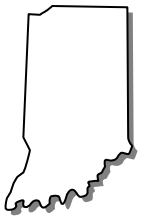

**PROVIDER BULLETIN**

BT200702 JANUARY 30, 2007

# To: All Providers

# Subject: Updated UB-04 Paper Claim Form Requirements

*The following information does not apply to providers rendering services in the risk based managed care (RBMC) delivery system. These providers should contact the managed care organization (MCO) with whom they are contracted for information about paper claim form transition.*

## Overview

The Centers for Medicare & Medicaid Services (CMS), through recommendations of the National Uniform Billing Committee (NUBC) is mandating that providers use revised paper claim forms. The Indiana Health Coverage Programs (IHCP) will discontinue acceptance of the current UB-92 paper claim form effective May 23, 2007. Beginning May 23, 2007, only the revised UB-04 claim form will be accepted. Paper claims submitted on the old form will not be processed after May 22, 2007, and will be returned to the provider.

*Note: The information in this bulletin supersedes information that has been previously communicated through bulletins, banner pages, or workshop training materials.*

Table 1 – Timeline Revised Paper Claim Forms

| Current Form | New Form | Transition Period (Old and New Forms Accepted) | | Only New Forms Accepted (Cutover Date) |
|---|---|---|---|---|
| | | Start Date | End Date | |
| UB-92 | UB-04 | April 1, 2007 | May 22, 2007 | May 23, 2007 |

**Note 1:** The new claim form includes fields for the National Provider Identifier (NPI). The NPI implementation date is May 23, 2007. During the transition period, billing providers who have been assigned an NPI should include both their NPI and their IHCP provider number (legacy provider identifier or LPI) on the paper claim form. Providers must remember to report the NPI assigned by the National Plan and Provider Enumeration System (NPPES) to IHCP Provider Enrollment before submitting claims using the NPI. Claims received after May 22, 2007 with an NPI that has not been reported to the IHCP will not be processed and will be returned to the provider.

**Note 2:** The UB-04 paper claim form does not have a signature designated field. Therefore all providers must have the *Claim Certification Statement for Signature on File* form on file with the IHCP for the UB-04 claim form to be processed. The *Claim Certification Statement for Signature on File* form can be obtained on the forms page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp.

**Note 3:** With the implementation of the new UB-04 paper claim form, the IHCP will accept up to 66 lines for any one paper claim.

# UB-04 Claim Form Requirements

This section provides a brief overview of the changes required for completion of the UB-04 claim form. The UB-92 claim form will no longer be accepted after May 22, 2007.

These instructions are effective for paper claim submission starting April 1, 2007. Paper claims received beginning May 23, 2007, must meet the new claim form requirements. Beginning May 23, 2007, non-compliant paper claims submitted for processing, will be returned to the provider. During the transition, providers who have been assigned an NPI should include both their NPI and their IHCP provider number (LPI) on the paper claim form.

## *Reporting the NPI Using the NPI Reporting Tool*

All providers required to report an NPI when submitting claims must first report the NPI and taxonomy code(s) via the NPI Reporting Tool available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/NPITool/npi_logon.aspx or by using the *NPI Reporting Form* available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Providers must use the taxonomy codes reported. The *National Provider Identifier (NPI)* page, located at http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp, contains information about the *IHCP NPI Implementation Plan* and instructions for obtaining an NPI.

## *Definitions*

| | |
|---|---|
| legacy provider identifier (LPI) | The provider number issued by the IHCP. |
| National Provider Identifier (NPI) | New identifier issued through the NPPES developed by CMS. NPI will replace all institutional IHCP provider numbers (LPI) currently used for billing purposes. |
| qualifier | Identifies what the value to the immediate right on the claim represents. |
| | B3 – Healthcare provider taxonomy code |
| | 0B – State license number |
| taxonomy number | National code identifying a provider type and specialty. |

## *UB-04 Claim Form Fields*

This section explains completion of the UB-04 claim form. Some information is required to complete the claim form, while other information is optional.

The UB-04 Claim Form Locator Descriptions (Table 2) indicates in **bold** type if a field is **Required** or **Required, if applicable**. *Optional* and *Not applicable* information is displayed in normal type. Specific instructions applicable to a particular provider type are included. The table describes each form locator by referring to the number found in the left corner of each box on the UB-04 claim form. These boxes contain the data elements.

> *Note: These instructions apply to the IHCP guidelines only and are not intended to replace instructions issued by the NUBC. The NUBC instruction manual can be accessed at http://www.nubc.org.*

With the implementation of the new UB-04 paper claim form, the IHCP will accept up to 66 lines for any one paper claim.

An example of the new claim form is included in this bulletin.

All form locator fields with a change are noted with an asterisk (*) in Table 2.

Table 2 – UB-04 Claim Form Locator Descriptions

| Form Locator | Narrative Description/Explanation |
|---|---|
| 1* | **PLEASE REMIT PAYMENT TO** – Enter the billing provider service location name, address and the expanded ZIP Code + 4 format. **Required**.<br>*Note: If the Postal Service provides an expanded ZIP Code for a geographic area, this expanded ZIP Code must be entered on the claim form.* |
| 2 | UNLABELED FIELD – Not applicable. |
| 3a | **PATIENT CONTROL NO. —** Enter the internal patient tracking number. Optional. |
| 3b | **Medical Record Number –** Enter the number assigned to the patient's medical or health record by the provider. Optional. |
| 4 | **TYPE OF BILL** – Enter the code indicating the specific type of bill. This three-digit code requires one digit from each of the following categories in the following sequence; all positions must be fully coded. **Required**.<br>• First position – Type of Facility<br>• Second position – Bill Classification<br>• Third position – Frequency<br>*Note: See http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf for a current list of Type of Bill codes. The NUBC maintains this code set, which is considered an external code set by the HIPAA requirements. Therefore, the IHCP is not responsible for updating the type of bill code set. It is the provider's responsibility to monitor the changes made to this external code set.* |
| 5 | FED. TAX NO. – Not applicable. |
| 6 | **STATEMENT COVERS PERIOD, FROM/THROUGH** – Enter the beginning and ending service dates included on this bill. For all services rendered on a single day, use both the FROM and THROUGH dates. Indicate dates in MMDDYY format, such as 122506. **Required.** |
| 7 | UNLABELED FIELD — Not applicable. |
| 8a* | PATIENT IDENTIFIER — Not applicable.<br>*Report recipient ID in field 60.* |
| 8b* | **PATIENT NAME** — Last name, first name, and middle initial of the member. **Required.** |
| 9a* | PATIENT ADDRESS-STREET – Enter the member's street address. Optional. |
| 9b* | PATIENT ADDRESS – CITY – Enter the member's city. Optional. |
| 9c* | PATIENT ADDRESS – STATE – Enter the member's two alpha character state abbreviation. Optional. |
| 9d* | PATIENT ADDRESS – ZIP CODE – Enter the member's ZIP Code. Optional. |
| 9e* | PATIENT ADDRESS – COUNTRY CODE – Enter the three character country code, if other than USA. Optional. |
| 10* | BIRTHDATE – Enter the member's date of birth in a MMDDYY format. Optional. |

Table 2 – UB-04 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="4">Narrative Description/Explanation</th></tr>
<tr><td>11*</td><td colspan="4">SEX – Enter the member's gender. M for Male, F for Female. Optional.</td></tr>
<tr><td>12*</td><td colspan="4">ADMISSION DATE – Enter the date the patient was admitted to inpatient care in a MMDDYY format. Required for inpatient and LTC.</td></tr>
<tr><td>13*</td><td colspan="4">ADMISSION HOUR – Enter the hour during which the patient was admitted for inpatient care. Required for inpatient.</td></tr>
<tr><td></td><td colspan="4">Admission Hour Code Structure
<table>
<tr><th>Code</th><th>Timeframe a.m.</th><th>Code</th><th>Timeframe p.m.</th></tr>
<tr><td>00</td><td>12 a.m. – 12:59 a.m.</td><td>12</td><td>12 p.m. – 12:59 p.m.</td></tr>
<tr><td>01</td><td>1 a.m. – 1:59 a.m.</td><td>13</td><td>1 p.m. – 1:59 p.m.</td></tr>
<tr><td>02</td><td>2 a.m. – 2:59 a.m.</td><td>14</td><td>2 p.m. – 2:59 p.m.</td></tr>
<tr><td>03</td><td>3 a.m. – 3:59 a.m.</td><td>15</td><td>3 p.m. – 3:59 p.m.</td></tr>
<tr><td>04</td><td>4 a.m. – 4:59 a.m.</td><td>16</td><td>4 p.m. – 4:59 p.m.</td></tr>
<tr><td>05</td><td>5 a.m. – 5:59 a.m.</td><td>17</td><td>5 p.m. – 5:59 p.m.</td></tr>
<tr><td>06</td><td>6 a.m. – 6:59 a.m.</td><td>18</td><td>6 p.m. – 6:59 p.m.</td></tr>
<tr><td>07</td><td>7 a.m. – 7:59 a.m.</td><td>19</td><td>7 p.m. – 7:59 p.m.</td></tr>
<tr><td>08</td><td>8 a.m. – 8:59 a.m.</td><td>20</td><td>8 p.m. – 8:59 p.m.</td></tr>
<tr><td>09</td><td>9 a.m. – 9:59 a.m.</td><td>21</td><td>9 p.m. – 9:59 p.m.</td></tr>
<tr><td>10</td><td>10 a.m. – 10:59 a.m.</td><td>22</td><td>10 p.m. – 10:59 p.m.</td></tr>
<tr><td>11</td><td>11 a.m. – 11:59 a.m.</td><td>23</td><td>11 p.m. – 11:59 p.m.</td></tr>
<tr><td></td><td></td><td>99</td><td>Hour Unknown</td></tr>
</table></td></tr>
<tr><td>14*</td><td colspan="4">ADMISSION TYPE – Enter the code indicating the priority of this admission. Required for inpatient and LTC.
<table>
<tr><th colspan="2">Admission Codes</th></tr>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Emergency</td></tr>
<tr><td>2</td><td>Urgent</td></tr>
<tr><td>3</td><td>Elective</td></tr>
<tr><td>4</td><td>Newborn</td></tr>
<tr><td>5</td><td>Trauma Center</td></tr>
</table></td></tr>
<tr><td>15*</td><td colspan="4">ADMISSION SRC – Optional.</td></tr>
<tr><td>16*</td><td colspan="4">(DHR) DISCHARGE HOUR – Enter the hour during which the patient was discharged from inpatient care. Valid values are the same as form Field 13. Optional.</td></tr>
</table>

Table 2 – UB-04 Claim Form Locator Descriptions

| Form Locator | Narrative Description/Explanation | |
|---|---|---|
| 17* | **STATUS** – Enter the code indicating the member discharge status as of the ending service date of the period covered on this bill. **Required for inpatient and LTC.** | |
| | **Patient Status Codes** | |
| | **Code** | **Description** |
| | 01 | Discharged to home or self-care, routine discharge |
| | 02 | Discharged or transferred to another short-term general hospital for inpatient care |
| | 03 | Discharged or transferred to skilled nursing facility (SNF) |
| | 04 | Discharged or transferred to an intermediate care facility (ICF) |
| | 05 | Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution |
| | 06 | Discharged or transferred to home under care of organized home health service organization |
| | 07 | Left against medical advice or discontinued care |
| | 08 | Discharged or transferred to home under care of a home intravenous provider |
| | 20 | Expired |
| | 30 | Still a patient |
| | 43 | Discharged or transferred to a federal health care facility |
| | 50 | Discharged to hospice – home |
| | 51 | Discharged to hospice – medical facility |
| | 61 | Discharged or transferred within this institution to hospital based Medicare swing bed |
| | 62 | Discharged or transferred to another rehabilitation facility including discharge planning units of hospital |
| | 63 | Discharged or transferred to a long-term care facility |
| | 64 | Discharged or transferred to a nursing facility Medicaid-certified but not Medicare-certified |
| | 65 | Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital |
| | 66 | Discharges/Transfers to a critical access hospital (effective January 1,2006) |

Table 2 – UB-04 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="2">Narrative Description/Explanation</th></tr>
<tr><td rowspan="15">18 – 24*<br>Seven maximum allowed</td><td colspan="2">CONDITION CODES – Enter the applicable code to identify conditions relating to this bill that may affect processing. A maximum of seven codes can be entered. Required, if applicable. The IHCP uses the following codes:</td></tr>
<tr><td colspan="2">Condition Codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>02</td><td>Condition is employment related</td></tr>
<tr><td>03</td><td>Patient covered by insurance not reflected here</td></tr>
<tr><td>05</td><td>Lien is filed</td></tr>
<tr><td>07</td><td>Medicare hospice by non-hospice provider</td></tr>
<tr><td colspan="2">Accommodation Code</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>40</td><td>Same day transfer</td></tr>
<tr><td colspan="2">Prospective Payment codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>61</td><td>Cost outlier</td></tr>
<tr><td>82</td><td>Non-covered by other insurance</td></tr>
<tr><td colspan="2">Special Program Indicator Codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>A7</td><td>Induced abortion, danger to life</td></tr>
<tr><td>A8</td><td>Induced abortion, victim of rape or incest</td></tr>
<tr><td>25 – 28*</td><td colspan="2">CONDITION CODES - Not used.</td></tr>
<tr><td>29*</td><td colspan="2">ACDT STATE – Enter the state where the accident occurred. Optional.</td></tr>
<tr><td>30*</td><td colspan="2">Unlabeled Field – Not applicable.</td></tr>
</table>

Table 2 – UB-04 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="2">Narrative Description/Explanation</th></tr>
<tr><td>31a – 34b*</td><td colspan="2">OCCURRENCE CODE and DATE – Enter the applicable code and associated date to identify significant events relating to this bill that may affect processing. Dates are entered in a MMDDYY format. A maximum of eight codes and associated dates can be entered. Required, if applicable. The IHCP use these codes:<br><br>Note: Effective October 16, 2003, State-assigned Occurrence Codes 50-69 were discontinued due to the HIPAA requirements. In the interim, the IHCP continues to use these non-HIPAA compliant codes on UB paper claim forms and the 837I electronic transactions until an alternative method of processing is established.</td></tr>
<tr><td></td><td colspan="2">Occurrence Codes</td></tr>
<tr><td></td><td>Code</td><td>Description</td></tr>
<tr><td></td><td>01</td><td>Auto accident</td></tr>
<tr><td></td><td>02</td><td>No fault insurance involved – including auto accident or other</td></tr>
<tr><td></td><td>03</td><td>Accident or tort liability</td></tr>
<tr><td></td><td>04</td><td>Accident or employment related</td></tr>
<tr><td></td><td>05</td><td>Other accident</td></tr>
<tr><td></td><td>06</td><td>Crime victim</td></tr>
<tr><td></td><td>25</td><td>Date benefits terminated by primary payer</td></tr>
<tr><td></td><td>27</td><td>Date home health plan established or last reviewed</td></tr>
<tr><td></td><td>50</td><td>Previous hospital discharge – This code is used to bypass prior authorization (PA) editing when certain nursing and therapy services are to be conducted during the initial period following a hospital discharge. The discharge orders must include the requirement for such services. Details can be found in the applicable sections of the Indiana Administrative Code (IAC).</td></tr>
<tr><td></td><td>51</td><td>Date of discharge – This code is used to show the date of discharge from the hospital confinement being billed, the date of discharge from a long-term care facility, or the date of discharge from home health care, as appropriate.</td></tr>
<tr><td></td><td>52</td><td>Initial examination – This code is used to show that an initial examination or initial evaluation is being billed in a hospital setting. This code bypasses certain PA editing. Details can be found in the applicable sections of the IAC.</td></tr>
<tr><td></td><td>53</td><td>Therapy evaluation, HHA – This code is used to show HHA billing for initial therapy evaluations. This code exempts the evaluation from PA editing. Revenue codes specific to therapy evaluations must be billed. Details can be found in the applicable section of the IAC.</td></tr>
<tr><td></td><td>61</td><td>Home health overhead amount—one per day</td></tr>
<tr><td></td><td>62</td><td>Home health overhead amount—two per day</td></tr>
<tr><td></td><td>63</td><td>Home health overhead amount—three per day</td></tr>
<tr><td></td><td>64</td><td>Home health overhead amount—four per day</td></tr>
<tr><td></td><td>65</td><td>Home health overhead amount—five per day</td></tr>
<tr><td></td><td>66</td><td>Home health overhead amount—six per day</td></tr>
</table>

Table 2 – UB-04 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="2">Narrative Description/Explanation</th></tr>
<tr><td rowspan="3">35a–36b</td><td colspan="2">OCCURRENCE SPAN CODE, FROM/THROUGH – Enter the code and associated dates for significant events relating to this bill. Each Occurrence Span Code must be accompanied by the span From and Through date. The only valid home health overhead Occurrence Span Code is 61. Optional.</td></tr>
<tr><td colspan="2">Occurrence Span Code</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>37*</td><td colspan="2">UNLABELED FIELD – Enter the Medicaid Select primary medical provider (PMP) two-character alphanumeric certification code for dates of service rendered. Required for IHCP members enrolled in Medicaid Select when the service is not rendered by the member's PMP with exception of outpatient laboratory, pathology, radiology, and therapy services performed in a hospital setting for Medicaid Select members. The bypass of these outpatient hospital services is based on the revenue codes being billed. Revenue codes and descriptions that bypass the two-digit PMP certification code are denoted in the IHCP Provider Manual, Chapter 8. The IHCP Provider Manual is available on the Manuals page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/manuals.htm.<br>Report the PMP NPI in field 78 for claim reimbursement of these hospital services.</td></tr>
<tr><td>38*</td><td colspan="2">UNLABELED FIELD – Not applicable.</td></tr>
<tr><td rowspan="2">39a – 41d*<br><br>42</td><td colspan="2">VALUE CODES –Use these fields to identify Medicare Remittance Notice (MRN) information. The following value codes must be used along with the appropriate dollar or unit amounts for each. Required, if applicable.<br>• Value Code A1 – Medicare deductible amount<br>• Value Code A2 – Medicare co-insurance amount<br>• Value Code 06 – Medicare blood deductible amount<br>• Value Code 80 – IHCP covered days</td></tr>
<tr><td colspan="2">REV. CD. – Enter the applicable revenue code that identifies the specific accommodation, ancillary service, or billing calculation. The appropriate three-digit, numeric revenue code must be entered to explain each charge entered in form field 47. Refer to the IAC for covered services and limitations, and medical policy rules. Use the specific revenue code when available. Required.</td></tr>
<tr><td>43</td><td colspan="2">DESCRIPTION – Enter a narrative description of the related revenue code category on this bill. Abbreviations may be used. Only one description per line. Optional.</td></tr>
<tr><td>44</td><td colspan="2">HCPCS/RATES – Use the Healthcare Common Procedure Coding System (HCPCS) code applicable to the service provided. Only one service code per line is permitted. Required for home health, outpatient, and ASC services. This field is also used to identify procedure code modifiers. Provide the appropriate modifier, as applicable. Up to four modifiers are allowed for each procedure code. This is a thirteen character field. Required, if applicable.</td></tr>
<tr><td>45</td><td colspan="2">SERV. DATE – Provide the date the indicated outpatient service was rendered. Required for home health, hospice, independent laboratories, dialysis, ASC, and outpatient.<br>Creation Date Field 45, line 23, enter the date the bill is submitted. Required.</td></tr>
<tr><td>46</td><td colspan="2">SERV. UNITS – Provide the number of units corresponding to the revenue code or procedure code submitted. Seven digits are allowed. Units must be billed using whole numbers. Required.</td></tr>
</table>

Table 2 – UB-04 Claim Form Locator Descriptions

| Form Locator | Narrative Description/Explanation |
|---|---|
| 47 | **TOTAL CHARGES** – Enter the total charges pertaining to the related revenue code for the STATEMENT COVERS PERIOD. Enter the sum of all charges billed reflected in field 47, line 23. The sum should be entered only on the last page of the claim. Ten numeric digits are allowed per line, such as 99999999.99. **Required**. |
| 48 | NON-COVERED CHARGES – Not applicable. Information entered in this block and applied to the bill results in an out-of-balance bill and subsequent denial. Do not enter information in this field. |
| 49 | UNLABELED FIELD – Not applicable. |
| 50A–55C | **FORM FIELDS 50A-55C** – Medicare is always listed first (50A), if applicable. Other insurers, such as a Medicare supplement (commercial insurer), are listed in the second form field (50b), if applicable. The IHCP information is listed last (50C). EXCEPTION: Section 5-1 notes that the IHCP is primary to Children's Special Health Care Services (CSHCS) and Victim Assistance coverage. **Required, if applicable**.<br>**FORM FIELDS 50A-C –** Such as Medicare, Medicare supplement, and Traditional Medicaid. **Required, if applicable.** |
| 50A | **PAYER** – Enter the Medicare carrier's name. **Required, if applicable.** |
| 50B | **PAYER** – Enter the third-party carrier's name and additional payer names. **Required, if applicable.** |
| 50C | **PAYER** – Enter the applicable IHCP, such as Traditional Medicaid or 590 Program. **Required**. |
| 51A–51C | HEALTH PLAN ID – The Payer C, billing IHCP provider number are entered in Fields 56 and/or 57. Provider numbers pertaining to 50A, *Medicare Payer*, or 50B, *TPL Payer*, are optional. |
| 52A–52C | REL INFO – Not applicable. |
| 53A–53C | ASG BEN – Mark **Y** for yes, benefits assigned. The *IHCP Provider Agreement* includes details about accepting payment for services. Optional. |
| 54A–54C* | **PRIOR PAYMENTS** – Enter the amount paid by the carrier entered in form fields 50A-C. **Required, if applicable**.<br>*Note: When a third party liability (TPL) carrier makes payment on a claim, the Explanation of Benefits (EOB) is not required. If the Medicare payment is greater than zero, the MRN is not required.* |
| 55A–55C | EST. AMOUNT DUE – Not applicable. |
| 55C | **EST. AMOUNT DUE** – Enter the amount billed. Calculate the estimated amount due by subtracting the amounts in fields 54A-C from form field 47, *Revenue Code 001, Total Charge Amount*. This field accommodates 10 digits, such as 99999999.99. **Required**. |
| 56* | **NPI** – Enter the 10-digit NPI for the billing provider. The billing physician's taxonomy should be entered in field 81CCa. **Required**. |
| 57A* | **OTHER PROVIDER ID** – Enter the IHCP provider number or LPI for the billing provider. The LPI includes nine numeric characters and one alpha character for the service location. **Required, if applicable**. |
| 58A–58C | **INSURED'S NAME** – Enter member's last name, first name, and middle initial. IHCP member information is required. Enter TPL information. **Required, if applicable**. |

Table 2 – UB-04 Claim Form Locator Descriptions

| Form Locator | Narrative Description/Explanation |
|---|---|
| 59A–59C | P. REL – Not applicable. |
| 60A–60C | **INSURED'S UNIQUE ID** – Enter the member's identification number for the respective payers entered in form fields 50A-C. The 12-digit member ID (RID) number is required in form field 60c. **Other carrier information is required, if applicable**. |
| 61A–61C | **GROUP NAME** – Enter the name of the group or plan through which insurance is provided to the member by the respective payers entered in form fields 50A-C. **Required, if applicable.** |
| 62A–62C | **INSURANCE GROUP NO**. – Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered, see form fields 50A-B. Enter the policy number as well. **Required, if applicable.** |
| 63A–63C | TREATMENT AUTHORIZATION CODES – Enter the number that indicates the payer authorized the treatment covered by this bill. Optional. |
| 64A–64C* | DOCUMENT CONTROL NUMBER – Not applicable. |
| 65A–65C | **EMPLOYER NAME** – Enter the name of the employer that might or does provide health care coverage for the insured individual identified in form field 58. **Required, if applicable.** |
| 66* | DX – Not applicable. |
| 67* | **PRIN. DIAG. CD.** – Provide the *International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM)* code describing the principal diagnosis, for example, the condition established after study to be chiefly responsible for the admission of the patient for care. **Required for inpatient, outpatient, LTC, hospice, ASC, and home health.** |
| 67A-Q* | **OTHER DIAGNOSIS CODES** – Provide the ICD-9-CM codes corresponding to additional conditions that coexist at the time of admission, or that develop subsequently, and that have an effect on the treatment received or the length of stay. **Required, if applicable, for inpatient, outpatient, hospice, ASC, and home health.** |
| 68* | UNLABELED FIELD – Not applicable. |
| 69* | **ADM. DIAG. CD** – Enter the ICD-9-CM code provided at the time of admission as stated by the physician. **Required for inpatient and LTC.** |
| 70* | PATIENT REASON DX – Enter the ICD-9-CM code that reflects the patient's reason for visit at the time of outpatient registration. Optional for outpatient. |
| 71* | PPS CODE – Not applicable. |
| 72* | **ECI (E-CODE)** – If used, use the appropriate E-code provided at the time of admission as stated by the physician. The E-code indicates the external cause of injury, poisoning, or adverse effect. **Required, if applicable.** |
| 73 | UNLABELED FIELD – Not applicable. |
| 74* | **PRINCIPAL PROCEDURE CODE/DATE** – Use the ICD-9-CM procedure code that identifies the principal procedure performed during the period covered by this claim, and the date the principal procedure described on the claim was performed. **Required for inpatient procedures.** |
| 74a-e* | **OTHER PROCEDURE CODE/DATE –** Use the ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure, and the dates, identified by code, the procedures were performed. Report the codes that are most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. **Required, when appropriate, for inpatient procedures.** |
| 75* | UNLABELED FIELD – Not applicable. |

Table 2 – UB-04 Claim Form Locator Descriptions

| Form Locator | Narrative Description/Explanation |
|---|---|
| 76* | **ATTENDING PHYS. ID** – Enter the attending physician's 10-digit numeric NPI. The attending physician's taxonomy should be entered in field 81CCb. The state license number will be accepted through May 22, 2007. If submitting the state license number, enter 0B in the box next to QUAL, with the license number in the following box. **Required for inpatient, outpatient, ASC and LTC.** |
| 77* | **OPERATING PHYS ID** – Enter the operating physician's 10-digit numeric NPI. **Required for inpatient.** |
| 78* | **OTHER** – Enter other physician's (referring/PMP physician) 10-digit numeric NPI. **Required, if applicable.** |
| 79* | OTHER – Not applicable. |
| 80* | REMARKS – Use this field for claim note text. Provide information, using as many as 80 characters, that may be helpful in further describing the services rendered. Optional.<br>*Note: The Claim Note Text field is not used systematically for claim processing at this time, but maybe used by the Claim Resolutions Unit for more information if the claims suspend for review during processing.* |
| 81CC a, b* | **ADDITIONAL CODES** – Enter B3 taxonomy qualifier and corresponding 10-digit alphanumeric taxonomy code. **Required**.<br>81CC a – 1st box *B3* qualifier, 2nd box taxonomy code for billing provider from field 56<br>81CC b – 1st box *B3* qualifier, 2nd box taxonomy code for attending provider from field 76 |

## UB-04 Claim Form, Effective April 1, 2007