Uniform Bill Form (UB-04), page 1

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**Sample—Do not use.**
Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician’s certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient’s need for services are on file.

5. Signature of patient or his representative on certifications, authorizations to release information, and payment statements as required by Federal Law and Regulations (42 USC 1395, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 190) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bills is in conformance with the Civil Rights Act of 1964 as amended. Records accurately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient’s signature on the provider’s request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, omissions, or concealment of a material fact are subject to prosecution under applicable Federal or State Law.

9. For TRICARE Purposes:
   (e) The information on the face of this claim is true, accurate and complete to the best of the submitter’s knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient’s parent or guardian has responded directly to the provider’s request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary’s cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, except in the case of an individual who is in the military service of the United States, including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, members of the Uniformed Services do not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(l) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS
## Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the form locator (FL) information.

<table>
<thead>
<tr>
<th>FL</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL 1</td>
<td>Provider name, physical address and telephone number <strong>required</strong></td>
</tr>
<tr>
<td>FL 2</td>
<td>Pay-to name and address <strong>required</strong></td>
</tr>
<tr>
<td>FL 3a</td>
<td>Patient control number</td>
</tr>
<tr>
<td>FL 3b</td>
<td>Medical/health record number</td>
</tr>
<tr>
<td>FL 4</td>
<td>Type of bill (<em>three-character alphanumeric identifier</em>)</td>
</tr>
<tr>
<td>FL 5</td>
<td>Federal Tax Identification (ID) number</td>
</tr>
<tr>
<td>FL 6</td>
<td>Statement covers period (<em>from–through</em>). The beginning and ending dates of the period included on the bill are shown in numeric fields (<em>MM-DD-YY</em>).</td>
</tr>
<tr>
<td>FL 7</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 8a-b</td>
<td>Patient’s name (<em>surname first, first name, and middle initial, if any</em>). Enter the patient’s Social Security number (SSN) in field “a.” Enter the patient’s name in field “b.”</td>
</tr>
<tr>
<td>FL 9a-e</td>
<td>Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.</td>
</tr>
<tr>
<td>FL 10</td>
<td>Patient’s birth date (<em>MM-DD-YYYY</em>). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.</td>
</tr>
<tr>
<td>FL 11</td>
<td>Patient’s sex. This item is used in conjunction with FLs 66–69 (<em>diagnoses</em>) and FL 74 a–e (<em>surgical procedures</em>) to identify inconsistencies.</td>
</tr>
<tr>
<td>FL 12</td>
<td>Admission date</td>
</tr>
<tr>
<td>FL 13</td>
<td>Admission hour</td>
</tr>
<tr>
<td>FL 14</td>
<td>Type of admission. This code indicates priority of the admission.</td>
</tr>
<tr>
<td>FL 15</td>
<td>Source of Admission. This code indicates the source of admission or outpatient registration.</td>
</tr>
<tr>
<td>FL 16</td>
<td>Discharge hour</td>
</tr>
<tr>
<td>FL 17</td>
<td>Patient status. This code indicates the patient’s status as of the “Through” date of the billing period (FL 6).</td>
</tr>
<tr>
<td>FLs 18–28</td>
<td>Condition codes</td>
</tr>
<tr>
<td>FL 29</td>
<td>Accident state</td>
</tr>
<tr>
<td>FL 30</td>
<td>Not required</td>
</tr>
<tr>
<td>FLs 31–34</td>
<td>Occurrence codes and dates</td>
</tr>
<tr>
<td>FLs 35–36</td>
<td>Occurrence span code and dates</td>
</tr>
<tr>
<td>FL 37</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 38</td>
<td>Responsible party name and address</td>
</tr>
<tr>
<td>FLs 39–41</td>
<td>Value codes and amounts</td>
</tr>
<tr>
<td>FL 42</td>
<td>Revenue code</td>
</tr>
<tr>
<td>FL 43</td>
<td>Revenue description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.</td>
</tr>
<tr>
<td>FL 44</td>
<td>HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.</td>
</tr>
<tr>
<td>FL 45</td>
<td>Service date. If submitting claims for outpatient services, report a separate date for each day of service.</td>
</tr>
<tr>
<td>FL 46</td>
<td>Service units. The entries in this column quantify services by revenue category (<em>e.g., number of days, a particular type of accommodation, pints of blood</em>). Up to seven digits may be entered.</td>
</tr>
<tr>
<td>FL 47</td>
<td>Total charges</td>
</tr>
<tr>
<td>FL 48</td>
<td>Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.</td>
</tr>
<tr>
<td>FL 49</td>
<td>Not required</td>
</tr>
<tr>
<td>FLs 50A–C</td>
<td>Payer identification. Enter the primary payer on line A.</td>
</tr>
<tr>
<td>FLs 51A–C</td>
<td>Health plan ID number</td>
</tr>
<tr>
<td>FLs 52A–C</td>
<td>Release of information. A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.</td>
</tr>
<tr>
<td>FLs 53A–C</td>
<td>Assignment of benefits certification indicator</td>
</tr>
<tr>
<td>FLs 54A–C</td>
<td>Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.</td>
</tr>
<tr>
<td>FLs 55A–C</td>
<td>Not required</td>
</tr>
</tbody>
</table>
**FL 56** National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.

**FLs 57A–C** Other provider identifier number

**FLs 58A–C** Insured’s name

**FLs 59A–C** Patient’s relationship to insured

**FLs 60A–C** Insured unique ID/SSN/health insurance claim/ID number

**FLs 61A–C** Group name. Indicate the name of the insurance group or plan.

**FLs 62A–C** Insurance group number

**FLs 63A–C** Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.

**FLs 64A–C** Document Control Number (DCN). Original DCN number of the claim to be adjusted.

**FLs 65A–C** Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.

**FL 66** Diagnosis and procedure code qualifier (*ICD Version Indicator*)

**FL 67** Principal diagnosis code. HCFA only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.

**FLs 67A–Q** Other diagnosis codes

**FL 68** Not required

**FL 69** Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.

**FLs 70a–c** Patient’s reason for visit

**FL 71** Prospective payment system (PPS) code

**FLs 72a–c** External cause of injury (ECI) code

**FL 73** Not required

**FL 74** Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

**FLs 74a–e** Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (*which is shown in FL 74*). The date of each procedure is shown in the date portion of Item 74, as applicable (*MM-DD-YY*).

**FL 75** Not required

**FL 76** Attending/referring physician ID

**FL 77** Operating physician name and identifiers

**FLs 78–79** Other physician ID

**FL 80** Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.

**FLs 81a–d** Code field

### Condition Codes

02 Condition is employment related

03 Patient covered by insurance not reflected here

06 End-stage renal disease (ESRD) patient in first 30 months of entitlement covered by employer group health insurance

08 Beneficiary would not provide information concerning other insurance coverage

18 Maiden name retained

19 Child retains mother’s name

31 Patient is student (*full time—day*)

33 Patient is student (*full time—night*)

34 Patient is student (*part time*)

36 General care patient in a special unit

38 Semiprivate room not available

39 Private room medically necessary
Same-day transfer
Partial hospitalization
Nonavailability statement on file
Psychiatric residential treatment centers for children and adolescents
SNF bed not available
Medical appropriateness
Day outlier
Cost outlier
Beneficiary elects not to use lifetime reserve days
TRICARE External Partnership Program
Physically Handicapped Children’s Program
Approved as billed
Automatic approval as billed based on focused review
Partial approval
Admission/services denied
Post-payment review applicable
Admission pre-authorization
Extended authorization
Distinct medical visit (OPPS)

First day of the Medicare Coordination Period for ESRD beneficiaries covered by Employer Group Health Plan (EGHP)

Value Codes and Amounts
Most common semiprivate rate
Hospital has no semiprivate rooms
Professional component included in charges and also billed separate to carrier
Preadmission testing
Patient liability amount
Pints of blood furnished
Number of grace days

Occurrence Span Codes
Auto accident
No-fault insurance involved—including auto accident/other
Accident/tort liability
Accident/employment related
Accident/no medical or liability coverage
Crime victim
Date UR notice received
Date active care ended
Date insurance denied
Date benefits terminated by primary payer
Date SNF bed became available
Date of hospice certification or recertification
Date comprehensive outpatient rehabilitation plan established or last reviewed
Date outpatient physical therapy plan established or last reviewed
Date outpatient speech pathology plan established or last reviewed
Date beneficiary notified of intent to bill (accommodations)
Date beneficiary notified of intent to bill (procedures or treatments)