CHAPTER 9:

Billing on the UB Claim Form

Reviewed/Revised: 01/01/24

9.0 INTRODUCTION

The UB claim form is used to bill for all hospital inpatient, outpatient, emergency room services, dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services. This chapter covers paper claim submission only, for additional information on electronic claim submission and general billing requirements please see Chapter 7 *General Billing Rules.*

The information is provided "as is" without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by Noridian Healthcare Solutions (Noridian) and the CMS. The most current edition of the information contained can be found on the Noridian website and the CMS website.

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim. For example, hospice revenue codes 0651, 0652, 0655, and 0656 can only be billed on a UB with a bill type 81X-82X (Special Facility Hospice).
- ICD-10 diagnosis codes are required and must be valid on the date of admission.
- ACA StandardHealth with Health Choice does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied
- ICD-10-PCS codes must be used to identify surgical procedures billed on the Inpatient UB.
- CPT/HCPCS and modifiers (as appropriate) must be used in combination with Revenue codes to identify services rendered on the Outpatient UB.
- The pay to and practice addresses on the claim form must match the information in the ACA StandardHealth with Health Choice claims payment system. Your Provider Performance Representative can assist with corrections if needed.

9.1 COMPLETING THE UB CLAIM FORM

The following instructions explain how to complete the UB-04 Claim Form and whether a field is “Required,” “Required if applicable,” or “Not required.” These instructions are to be supplemented with the information and codes in the AHA *Uniform Billing Manual for the UB-04*. These instructions are only applicable to filling out a **paper UB-04 claim form, *for DRG-excluded facilities*.** Each field number corresponds with the field numbers shown on the UB-04 claim

form. Refer to Chapter 19 *Hospital Services* for specific billing requirements of the DRG reimbursement methodology.

1. Provider Data **Required**

Enter the name, address, and phone number of the provider rendering service.

1. **Arizona Hospital**
   123 Main Street
   Scottsdale, AZ 85252

2. Pay-To name and Address **Required if applicable**

The address that the provider submitting the bill intends payment to be sent IF different than that of the Rendering Provider in Field #1.

3a. PAT CNTL # - Patient Control No. **Required if applicable**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. ACA StandardHealth with Health Choice will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the ACA StandardHealth with Health Choice Claim Reference Number (CRN) and the facility's accounting or tracking system.

3b. MED REC. # - Medical Record No. **Required if applicable**

4. Bill Type **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *AHA Uniform Billing Manual* for codes.

2.	3a. PATIENT CONTROL NO.	4. TYPE OF BILL
	b. MED REC NO.	**111**

5. Fed Tax No. **Required**

Enter the facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS FROM	PERIOD	7. COV'D
86-1234567			

6. Statement Covers Period **Required**

Enter the beginning and ending dates of the billing period. This should be the date the patient was admitted for care thru end of care and cannot be greater than the date indicated in field #12.

5. FED TAX NO.	6. STATEMENT COVERS FROM	PERIOD THROUGH	7. COV'D
	02/15/2003	**02/20/2003**	

7. Blank Field **Not Required**

8(a-b). Patient Name **Required**
Last name, first name and, if any, middle initial of the patient and the patient identifier as assigned by the payer**.**

9(a-e). Patient Address **Required**
The mailing address of the patient**.**

10. Birthdate (Patient) **Required**

11. Sex (Patient) **Required if applicable**

12. Date – Admission Start of Care Date **Required**
The start date is required for all inpatient claims. The hospital enters the date the patient was admitted for inpatient care (MMDDYYYY)

13. HR - Admission Hour **Required if applicable**

14. Type - Priority of Visit/Admission **Required**
Required for all claims. Enter the code that best describes the members' status for this billing period. An Admit Type of "1" is required for emergency inpatient and outpatient claims.

1. Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
2. Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
3. Elective: Patient's condition permits time to schedule services.
4. Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.
5. Trauma Center: Visit to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

15. SRC - Point of Origin for Admission or Visit **Required**
A code indicating the source of the referral for this admission or visit.

16. DHR - Discharge Hour **Required if applicable**
Required for inpatient claims when the recipient has been discharged.

17. STAT - Patient Discharge Status **Required**
This code indicates the patient's discharge status as of the "Through" date of the billing period.

01 Discharged to home or self-care (routine discharge)
02 Discharged/Transferred to a short-term general hospital for inpatient care

03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care
04 Discharge/Transferred to a facility that provides custodial or supportive care intermediate care (IFC)
05 Discharge/Transferred to a designated cancer center or children's hospital
06 Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
09 Admitted as an inpatient to this hospital
20 Expired
21 Discharged/Transferred to Court/Law Enforcement
30 Still a patient
40 Expired at home
41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice
42 Expired, place unknown (hospice only)
43 Discharged/Transferred to a federal health care facility
50 Discharged to Hospice - home
51 Discharged to Hospice - medical facility (certified) providing hospice level of care
61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital
66 Discharges/Transfers to a Critical Access Hospital
70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18 - 28. Condition Codes **Required if applicable**

A code(s) used to identify conditions or events relating to this bill. To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "G0".

29. ACDT State - Accident State **Required if applicable**

30. Reserved **Not Required**

Not currently used.

31 – 34. Occurrence Codes and Dates **Required if applicable**

Occurrence codes and associated dates define a significant event relating to this bill that may affect processing.

35 – 36. Occurrence Spans Codes and Dates **Required if applicable**

A code a related dates that identify an event that relates to the payment of the claim.

37. Reserved (Not currently used) **Not Required**

38. Responsible Party Name and Address **Required if applicable**
The name and address of the party responsible for the bill.

39 – 41. Value Codes and Amounts **Required if applicable**
A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. These fields contain codes and the dollar amounts related to them identifying data required for processing claims. Refer to the NUBC manual for specific codes. These fields are required for Medicare part A and B and for Dialysis patients:

A1 Use for Medicare Part A deductible
A2 Use for Medicare Part B coinsurance
A3 Benefits Exhausted
B1 Use for Medicare part B deductible
B2 Use for Medicare Part B coinsurance
C1 Third Party Payer deductible
C2 Third Party Payer coinsurance
49 Hematocrit test results
68 EPO units administered A8 Patient weight A9 Patient height.

42. Revenue Codes **Required**
Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

Revenue Code categories are four digits.

42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	45. SERV. DATE
013			
025			
025			

43. Revenue Description/NDC **Required/NDC if applicable**
The standard abbreviated description of the related revenue code categories included on the bill in Field 42. The description should correspond with the Revenue Codes as defined by the NUBC.

42. REV. CD.	**43. DESCRIPTION**	44. HCPCS/RATES	46. SERV. UNITS
	OB/3&4 BED		
	DRUGS/GENERIC		
	IV SOLUTIONS		

Providers must report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens or spaces.
- The NDC Unit of Measurement Qualifier
- The NDC Unit Quantity is the amount of medication administered. If it includes a decimal point, a decimal point must be used and a blank space cannot be left in place of the decimal point.
- The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens or spaces.
- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

42. REV. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00

44. HCPCS/Rate/HIPPS Code **Required if applicable**

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

42. REV. CD.	43. DESCRIPTION	**44. HCPCS/RATES**	46. SERV. UNITS
		1,088.00	
		855.95	
		959.00	

Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

42. REV. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	**N400074115278ML10**	**J1642**	**2.00**

45. SERV DATE - Service Date (Outpatient) **Required**

The date (MMDDYYYY) the *outpatient* service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form.

46. Service Units **Required**

Number of units for ALL services must be indicated.

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 17) and statement covers period (Field 6). If the recipient has been discharged, ACA StandardHealth with Health Choice covers the admission date to but not including the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, ACA StandardHealth with Health Choice covers the admission date through last date billed.

Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

42. REV. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10	J1642	**2.00**

47. Total Charges **Required**

Total charges pertaining to the related revenue code (Field 42) for the current billing period is entered in the statement covers period. Total Charges includes both covered and non-covered charges. Total charges are obtained by multiplying the units of service by the unit charge for each service.

Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 0001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

Note – the 23rd line contains an incrementing page count and total number of pages for the claim on each page creation date of the claim on each page, and a claim total on the final page. Use Rev Code 0001 for the total charges. Multi-page claims should have this field left blank. A**ll lines (1-22) must be completed on the first page, before proceeding to the second page** of the claim. The total charges should *only be entered on the last page of a multi-page claim.*

48. Non-covered Charges **Required if applicable**

Reflect the non-covered charges for the payer as it pertains to the related revenue code.

The last entry is total non-covered charges, represented by revenue code 0001. Do not subtract this amount from total charges.

49. Reserved (Currently not used) **Not Required**

50(A-C). Payer Name **Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than ACA StandardHealth with Health Choice should be the last entry. If there are no payers other than ACA StandardHealth with Health Choice will be the only entry.

51(A-C). Health Plan ID **Required**
Entered the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. This is a number used by the health plan to identify itself.

52(A-C). REL INFO - Release of Information Certification Indicator **Not Required**
Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.

53(A-C). ASG BEN - Assignment of Benefits Certification Indicator **Not Required**
Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

54(A-C). Prior Payments – Payer **Required if applicable**
The amount the provider has received (to date) by the other health plan or patient toward payment of this bill.

55(A-C). EST. AMOUNT DUE - Payer **Not Required**
The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56. NPI - National Provider Identifier **Required**
The unique identification number assigned to the provider submitting the bill; NPI is the National Provider Identifier.

57. Other - Billing Provider Identifier **Required if applicable**
A unique identification number assigned to the provider submitting the bill by the health plan.

58(A-C). Insured's Name **Not Required**
The name of the individual under whose name the insurance benefit is carried as listed in Field 50.

59(A-C). P. REL - Patient's Relationship to Insured **Not Required**
Code indicating the relationship of the patient to the identified insured.

60(A-C). Insured's Unique ID (ACA StandardHealth with Health Choice ID**#)** **Required**

Enter the recipients ACA StandardHealth with Health Choice ID number as reflected on the members ID card. The unique number assigned to the health plan to the insured.

61(A-C). Group Name **Not Required**
The group or plan name through which the insurance is provided to the insured.

62(A-C). Insurance Group No. **Not Required**

The identification number, control number, or code assigned by the carrier or administrator to identify the group number under which the individual is covered.

63(A-C). Treatment Authorization Codes **Not Required**
A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payer. You may include the ACA StandardHealth with Health Choice Prior Authorization Number. If there is a Prior Authorization approved within the ACA StandardHealth with Health Choice Claims system, the claim will validate the presence of the Authorization during processing. If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456).

64(A-C). Document Control Number (DCN) **Required if applicable**
A control # assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. **If the claim is a replacement or void, the original CRN shall be entered in this field.**

65(A-C). Employer Name (of the Insured) **Not Required**
The name of the employer that provides health care coverage for the insured individual.

66. DX - Diagnosis and Procedure Code Qualifier (ICD) **Required**
The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
0 = ICD-10-CM

67. Principal Diagnosis code and,
Present On Admission (POA) indicator (shaded area) **Required**
Enter the **principal** *ICD diagnosis code*.

SHADED AREA – Present On Admission Indicator
In each diagnosis code box there is a grayed out area. This is the diagnosis indicator area. If a diagnosis code is entered in, please enter in the appropriate diagnosis indicator (i.e. Y or N) POA Indicator.

69. ADMIT DX – Admitting Diagnosis **Required**
This field is required for inpatient bills. Enter the ICD diagnosis code that represents the significant reason for admission.

70. PATIENT REASON DX – Patient's Reason for Visit **Required if applicable**

71. PPS CODE **Required if applicable**
Enter the DRG diagnosis code for the claim in this field.
72. ECI – E Codes **Required if applicable**

73. Reserved (Currently not used) **Not Required**

74. Principal Procedure Code and Date **Required if applicable**
Enter the Principal ICD procedure code and the corresponding date on which the principal procedure was performed during the inpatient stay or outpatient visit. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

75. Reserved (Currently not used) **Not Required**

76. Attending Provider Name and Identifiers (NPI) **Required if applicable**
NPI, ID (QUAL), First and Last name. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. **Required on inpatient claims** and to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

77. Operating Physician Name and Identifiers (NPI) **Required if applicable**
NPI, ID (QUAL), First and Last name. The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if a surgical procedure code is listed on the claim.

78. OTHER – Referring Provider **Required if applicable**
NPI, ID (QUAL), First and Last name.

79. OTHER - Provider (Individual) Names and Identifier **Not Required**
The name and NPI number of the individual corresponding to the Provider Type category indicated in this section of the claim.

80. Remarks **Required if applicable**
Area to capture additional information necessary to adjudicate the claim. Enter the Claims Reference Number (CRN) assigned to the original bill by **BCBSAZ Health Choice**. **Required when a claim is a replacement or void** to a previously adjudicated claim and the Bill Type (FL-04) indicates a void or replacement.

81(a). CC – Other Procedure Codes **Required if applicable**
Enter taxonomy code

81(b-d). CC – Other Procedure Codes **Not Required**
To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC.