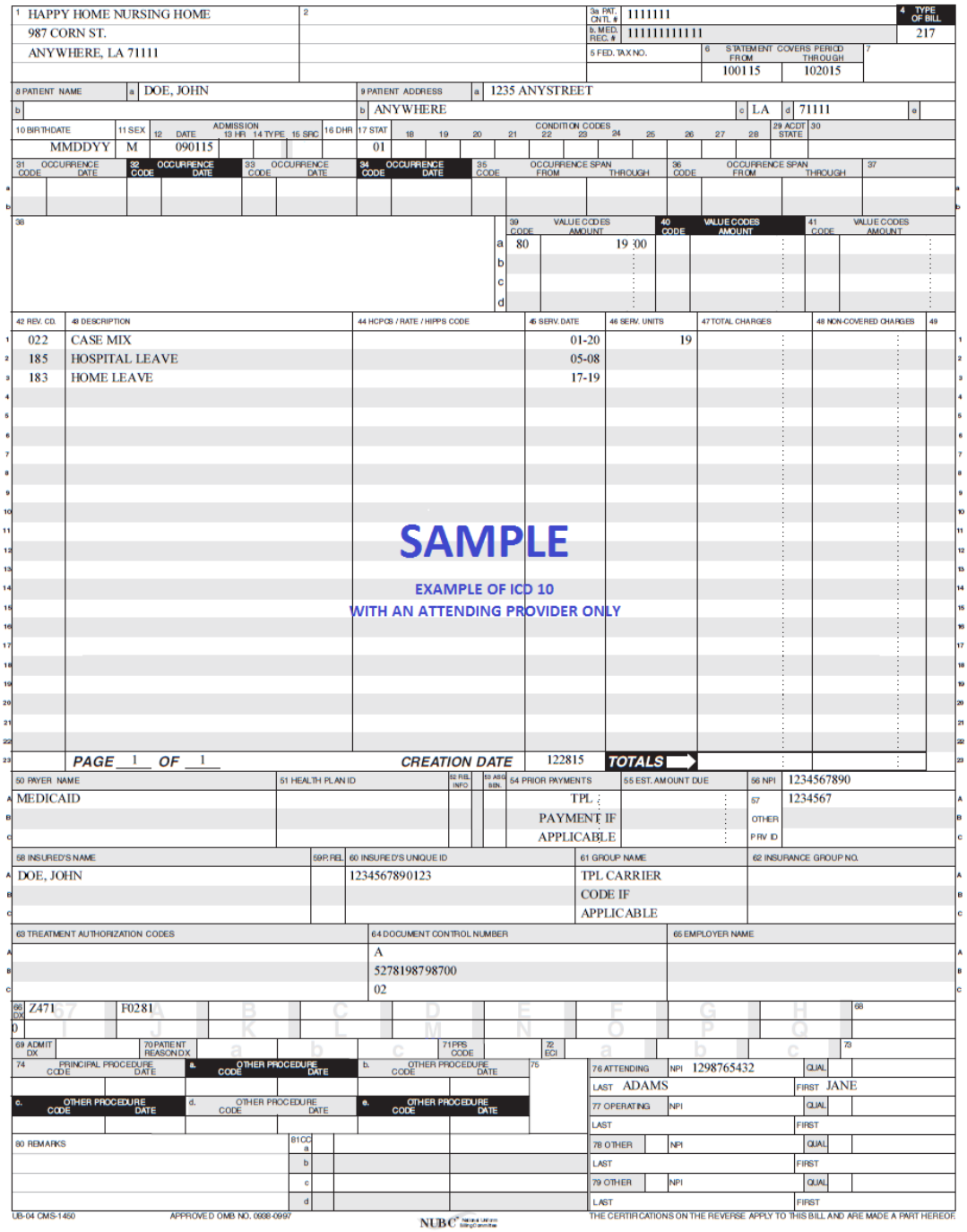
78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

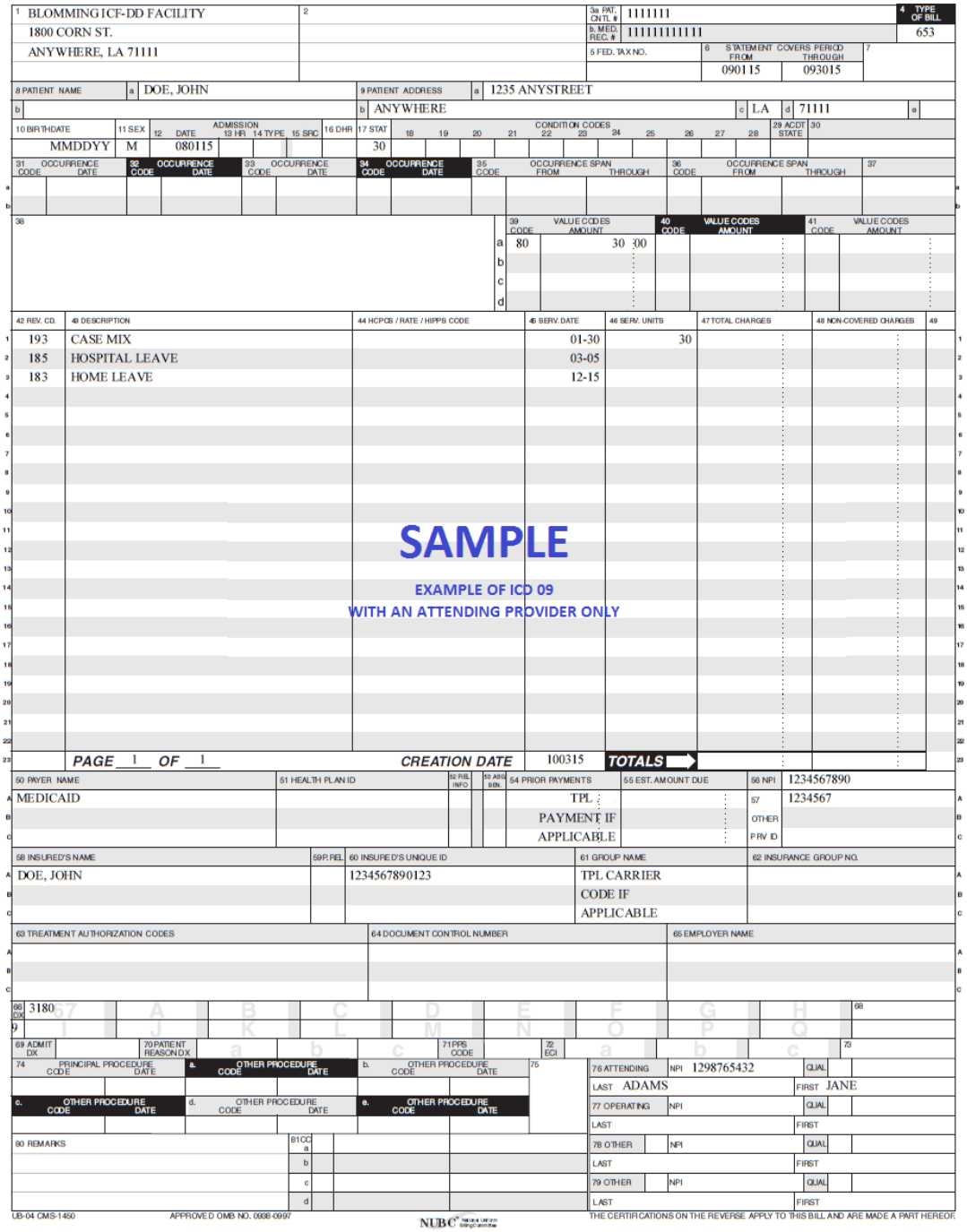
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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



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



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

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
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
29 ACDT STATE

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1	193	CASE MIX		01-30	30		
2	185	HOSPITAL LEAVE		03-05			
3	183	HOME LEAVE		12-15			

SAMPLE
EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 100315 TOTALS

39 VALUE CODES a 80 30.00
40 VALUE CODES
41 VALUE CODES

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 123456789012 3
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9 3180
67 A T J B K C L D M E N F O G P H Q
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

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

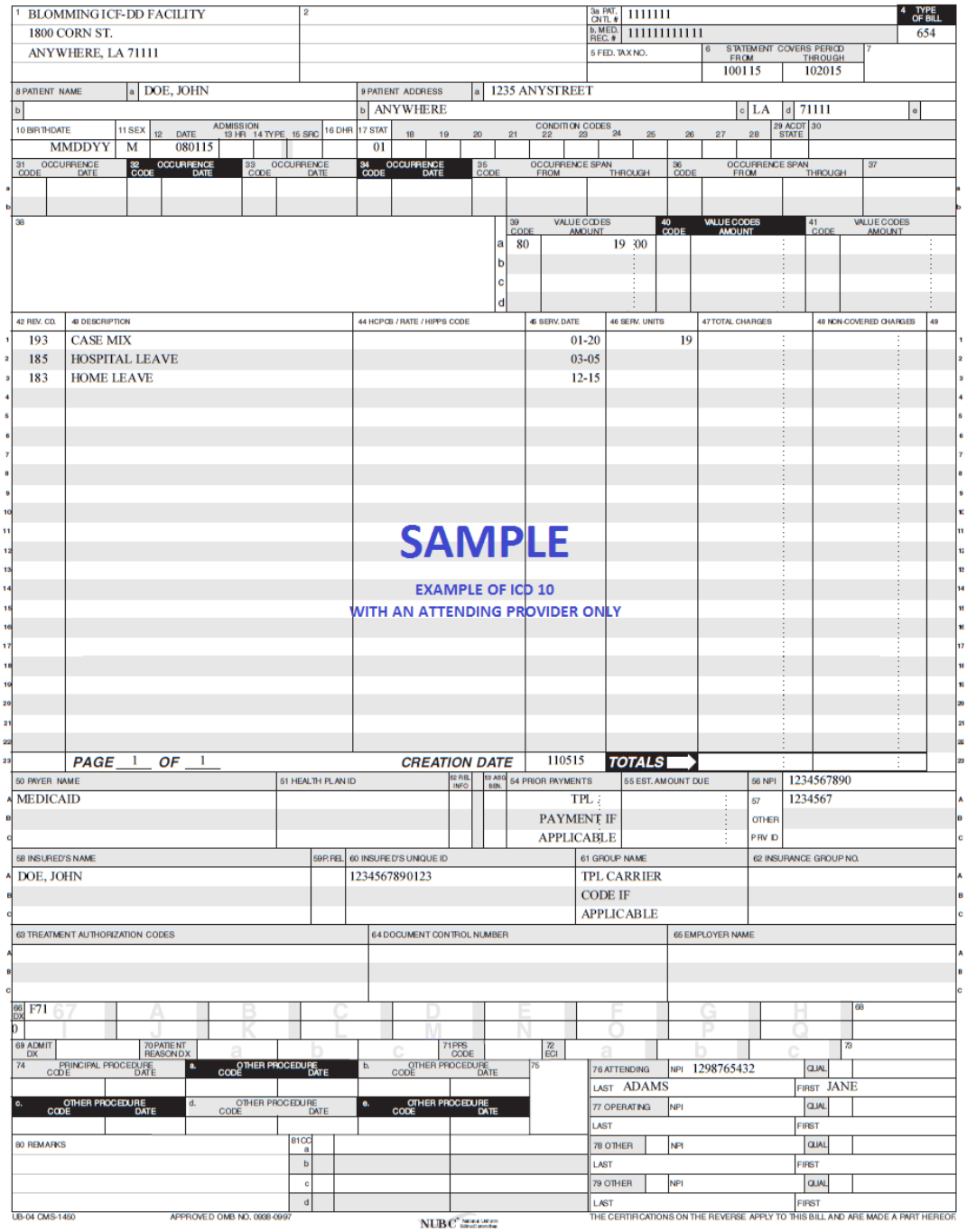
76 ATTENDING NPI 1298765432 QUAL LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

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

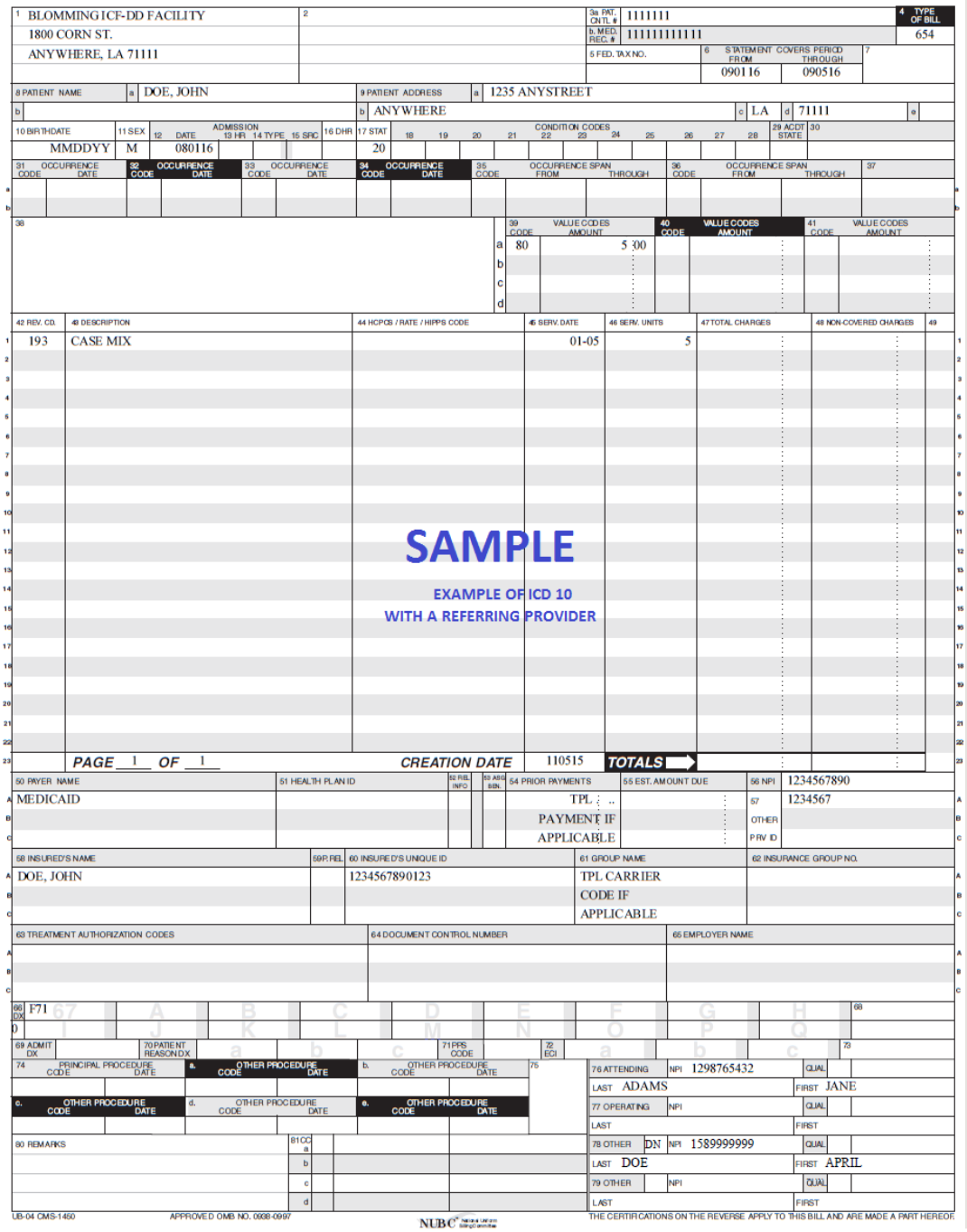
SAMPLE ICF/ID FACILITY CLAIM FORM WITH AN ATTENDING PROVIDER ONLY

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

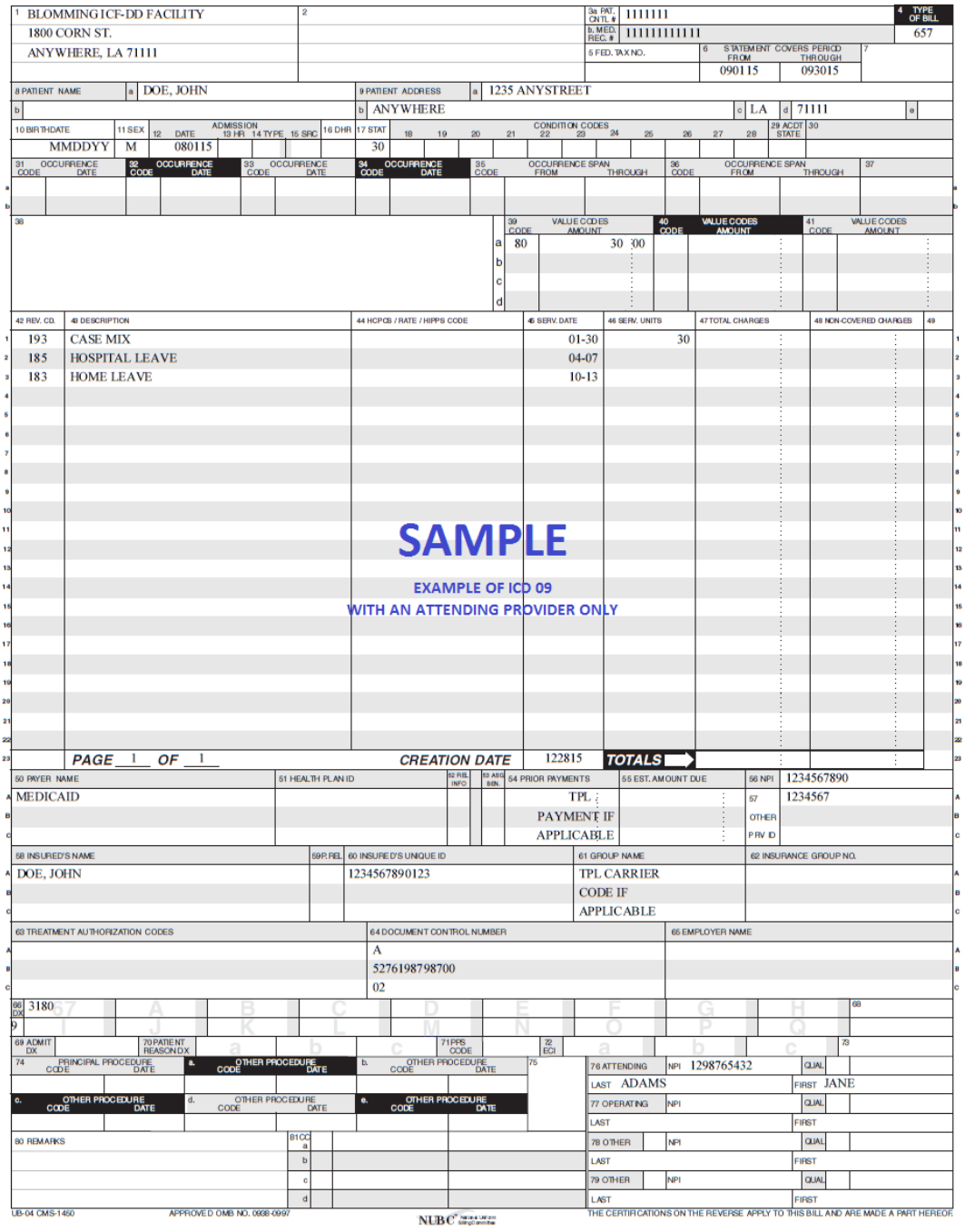


SAMPLE ICF/ID FACILITY CLAIM FORM WITH A REFERRING PROVIDER

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

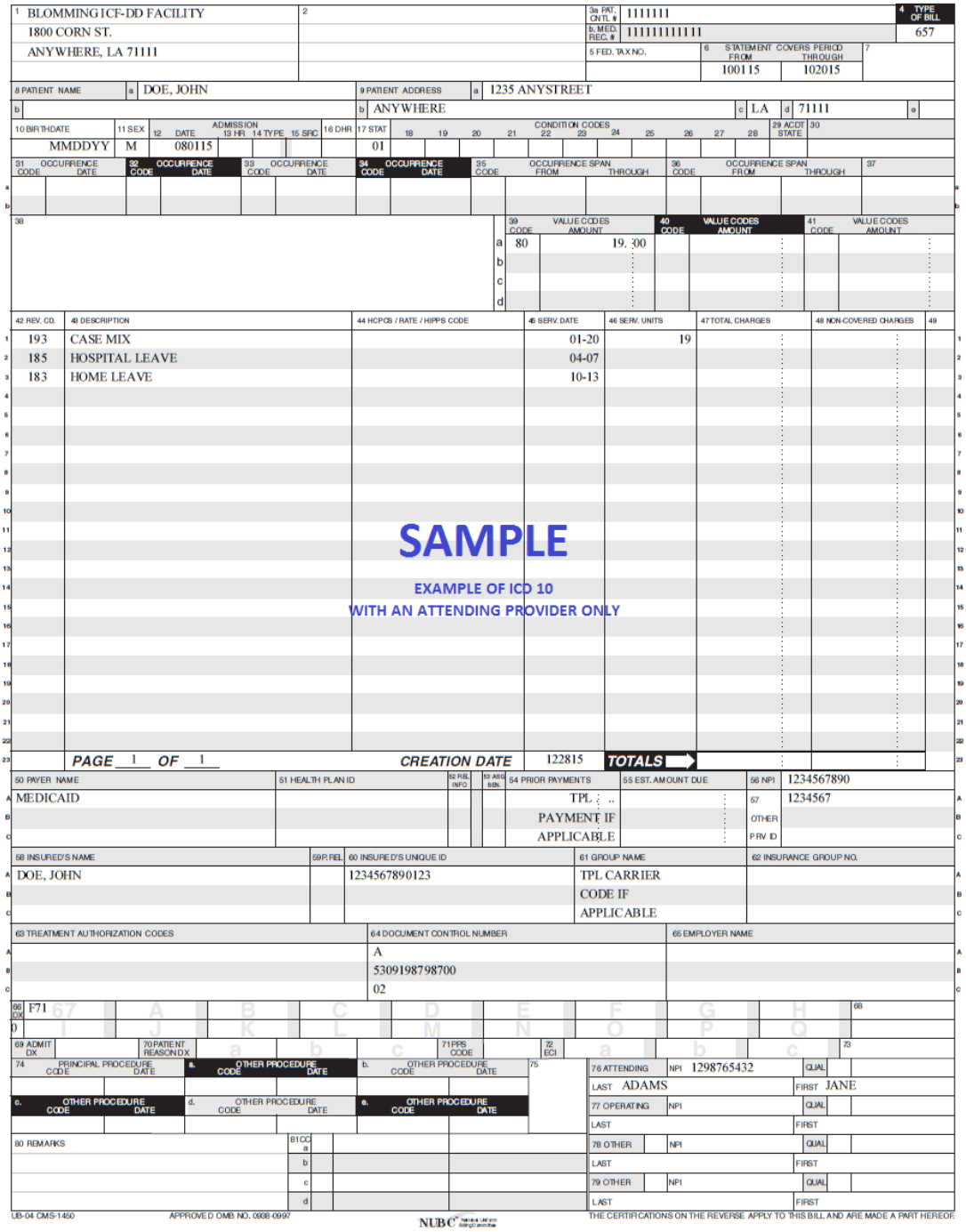


SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)



SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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



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

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 657
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 080115 | 16 DHR | 17 STAT 01 | 29 ACDT STATE

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		04-07			
183	HOME LEAVE		10-13			

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 122815 TOTALS

39 VALUE CODES a 80 19.00

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 123456789012
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

64 DOCUMENT CONTROL NUMBER A 5309198798700 02

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.

Instructions for Completing the UB04 for ICF/ID Facility

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ Identification Number(ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	Required. Enter the appropriate 3-digit code as follows: *FOR NURSING FACILITY PROVIDERS:* First 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 Care (LOC = Case mix) Second Digit - Classification 1 = Skilled Nursing -Inpatient	2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by the National Uniform Billing Committee (NUBC). Use 2nd Digit "1" instead.

Locator #	Description	Instructions	Alerts
4 (cont'd)	Type of Bill (cont'd)	*FOR ICF/ID PROVIDERS:* *First digit - type of facility* 6 = Intermediate Care (LOC =ICF/ID) *Second digit - classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II *FOR NURSING FACILITY and ICF/ID:* *Third Digit – frequency definition* 1 = Admit through discharge claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 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 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 Number	Optional.	
6	Statement Covers Period (the from and through dates of the period covered by this bill)	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, middle initial.	

Locator #	Description	Instructions	Alerts
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 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	
12	Admission Date	Required for Hospital Services. 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.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

Locator #	Description	Instructions	Alerts
17	Patient Status	Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). Valid Codes 01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/discharged due to death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 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.	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	Required. Enter the appropriate value code. *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	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.
42	Revenue Code	Required. Enter the 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 Louisiana Medicaid: FOR NURSING FACILITY PROVIDERS: 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 and Board-Private Subacute Rehabilitation (31 = NF rehabilitation 20 = SNF/Hospice in nursing facility 21 = ICF I/Hospice in nursing facility 22 = ICF II) 193 = Subacute Care Level III (Complex Care) (32 = NF Complex Care) 194 = Subacute Care Level IV (28 = SNF technology dependent care) 199 = Other Subacute Care (30 = SNF infectious disease)	

Locator #	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	FOR ICF-ID PROVIDERS: Revenue Code & Description (Corresponding Level of Care) 193 = Pervasive level of care (Inventory for Client and Agency Planning (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 NURSING FACILITY & ICF/ID: Revenue Code & Description Leave of Absence 183 = Leave of Absence - Subcategory therapeutic (for home leave) 185 = Leave of Absence - Subcategory nursing home (for hospitalization)	
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.	

Locator #	Description	Instructions	Alerts
45	Service Date	Required. Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care (Revenue Code 194) is 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 06 -12, the service date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11). Note: The claim must reflect the total number of days billed at a particular level of care (LOC) corresponding to the revenue code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate revenue code for that LOC and the correct number of days indicated for that LOC for the month of service. Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	
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: 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: (Revenue Code 185), Service date 07-12, service units should be left blank.	
47	Total Charges	Leave Blank.	

Locator #	Description	Instructions	Alerts
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. If the patient is a Medically Needy Spend-Down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. 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 Identification (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 Certification Indicator	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 Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI.	The 10-digit NPI must be entered here.

Locator #	Description	Instructions	Alerts
57	Other Provider Identification (ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58- A,B,C	Insured's Name	Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A. 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 to Insured	Situational. If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	

Locator #	Description	Instructions	Alerts
60- A,B,C	Insured's Unique Identification (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 HMOs in this field. DO NOT enter dashes, hyphens or the word TPL in the field. NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE.
62- A,B,C	Insured's Group Number (Medicaid not Primary)	Situational If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Authorization Code	Leave blank.	

Locator #	Description	Instructions	Alerts
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.	
66	DX Version Qualifier (Diagnosis and Procedure Code 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	

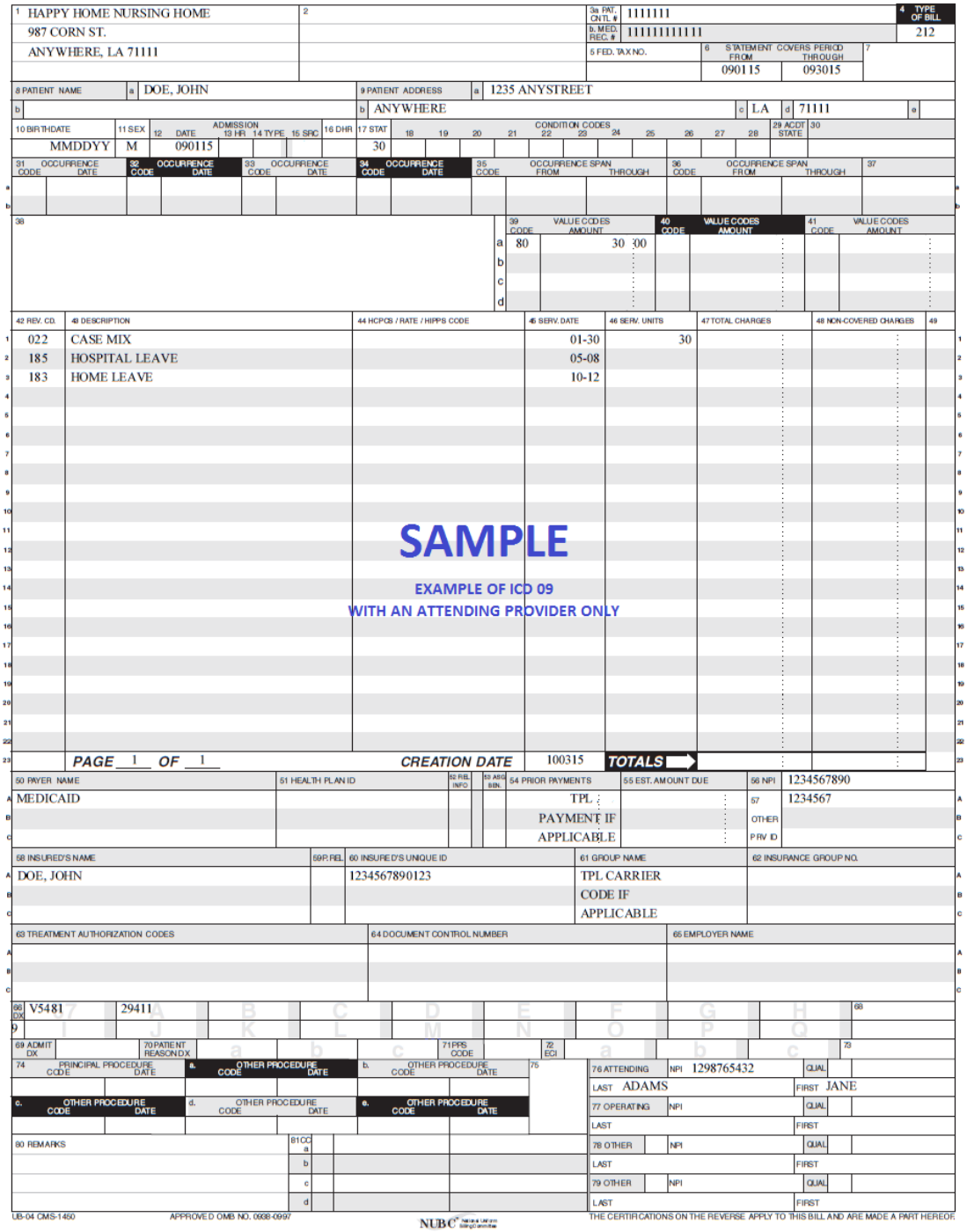
Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. Enter the most current ICD diagnosis code. Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim. NOTE: ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any diagnosis code. ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that 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 on or after 10/1/15. 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	Prospective Payment System (PPS) Code	Leave blank.	
72- A,B,C	ECI (External Cause of Injury)	Leave blank.	

Locator #	Description	Instructions	Alerts
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 NPI number of the physician ordering the plan of care.	This field must be completed. The attending provider name and NPI cannot be the billing provider. The individual attending provider information must be entered in this field. The attending provider must be enrolled with Louisiana Medicaid.
77	Operating	Leave blank.	

Locator #	Description	Instructions	Alerts
78	Other	Situational. If applicable, enter the name and NPI of the referring provider or other physician. Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.	A referring provider is NOT required on the claim. However, if a referring provider is entered on the claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider. The referring provider cannot be the billing provider. The individual referring provider information should be entered in this field. If entered, the referring provider must be enrolled with LA Medicaid.
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

SIGNATURE IS NOT REQUIRED ON THE UB-04.

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



1 HAPPY HOME NURSING HOME
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: DOE, JOHN
9 PATIENT ADDRESS: 1235 ANYSTREET; ANYWHERE; LA; 71111
10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 090115
17 STAT: 30

39 VALUE CODES: 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
022	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		05-08			
183	HOME LEAVE		10-12			
	PAGE 1 OF 1		CREATION DATE 100315		TOTALS	

SAMPLE
EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

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

66 DX 9: V5481
44: 29411

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 NURSING FACILITY CLAIM FORM WITH AN ATTENDING PROVIDER ONLY

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

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

Field	Value
3a PAT. CNTL #	1111111
b. MED. REC. #	11111111111
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
14 TYPE	1
17 STAT	01

39 VALUE CODES CODE	AMOUNT
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		18-19			

PAGE 1 OF 1 CREATION DATE 110515 TOTALS

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

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

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

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: Z471 | F0281

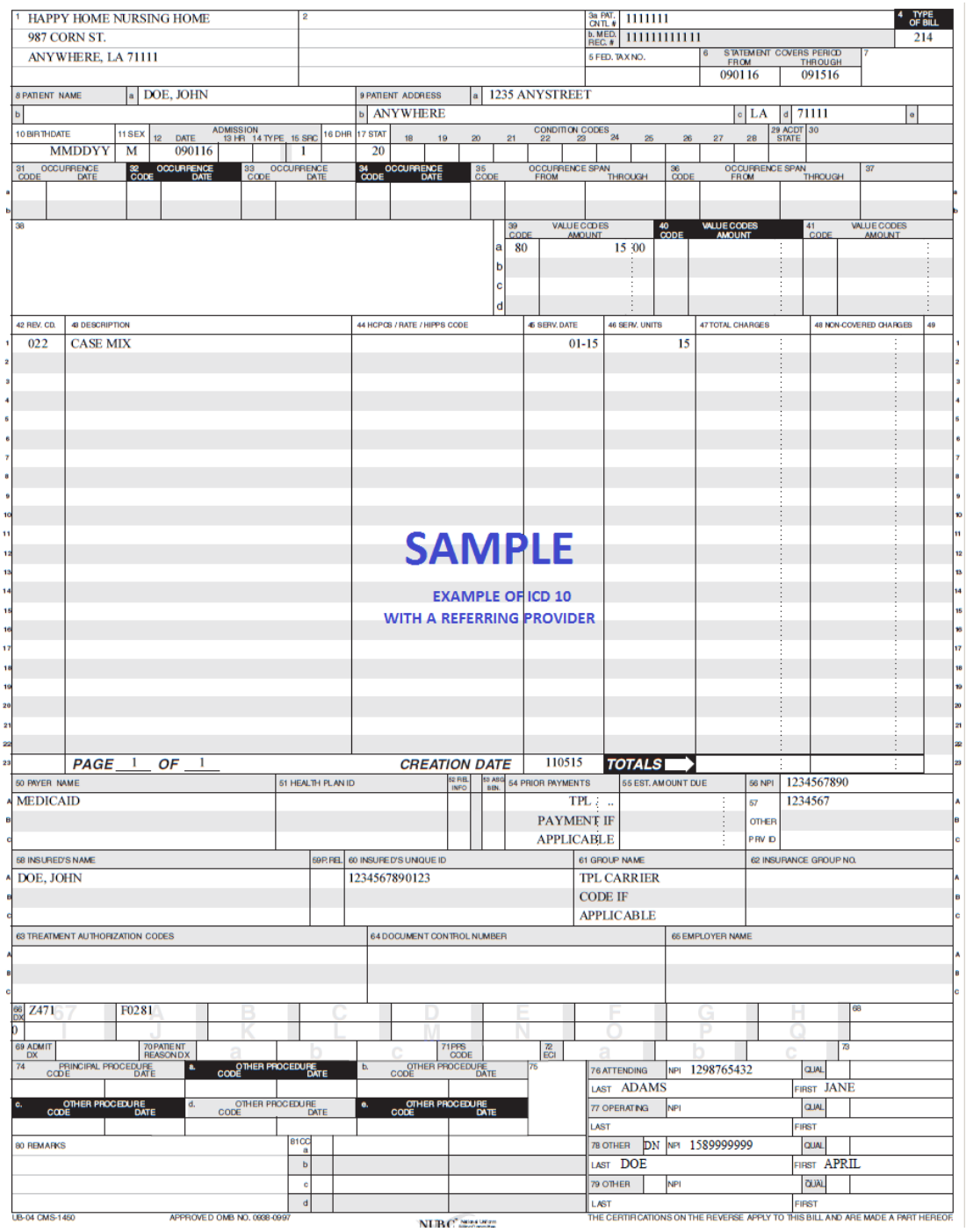
76 ATTENDING	NPI 1298765432
LAST ADAMS	FIRST JANE

77 OPERATING | 78 OTHER | 79 OTHER | 80 REMARKS | 81 CC

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 A REFERRING PROVIDER

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



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

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

2

3a PAT. CNTL. # 1111111
b. MED. REC. # 111111111111

4 TYPE OF BILL 217

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

7

8 PATIENT NAME a DOE, JOHN

9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE MMDDYY

11 SEX M

12 ADMISSION DATE 090115

13 HR 14 TYPE 15 SRC 16 DHR

17 STAT 30

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 80	30 00				
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	022	CASE MIX		01-30	30			
2	185	HOSPITAL LEAVE		05-07				
3	183	HOME LEAVE		10-12				
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	122815	TOTALS			

SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

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

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

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A	
B		5274198798700	
C		02	

66 DX 9: V5481 29411

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

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

80 REMARKS

81 CC a b c d

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE

77 OPERATING NPI QUAL
LAST FIRST

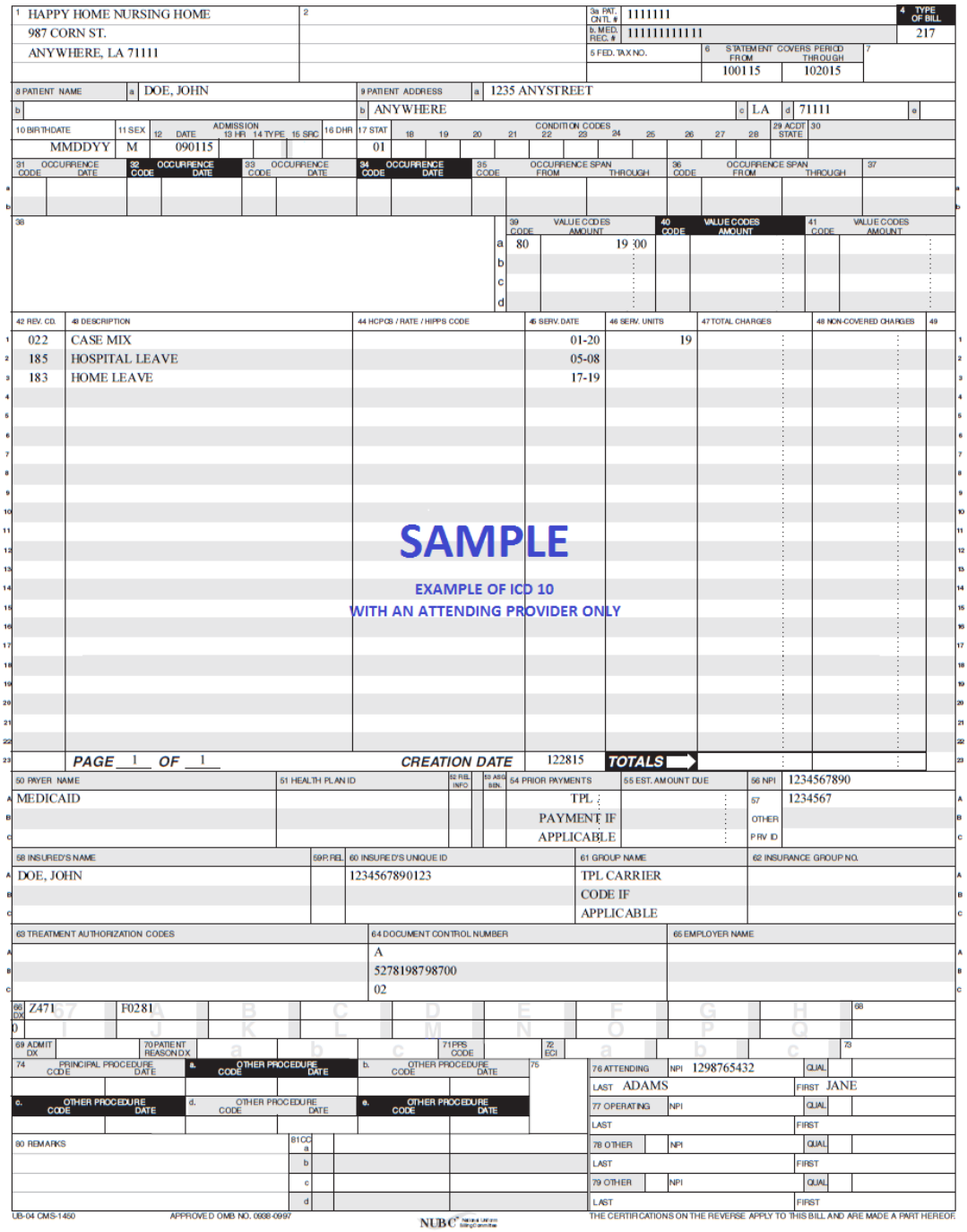
78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

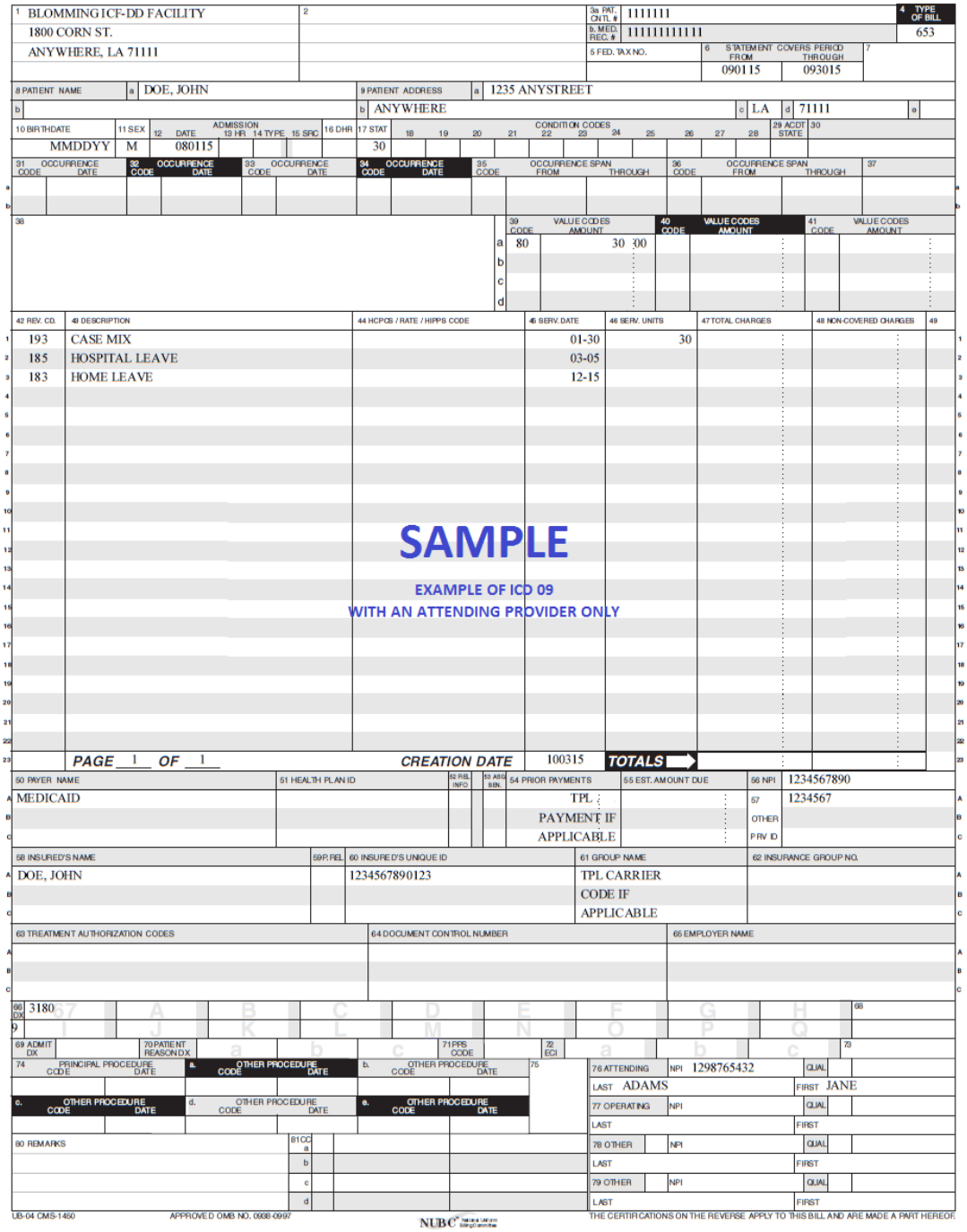
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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



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



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

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
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
29 ACDT STATE

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1	193	CASE MIX		01-30	30		
2	185	HOSPITAL LEAVE		03-05			
3	183	HOME LEAVE		12-15			

SAMPLE
EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 100315 TOTALS

39 VALUE CODES a 80 30.00
40 VALUE CODES
41 VALUE CODES

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 123456789012 3
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9 3180
67 A T J B K C L D M E N F O G P H Q
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

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

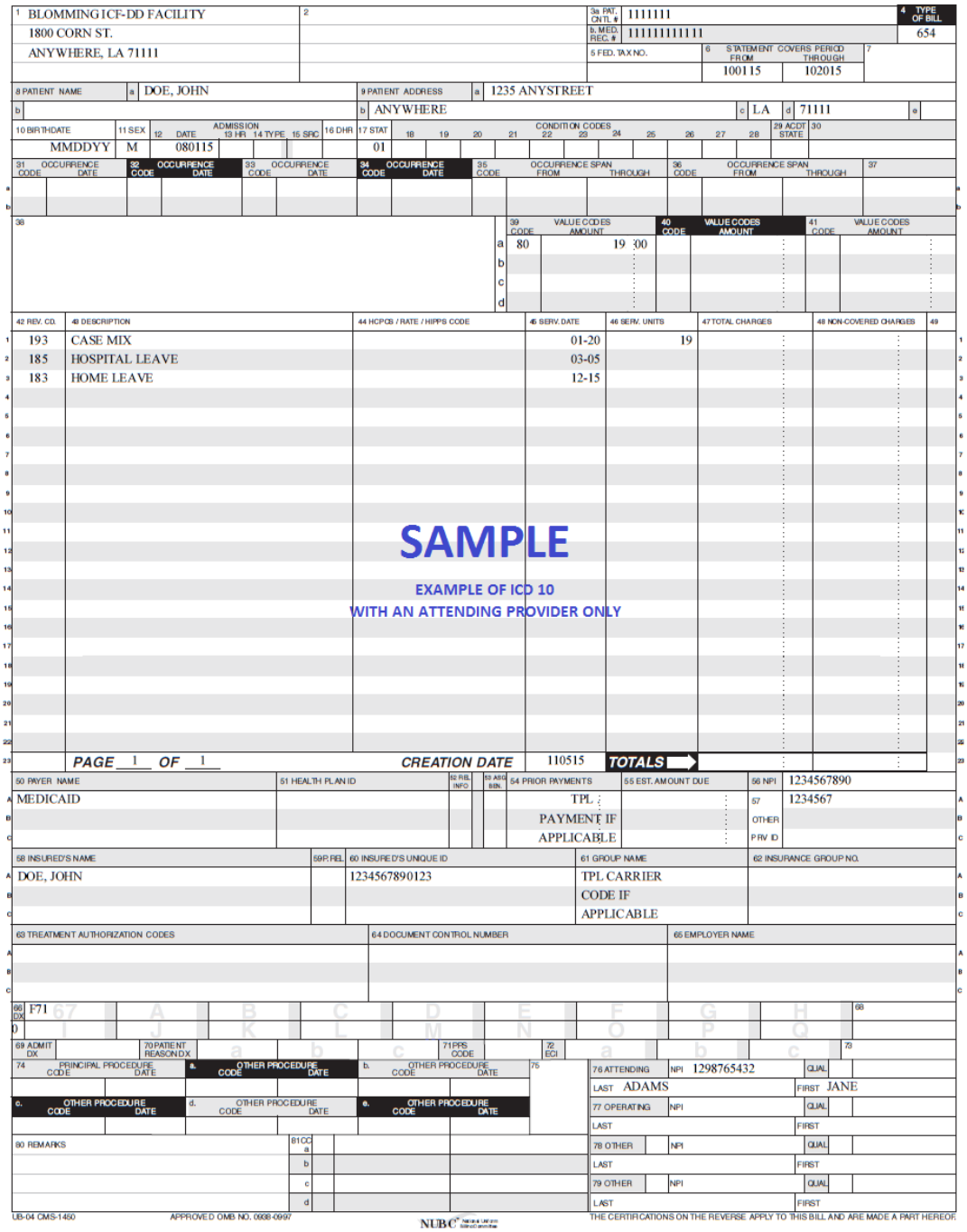
76 ATTENDING NPI 1298765432 QUAL LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

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

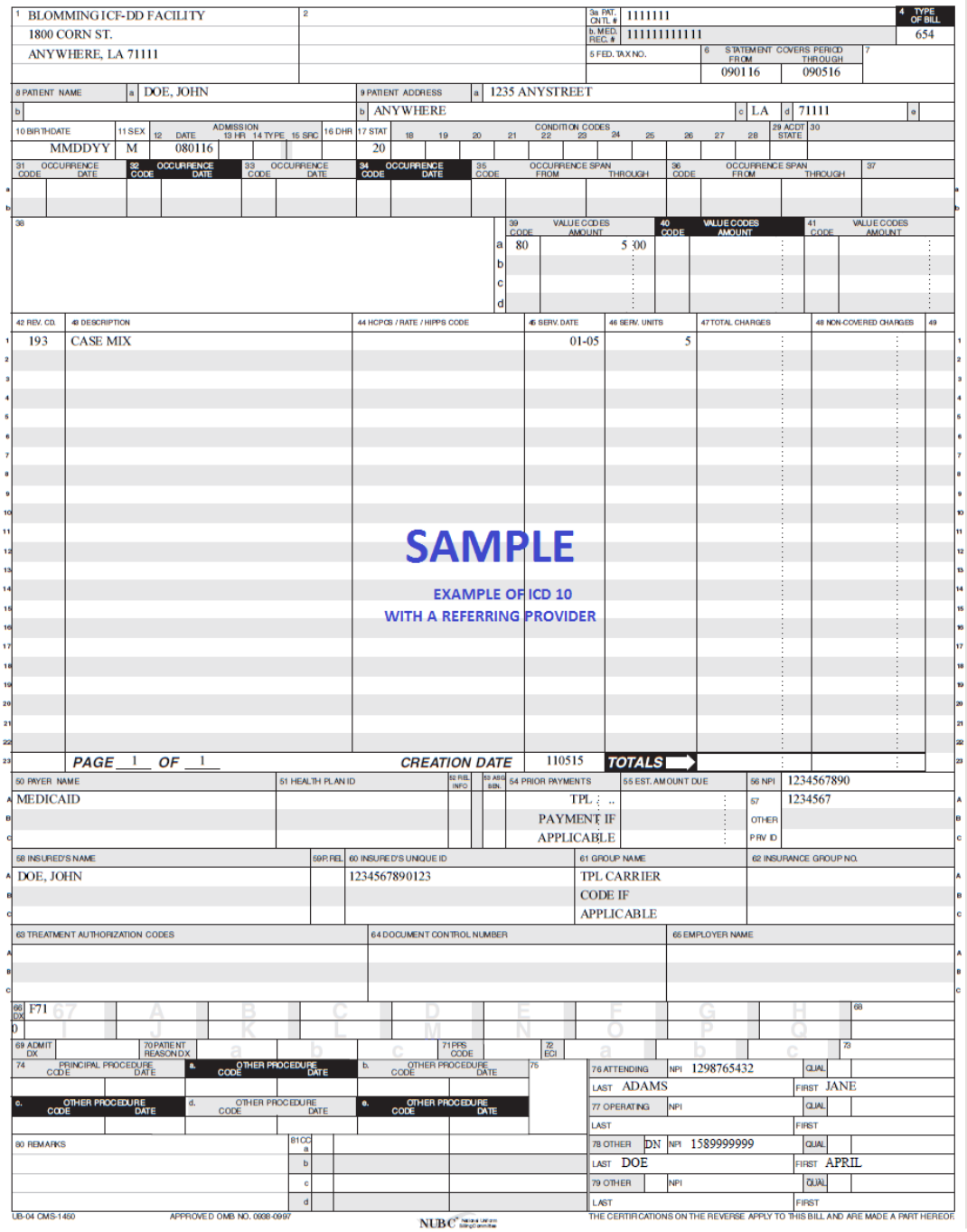
SAMPLE ICF/ID FACILITY CLAIM FORM WITH AN ATTENDING PROVIDER ONLY

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

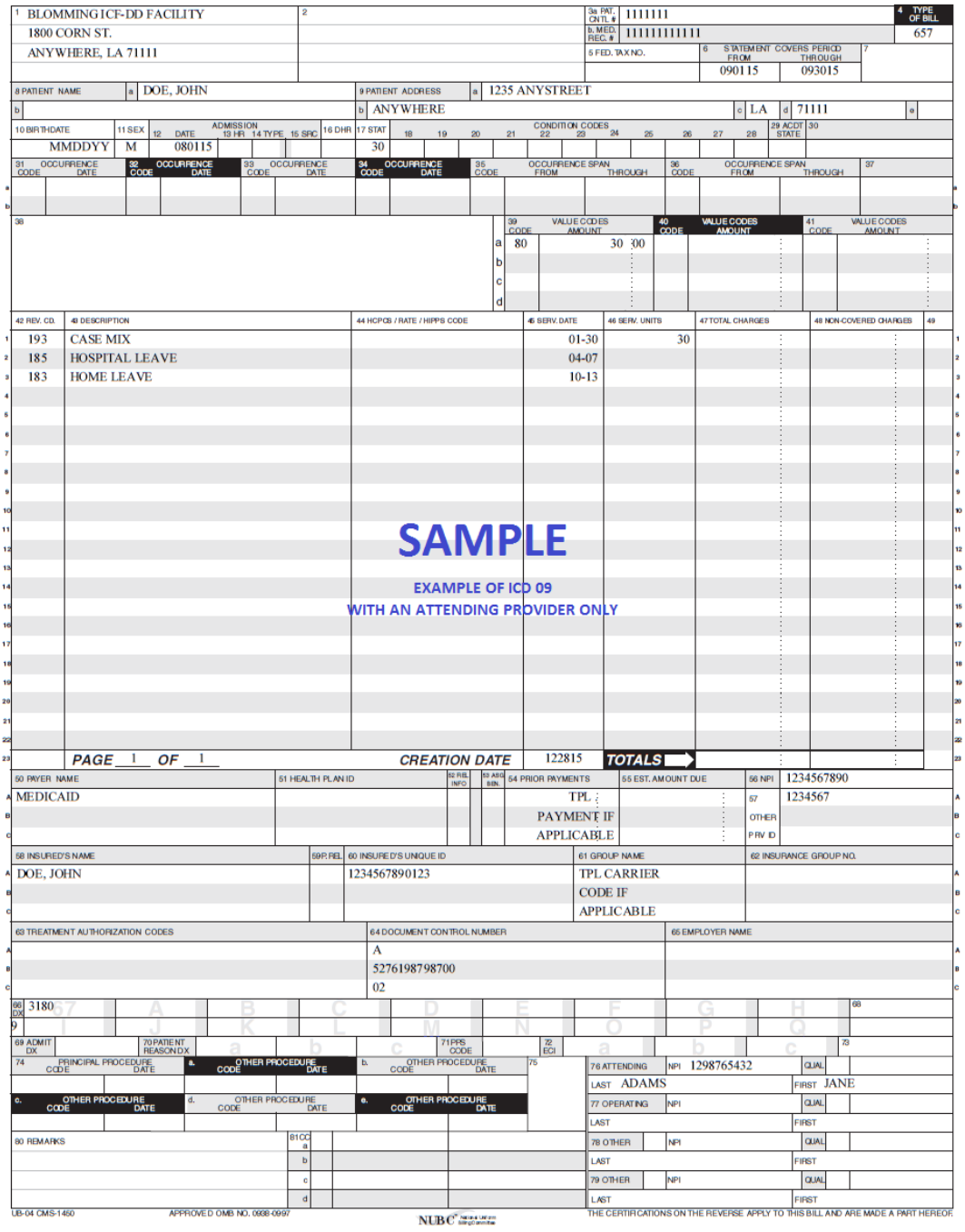


SAMPLE ICF/ID FACILITY CLAIM FORM WITH A REFERRING PROVIDER

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

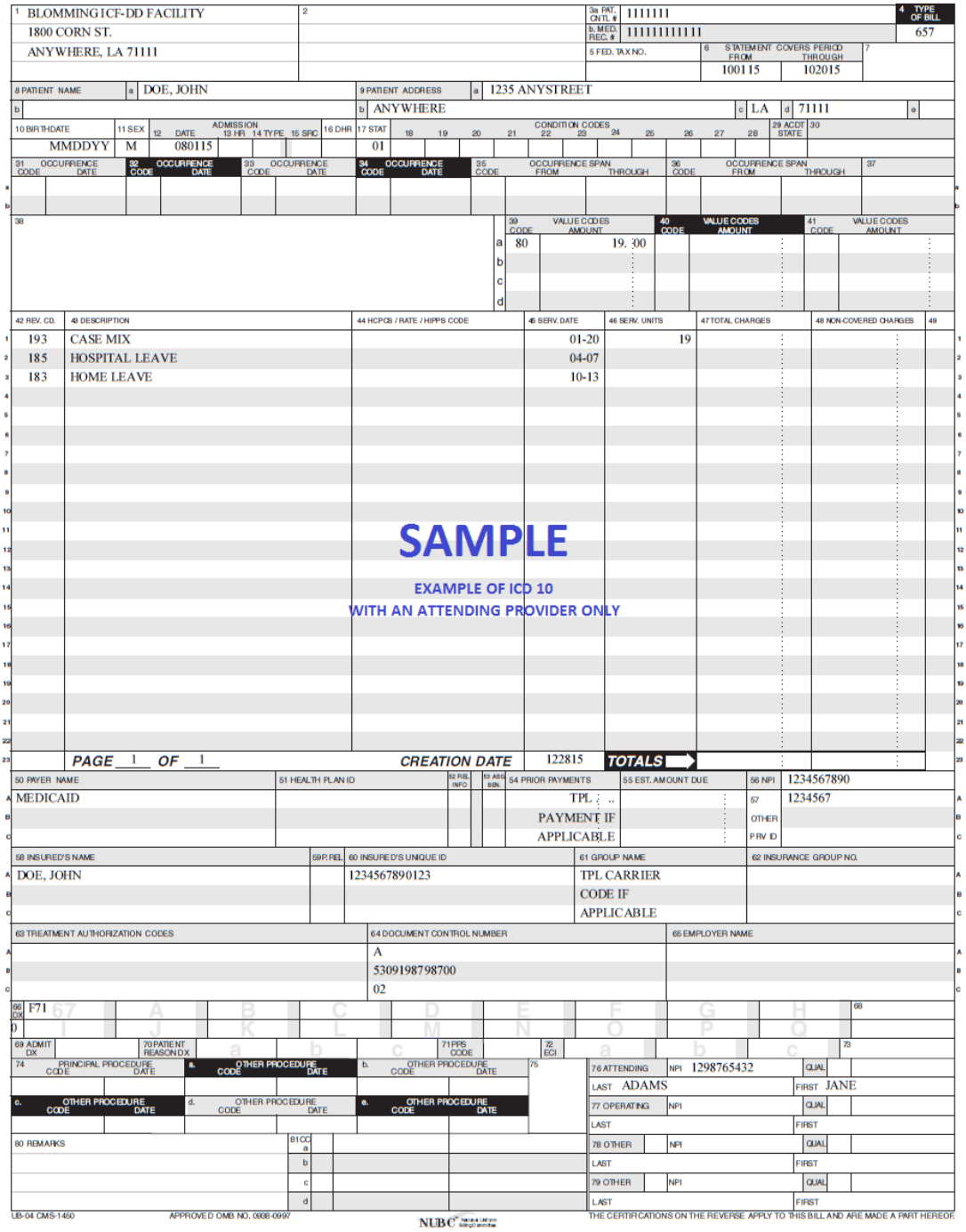


SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)



SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY

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



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

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 657
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 080115 | 16 DHR | 17 STAT 01 | 29 ACDT STATE

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		04-07			
183	HOME LEAVE		10-13			

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

PAGE 1 OF 1 CREATION DATE 122815 TOTALS

39 VALUE CODES a 80 19.00

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 123456789012
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

64 DOCUMENT CONTROL NUMBER A 5309198798700 02

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.