2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 8

Claim Forms

Introduction

Claim forms are used to report the procedures performed and the reason the procedures were performed to the insurance carrier to obtain payment for those services. There are two claim forms used; the CMS-1500 claim form and the UB-04 claim form. The CMS-1500 claim form is used to report the professional services performed by providers and Ambulatory Surgical Centers (ASCs). The UB-04 claim form is used to report facility services.

The objectives for this chapter include:

- Understand CMS-1500 claim form development and maintenance processes
- Identify types of providers who utilize the CMS-1500 claim form
- Understand completion of the CMS-1500 claim form
- Apply CMS-1500 claim form fields to electronic submission requirements
- Identify types of providers who utilize the UB-04 claim form
- Understand completion of the UB-04 claim form
- Apply UB-04 claim form fields to electronic submission requirements

National Uniform Claim Committee

The responsibility for development and maintenance of the CMS-1500 claim form rests with the National Uniform Claim Committee (NUCC). Originally the CMS-1500 claim form was developed under the direction of the Uniform Claim Form Task Force, which was co-chaired by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). The CMS-1500 claim form is considered public domain and is not subject to copyright restrictions. The NUCC consists of diverse stakeholders representing the interests of providers, payers, Designated Standards Maintenance Organizations (DSMO), vendors, and public health organizations.

The Health Insurance Portability and Accountability Act (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop, adopt, or modify standards that allow healthcare transactions to be exchanged electronically. Effective January 1, 2012, all HIPAA covered entities are required to send and receive the Accredited Standards Committee ASC X12 Version 5010 for electronic transactions which include:

- Claims (Institutional, Professional and Dental, COB [Professional and Institutional], and NCPDP) (837)
- Claims Status Requests and Responses (276/277)
- Remittance (835)
- Enrollment and Disenrollment in a health plan (834)
- Premium Payment (820)
- Eligibility Requests and Responses (270/271)
- Referral Requests and Responses and Prior Authorizations (278)
- Claims Acknowledgements (277CA)
- Acknowledgement for Healthcare Insurance (999)

To assist in this effort, four organizations - the American Dental Association (ADA), National Uniform Billing Committee (NUBC), NUCC, and Workgroup for Electronic Data Interchange (WEDI) - work together on the standards.

Additional areas of responsibilities of NUCC include identifying business needs of the healthcare industry related to the CMS-1500 claim form, advising HHS and CMS on issues related to uniformity of data content and administrative transaction standards, and maintaining the claim form to focus on bringing uniformity to the data content.

The approval process for CMS-1500 claim form revisions includes multiple reviews and approvals. Once the updates are approved by NUCC, the form is submitted to CMS for approval and then awaits public comment through CMS and the Office of Management and Budget (OMB) before receiving final approval and implementation.

As we discuss the paper forms and each of their fields in this chapter, we will also point out pertinent information for the electronic submissions of the claim form. While the term "item" is used for the field on the paper CMS-1500 claim form, electronic fields refer to the term "loop" for the data elements to be sent. It is important to understand that the Administrative Simplification Compliance Act (ASCA) requires that claims be sent electronically unless unusual circumstances are met. Electronic Data Interchange (EDI) for healthcare claims is a computer-to-computer exchange of claims. This method of claims submission replaces postal mail, fax, and email. For more information on the CMS-1500 claim form see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf.

- ANSI = American National Standards Institute
- ASC = Accredited Standards Committee
- X12N = Insurance section of ASC X12 for the health insurance industry's administrative transactions
- 837 = Standard format for transmitting healthcare claims electronically
- P = Professional version of the 837 electronic format
- Version 5010A1 = Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for healthcare professionals and suppliers.

BILLING TIP

HIPAA allows filing paper claims when it has been determined that due to limitations in the claims transaction formats adopted, it would not be possible to submit the claim electronically. Exceptions allowing for paper claims to be filed to Medicare include:

- Roster billing of inoculations covered by Medicare.
- Claims for payment under a Medicare demonstration project that specifies paper submission.
- "Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) claims when there is more than one primary payer
- MSP claims when there is more than one primary payer and more than one allowed amount

More information can be found on these exceptions by accessing the CMS Internet-Only Manuals, Publication 100-04 Medicare Claims Processing Manual, Chapter 24, 90.3- General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims.

Electronic claims can be submitted from the provider's computer to a clearinghouse or directly to a payer. To understand the process of electronic submissions, let's look at claims submitted to a Medicare Administrative Contractor (MAC). Once received, the MAC sends the claim through initial edits to determine if the claim has all the requirements necessary to meet the basic HIPAA requirements. If errors are detected at this level, the entire batch of claims is rejected for correction and resubmission. Once claims pass these front-end edits, they are then edited against the HIPAA implementation guide requirements. Claims that do not meet these standards are rejected on an individual level and returned electronically to the provider for correction and resubmission. After a claim passes through the first two sets of edits, the claim is then edited for compliance with Medicare coverage and payment policy requirements. The claim is then adjudicated or processed by either being denied or approved for payment. After claims are successfully transmitted, an acknowledgement report is generated. The acknowledgement report can either be sent back to the provider or placed in an electronic mailbox for the provider to download and process.

Private payers also process medical claims electronically, utilizing edits that reflect CPT® coding guidelines and conventions, National Correct Coding Initiative (NCCI) rules, and CMS guidelines. They may have additional edits that are specific for their individual coverage plans.

Paper claims are submitted to Medicare **only** on a limited basis. Providers who feel they should qualify for a waiver as result of an unusual circumstance must submit their waiver requests to the A/B MACs or DME MACs to whom they submit their claims. Private payers also may accept paper claims. It is recommended that medical billers become familiar with private payer guidelines relating to submitting paper claims.

Electronic claims offer important benefits that support the financial wellbeing of healthcare providers, facilities, and organizations. Submission of electronic claims is inexpensive compared to paper claims and allows improved tracking and faster payments.

All fields of the CMS-1500 and UB-04 claim forms must be completed according to payer specifications whether submitted via paper or electronically. The skilled medical biller will become familiar with each payer's guidelines for claims submission and implement the guidelines correctly to ensure tracking and prompt payment of claims.

BILLING TIP

More information about the Accredited Standards Committee (ASC) X12 can be found at x12.org.

The HIPAA implementation guide requirements are purchased through the Washington Publishing Company (wpc-edi.com). Many clearinghouse companies have the implementation standards built into their editing systems.

All major insurance payers have developed their individual claims submission methods, including online claim submission capabilities as well as traditional billing methods. Medical billers must be aware of their provider's major payers and become well versed in the policies and procedures. This will be key for correct and timely claims submission and payment. Some of the major insurance payers include UnitedHealthcare, WellPoint, Kaiser, Humana, Aetna, Cigna, and others. Payers may offer claim submission/real time adjudication options.

This process allows the medical biller to enter claims data directly into the payer's database by identifying the provider, patient (member), and then entering the details of the claim. Once this data is entered, a claim summary is generated, and adjudication status notification is delivered. Adjudication is the term used to describe the process of determining the validity of a claim and the amount the insurer will pay on the claim after the member's insurance benefits have been applied.

Section Review 8.1

1. Facility charges are reported on which claim form?

   A. UB-05 claim form
   B. CMS-1500 claim form
   C. UB-04 claim form
   D. Either CMS-1500 or UB-04 claim form

2. What does the acronym NUCC stand for?

   A. National Unified Claims Committee
   B. National Uniform Criteria Committee
   C. National Unified Claims Coordinators
   D. National Uniform Claim Committee

3. CMS-1500 claim form revisions undergo:

   A. One NUCC review prior to approval.
   B. One CMS review prior to approval.
   C. One HHS and one CMS review and approval.
   D. Multiple reviews prior to approval and implementation.

4. Which transaction is NOT specified in the 5010 transaction standards?

   A. Claims Institutional, Professional and Dental
   B. Eligibility Requests and Responses
   C. Acknowledgement for Healthcare Insurance
   D. Acknowledgement for Patient Payments

5. What regulation requires claims to be sent electronically unless unusual circumstances are met?

   A. Administrative Simplification Compliance Act (ASCA)
   B. False Claims Act (FCA)
   C. Electronic Claims Act (ECA)
   D. Health Information Technology for Economic and Clinical Health Act (HITECH)

CMS-1500

The CMS-1500 claim form is used to submit claims for physicians, non-physician practitioners (NPP), and ASC services to all payers. Other providers may also submit claims using the CMS-1500 claim form, but they will not be discussed in this chapter. CMS-1500 claim form Version 02/12 was implemented on April 1, 2014 to align with requirements in the Accredited Standards Committee X12 (ASC X12) healthcare claim: Professional (837P) Version 5010 and 5010A1 (electronic standard required by HIPAA for electronic claims). Each of the fields (items) will be discussed along with any necessary notations regarding electronic submissions for the claim form. Refer to the 02/12 Version of the CMS-1500 claim form (Image 8.A) provided in this chapter to understand each item as it is explained. Although it is important for the medical biller to know and understand the paper and electronic fields, much of the formatting and field completion is programmed into the practice management system or clearinghouse software.

Some of the formatting requirements differ from the paper format to the electronic format. For example, the date on a paper field is entered as MMDDCCYY (month, date, century, year) whereas the date in the electronic file is transmitted as CCYYMMDD (century, year, month, date). The format change is done behind the scenes by the practice management software or the clearinghouse software. When a medical biller looks at a claim for accuracy, whether it is transmitted electronically or sent as a paper claim, the claim is often viewed (either printed or electronically on screen) as a completed CMS-1500 claim form. There is typically one person within an office that will understand the full electronic file or that will work with the payer and/or the clearinghouse to troubleshoot behind-the-scene issues. The medical biller must understand completing the claim form with accurate information, but not the technical data elements required for the ASCX12 transmissions.

EXAMPLE

This is an excerpt of the 02/12 1500 Claim Form Map to the X12 837 Healthcare Claim. This excerpt identifies how the item numbers discussed in this chapter relate to the electronic transmission of claims.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
N/A	Carrier Block	2010BB	NM103 N301 N302 N401 N402 N403	
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	2000B	SBR09	
1a	Insured's ID Number	2010BA	NM109	
2	Patient's Name	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	Patient's Birth Date, Sex	2010CA or 2010BA	DMG02 DMG03	
4	Insured's Name	2010BA	NM103 NM104 NM105 NM107	
5	Patient's Address	2010CA	N302 N401 N402 N403	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Image 8.A

General Instructions:

Punctuation:

Names—Commas are used to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Address—Do not use punctuation or other symbols in the address. For example, a 9-digit ZIP code is entered without the hyphen. One of the top 10 reasons electronic claims are rejected is due to an invalid ZIP code.

Dates—Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31)

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Item Instructions:

Item 1—Shows the type of health insurance coverage applicable to this claim by checking the appropriate box (for example, if a Medicare claim is being filed, check the Medicare box). Other indicates health insurance including HMOs, commercial insurance (for example, BCBS, UHC, Aetna), automobile accident, liability, or workers' compensation.

BILLING TIP

When a patient presents for an encounter, the patient's insurance information must be obtained or updated. A copy of the patient's insurance card front and back should be obtained.

Item 1a—Enter the patient's insurance ID number. This information is found on the patient's insurance card.

For Medicare, enter the Medicare beneficiary identifier (MBI) whether Medicare is the primary or secondary payer. This is a required field. The patient is always the subscriber for Medicare. A common Medicare electronic claim rejection is for an invalid MBI.

For TRICARE, enter the DoD Benefits Number (DBN 11-digit number). This is found on the back of the military ID card and is also known as the Electronic Data Interchange-Personal Identification number (EDI-PI). There is also a 10-digit DoD ID number on the front of the card. This is not the number used to submit claims.

For BCBS, enter the member ID (for example, XYZ123456789, R12345678).

Item 2—Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's insurance card. This is a required field. The name on the insurance card must match identically to the name on the claim form. Confirm the patient's identity by verifying that the name on the insurance card and the name on the patient's photo ID are identical. When a patient has a junior or senior suffix, the last name suffix is entered after the last name and before the first name. Professional suffixes and titles should not be included.

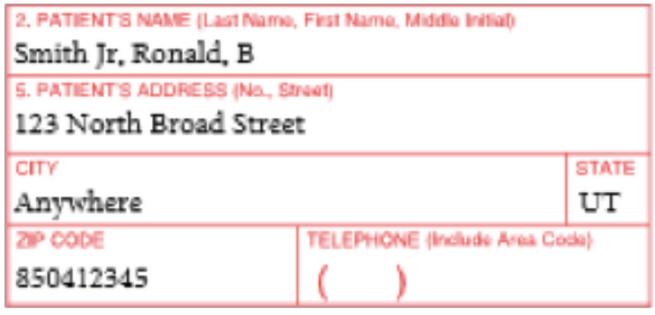
Item 3—Enter the patient's 8-digit birth date (MM|DD|CCYY) and sex. This information is usually provided by the patient when completing new patient paper work. Compare the information provided by the patient with the patient's photo ID.

Item 4—If the patient has insurance through a spouse or parent, enter the spouse or parent name as the insured.

Medicare: If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Workers' Compensation: Enter the name of the employer.

Item 5—Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number. This information is provided by the patient and confirmed with the photo ID. Remember: Punctuation is not used in the address. It is recommended that a phone number not be reported unless required by the carrier (for example, Workers' Compensation or Property and Casualty claims). The phone number is not transmitted in the electronic 837 file. The address used is the patient's permanent address. If the patient has a temporary address, such as a college student away for school, the temporary address is not reported.



Item 6—Check the appropriate box for patient's relationship to insured when item 4 is completed. This question is asked during the registration process and stored in the practice management system.

Item 7—Enter the insured's address and telephone number (the telephone number is only completed when required by the payer). When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

Complete this item only when item 4 is completed. It is recommended that a phone number not be reported unless required by the carrier (for example, Workers' Compensation or Property and Casualty Claims). The phone number is not transmitted in the electronic 837 file.

For Workers' Compensation claims, the address of the employer is reported.

Item 8—Leave blank. This field is reserved for NUCC use.

Item 9—Enter the last name, first name, and middle initial of the insured if the patient has a secondary insurance. This is completed if Item 11d is marked YES.

Medigap: Complete this information if the patient has a Medigap (Medicare supplemental insurance) policy and the insured's name is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his or her benefits under a MEDIGAP policy to the participating physician or supplier.

Item 9a—Enter the policy and/or group number of the secondary insurance. (for example, Medigap policy number preceded by MEDIGAP, MG, or MGAP).

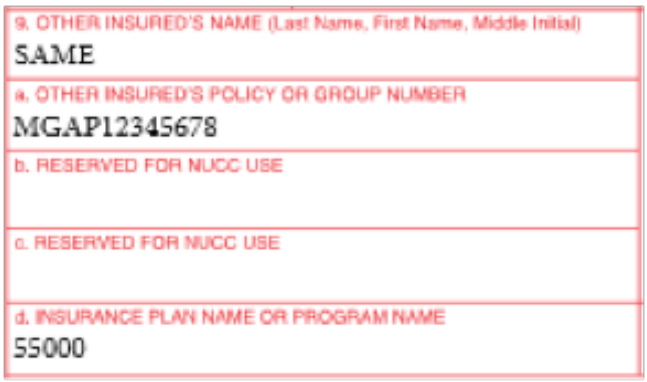
NOTE: Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.

Item 9b— Leave blank. This field is reserved for NUCC use.

Item 9c— Leave blank if Item 9d is completed. This field is reserved for NUCC use.

Item 9d—Enter the other insured's insurance plan or program name.

Medigap: Enter the 5-digit Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID).



Items 10a through 10c—Check YES or NO to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the state postal code. Any item checked YES indicates there may be other insurance primary to the patient's health insurance.

For example, if the encounter was to treat a patient's injury while at work, workers' compensation is the primary payer not the patient's health insurance. Identify primary insurance information in item 11.

Item 10d—Claim codes are entered in this item to identify additional information about the patient's condition on the claim. Current claim codes include condition codes. Condition codes approved for use in this item include codes for abortions, sterilization, and codes for workers' compensation claims.

Condition codes are not used when submitting a revised or corrected claim. Examples of workers' compensation condition codes are:

- W2 Duplicate of original bill
- W3 Level 1 appeal
- W4 Level 2 appeal
- W5 Level 3 appeal

Item 11—This item contains the insured's policy, group, or FECA number (9-character identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101) as it appears on the insured's healthcare identification card. Do not use a hyphen or space as a separator within the policy or group number. If item 4 is completed, this item must also be completed.

Medicare: This item is required by Medicare. By completing this item, the physician/supplier acknowledges having made a good faith effort to determine whether Medicare is primary or secondary payer. If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a–11c. This is determined by having the patient complete the Medicare Secondary Questionnaire. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, enter the word NONE and proceed to item 12. If the insured reports a terminating event with regard to insurance which was primary to Medicare (for example, insured retired), enter the word NONE and proceed to item 11b.

BILLING TIP

Medicare provides a list of questions to ask beneficiaries during the registration process to determine if Medicare is the secondary payer. This can be found in the Medicare Secondary Payer (MSP) Manual, Chapter 3, Section 20.2.1—Admission Questions to Ask Medicare Beneficiaries.

Item 11a—Enter the insured's 8-digit birth date (MM|DD|CCYY) and sex. If the gender is unknown, leave it blank.

Item 11b—Enter a qualifier (for example, Y4 Property Casualty Claim Number) followed by the identifier number.

For Medicare, enter employer's name. If there is a change in the insured's insurance status (for example, retired), enter either a 6-digit (MM|DD|YY) or 8-digit (MM|DD|CCYY) retirement date preceded by the word RETIRED. This information should be entered to the right of the vertical dotted line.

Item 11c—Enter the name of the insurance plan or program of the insured.

BILLING TIP

Some insurers require an identification number of the primary insurer rather than the name in this field.

Medicare: Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the complete primary payer's program or plan name. If the primary payer's explanation of benefits (EOB) does not contain the claims processing address, record the primary payer's claims

processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d—This is marked to indicate if the patient has secondary insurance. If this item is marked, items 9, 9a, and 9d must also be completed.

Medicare: Leave blank. It is not required.

BILLING TIP

If the patient has a primary and secondary insurance, the secondary insurer will not pay the claim until the primary insurance has decided. For Medicare, if the patient has a secondary insurance on file, Medicare will cross the claim over to the secondary payer once Medicare has made a payment determination (paid or denied). For payers that do not cross claims over, once the EOB is received from the primary insurance apply the payment or denial and submit a claim and copy of the primary insurance EOB to the secondary payer for consideration.

Item 12—The patient or authorized representative must sign and enter either a 6-digit date (MM|DD|YY), 8-digit date (MM|DD|CCYY), or an alpha-numeric date (for example, January 1, 2016) unless the signature is on file. In lieu of signing the claim form, the patient may sign a statement to be retained by the provider, physician, or supplier. This form is signed by the patient when completing new patient paperwork or updating paperwork.

NOTE: This can be Signature on File, SOF, or a computer-generated signature. A date is only entered when a legal signature is used.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Accepting assignment means the provider bills the patient's insurance and receives payment directly from the patient's insurance. By accepting assignment, the provider or facility agrees to the payer's fee schedule.

Item 13—The patient's signature or the statement Signature on File, or SOF in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.

Item 14—Enter either an 8-digit (MM|DD|CCYY) or 6-digit (MM|DD|YY) date of current illness, injury, or pregnancy (LMP).

Enter the applicable qualifier to the right of the vertical dotted line to identify which date is being reported. Qualifiers include:

431 Onset of Current Symptoms or Illness

484 Last Menstrual Period

Medicare: Medicare does not use the qualifier information. Do not enter a qualifier for Medicare claims.

BILLING TIP

Medicare commonly rejects claims for an invalid future date within the Onset, Acute Manifestation, Initial Treatment, Accident, or Last Menstrual Period date fields.

Item 15—Enter another date related to the patient's condition or treatment in either an 8-digit (MM|DD|CCYY) or a 6-digit (MM|DD|YY) format. Check with your payers to determine if this item needs to be completed.

For Medicare: Leave blank. This item is not required.

Enter the applicable qualifier to identify which date is being reported:

454 Initial Treatment

304 Latest Visit or Consultation

453 Acute Manifestation of a Chronic Condition

439 Accident

455 Last X-ray

471 Prescription

090 Report Start (Assumed Care Date)

091 Report End (Relinquished Care Date)

444 First Visit or Consultation

Item 16—If the patient is employed and unable to work in his or her current occupation, enter an 8-digit (MM|DD|CCYY)

or 6-digit (MM|DD|YY) date of when patient is unable to work. An entry in this item may indicate employment related insurance coverage. If the patient is treated for a work-related injury, the claim is submitted to workers' compensation not the patient's medical insurance.

Item 17—Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. The name should be entered as First Name, Middle Initial, Last Name, followed by the provider's credentials. Do not use commas or periods. A hyphen can be used for a hyphenated name.

In addition to the information above, the supervising physician can also be reported in this field. When multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider (Qualifier DN)
2. Ordering Provider (Qualifier DK)
3. Supervising Provider (Qualifier DQ)

Enter the applicable qualifier to the left of the vertical dotted line.

Medicare: All physicians who order services or refer Medicare beneficiaries must report this data. When more than one provider is involved, use a separate CMS-1500 claim form for each referring, ordering, or supervising physician.

Item 17a—Enter the Other ID number of the referring, ordering, or supervising provider.

Enter the qualifier to indicate what number is being reported:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (used for the supervising provider only)

Medicare: Leave blank.

Item 17b—Enter the National Provider Identifier (NPI) of the referring/ordering/supervising physician or non-physician practitioner listed in item 17. NPIs are required for all providers and facilities. Application for NPIs can be submitted online through the CMS website.

Item 18—Enter either an 8-digit (MM|DD|CCYY) or a 6-digit (MM|DD|YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19—Payers have different uses for this item. For example, enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs. NOC means the code is unspecified and the code alone will not adequately report the drug administered. The drug administered needs to be identified for the payer to determine proper reimbursement.

In addition to the information above, report the appropriate qualifier to describe the identifier. Qualifiers can be found in the NUCC claim form manual and include general qualifiers and Workers' Compensation qualifiers for the report type and transmission type.

When modifier 99 (multiple modifiers) is entered in item 24d, enter all applicable modifiers. If modifier 99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a 99 modifier should be listed as follows: 1= (mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

BILLING TIP

Item 19 allows for supplemental claim information. Sometimes, an attachment containing the supplemental information is required. For example, when an unlisted procedure code is reported, the operative note may be required for the carrier to process the claim. Claims requiring attachments, that are submitted electronically, require paperwork (PWK) information in loop 2300 or 2400:

Segment	Electronic Description
PWK01	Report Type Code
PWK02	Transmission Code (BM = By mail, EL = Electronic only)
PWK05	Identification code qualifier = AC
PWK06	Identification code (Attachment control number)

Medicare carriers have specific coversheets to fax information using the control number to match the claim attachment to the electronic claim. Attachments for Medicare claims must be sent to the carrier within 7 days; otherwise, the claim will be processed without it.

Item 20—Complete this item when billing for purchased services by entering an X in YES (for example, diagnostic tests subject to the anti-markup payment limitation). This is not used in an ASC. When YES is marked, charges are entered to the left of the vertical line, justified right. See the example below for $25.00 charge.

Item 21—Enter the ICD-9-CM or ICD-10-CM codes for the patient's diagnosis/condition. Enter the codes without decimals in the proper coding sequence. The applicable ICD indicator

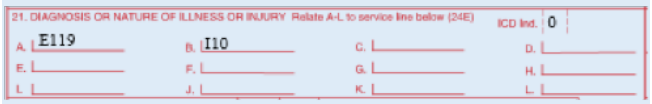
is entered to identify which version of ICD codes are being reported:

9 ICD-9-CM
0 ICD-10-CM

Do not insert a period in the ICD-9-CM or ICD-10-CM code(s).

EXAMPLE

E11.9 becomes E119



BILLING TIP

ICD-10-CM became effective October 1, 2015. Some payers may still accept ICD-9-CM codes (such as workers' compensation). You should never use both ICD-9-CM and ICD-10-CM on the same claim form.

Item 22—Enter the original reference number for resubmitted claims. Check with the payer to determine utilization of this field. When resubmitting a claim, enter the appropriate bill frequency:

7 Replacement of prior claim
8 Void/cancel of prior claim

This item number is not used for original claim submissions.

Medicare: Leave blank. Not required.

Item 23—The prior authorization number is entered here. Not all payers require a prior authorization. This item can also be used to report the referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer.

The 10-digit CLIA number can also be entered in this field when a CLIA covered procedure is performed. For providers reporting HCPCS codes G0181 or G0182, the NPI of the home health agency or hospice agency is entered here. Only one condition is reported in this field. Additional conditions are reported on a separate CMS-1500 claim form.

Item 24—The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

Item 24A—Enter a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "From" and "To" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required item. The claim will not be processed if a date of service extends more than 1 day and a valid "To" date is not present.

Item 24B—Enter the appropriate place of service code(s). Place of service codes can be found in the front of the CPT® code book. Place of service codes are necessary to support validity of services. For example, if E/M code 99285 (Level 5 emergency department visit) is billed with POS 11 (Office), this might trigger an edit. Emergency Department E/M codes can only be reported with POS 23 (Emergency Room-Hospital).

Item 24C—Not all payers require this item. For Medicaid, E is entered for an emergency. Other payers may require a Y for Yes or an N for No to indicate if the service was an emergency.

Medicare providers are not required to complete this item.

Item 24D—Enter the procedures, services, or supplies using CPT® and HCPCS Level II codes. You can also enter up to four modifiers. Do not use hyphens. When using an unlisted code (for example, 77499), a narrative description of the procedure should be included. When a narrative description is not included in the electronic file, it will cause a rejection of the claim. When more than four modifiers are required for a line item, enter modifier 99 here and the list of modifiers in Item 19.

Item 24E—Enter the diagnosis code reference letter as shown in item 21 to relate the date of service and the procedures performed to the diagnosis.

If there are two or more diagnoses that support a procedure code enter the reference letter for the primary diagnosis that supports the procedure first, then enter the other diagnosis codes as applicable. When multiple services are performed, enter the primary reference letter from A-L for each service first. Do not use commas if reporting multiple diagnosis reference letters for one service.

Medicare: Only the letter reference to the primary diagnosis is entered in Item 24E for Medicare patients. Only one reference letter is accepted per line item.

Item 24F—Enter the charge for each listed service.

Item 24G—Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. For anesthesia services based on time, the number of minutes must be reported as the units.

Item 24H—This item is used by Medicaid and reports services related to Early & Periodic Screening, Diagnosis, and

Treatment (EPSDT). If there is no requirement (for example, state requirements) to report a reason code, enter Y for Yes and N for No. If there is a state requirement, enter the two-character code for the reason. If there is a state requirement, refer to the NUCC Claims Manual for valid codes.

Medicare: Leave blank. Not required.

Item 24I—Enter the qualifier identifying if the number is a non-NPI. The qualifier identifies what type of number is used in 24J.

Medicare: Leave blank. Not required.

Item 24J—Enter the non-NPI number in the shaded area of the field and enter the rendering provider's NPI number in the unshaded portion. A common reason for electronic claims rejection is for an invalid NPI. Verify all NPI numbers are correct when entering them into the practice management system.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A–L to service line below (24E) ICD Ind. 0
A. I10 B. D2360 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	25	XX				11		99213	25	AB	160 00			NPI	1234567891
2	10	25	XX				11		11402		B	300 00			NPI	1234567891
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE

A provider removes 30 skin tags (11200, 11201 x 2) on a patient at his office on January 1, 20XX.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	XX	01	01	XX	11		11200		A	150 00	1		NPI	123456789
2	01	01	XX	01	01	XX	11		11201		A	100 00	2		NPI	123456789
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

In this example:

24A - The procedure was performed on January 1, 20XX. Date of service 01 01 XX is entered in 24A.

24B - The procedure was performed at the office. Place of Service code 11 is entered in 24B.

24C - Left blank for most payers.

24D - The procedure codes reported are 11200 and 11201 with no modifiers. Enter 11200 in line 1 and 11201 in line 2 for 24D (procedure 11201 is reported twice, this will be reported by adding 2 units to this line item in 24G).

24E - The diagnosis pointer is A. This refers to the ICD-10-CM code that is entered in Item 21A.

24F - The fee for 11200 is $150.00. The fee for two units of 11201 is $100.00. These amounts are entered in item 24F on the line item with the respective CPT® code.

24G - Days or Units. There is one unit of 11200 reported and two units of 11201 reported. 1 is reported in 24G for line item 1 and 2 is reported in 24G for line item 2.

24H - Left blank. This item is used for Medicaid EPSDT.

24I - Left blank. This item is used to report a non-NPI qualifier ID.

24J - The NPI of the provider is entered in the nonshaded portion.

BILLING TIP

Two of the top 10 reasons for electronic claims rejections by Medicare are for an invalid HCPCS Level II or CPT® code, or modifier for the date of service. The code sets are updated each year. Codes within a practice management system should be updated annually.

Item 25—Enter the Federal Tax ID number (Employer Identification Number or Social Security Number) of the provider of service or supplier and check the appropriate check box. This number is usually in the billing system and is not manually entered. A common reason for an electronic batch of claims to be rejected is when the Tax ID is not associated with the billing provider's NPI.

Item 26—Enter the patient's account number assigned by the provider of service's or supplier's accounting system. This item is optional to assist the provider in patient identification. Any account numbers entered here will be returned to the provider by the payer, so the patient can quickly be identified. Do not enter hyphens in this field. This field is typically auto populated by the practice management system.

Item 27—Check the appropriate block to indicate whether the provider of service or supplier accepts assignment. Accepting assignment means the provider agrees to the allowed amount (negotiated rate) for the charge.

BILLING TIP

When a provider accepts assignment, the difference between the charged amount and the allowed amount will be a contractual write-off for the provider.

Medicare requires the following types of providers to accept assignment:

- Clinical diagnostic laboratory services
- Physician services to individuals dually entitled to Medicare and Medicaid
- Participating physician/supplier services
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers
- Ambulatory surgical center services for covered ASC procedures
- Home dialysis supplies and equipment paid under Method II
- Ambulance services
- Drugs and biologicals
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine

Item 28—Enter total charges for the services (for example, total of all charges in item 24f). Do not enter a dollar sign. Dollars are entered to the left of the vertical line (justified right) and cents are entered to the right of the vertical line.

Item 29—Enter the total amount the patient and/or other payers paid on the covered services only. If the patient paid the copayment, enter the amount here.

Item 30—Leave blank. This field is reserved for NUCC use.

Item 31—Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|CCYY), or alpha-numeric date (for example, January 1, 2014) the form was signed. This can be completed as Signature on File, SOF, or a computer-generated signature. This field does not exist in the electronic version.

Item 32—Enter the address where the services were provided if different from the billing provider's address.

Item 32a—If required by the payer, enter the facility's NPI.

Item 32b—Enter the qualifier identifying the non-NPI number followed by the ID number.

Medicare: Leave blank.

Item 33—Enter the provider of service/supplier's billing name, address, 9-digit ZIP code (without the hyphen), and telephone number. This is a required item. The 5010A1 electronic version requires the billing provider address to be a physical address. This cannot be a P.O. box number. A P.O. box number in this field will cause the claim to be rejected.

Item 33a—Enter the NPI of the billing provider or group.

Item 33b—Enter the qualifier identifying the non-NPI number followed by the ID number. Qualifiers for use in the 5010A1 version are:

0B State License Number

G2 Provider Commercial Number

PXC Provider Taxonomy for electronic claims (ZZ is the Provider Taxonomy qualifier for paper claims)

Medicare: This field is generally left blank; however, you may be required by some carriers to complete this field. If the payer requires this field, follow the carrier's instructions.

For instruction on the proper completion of the CMS-1500 claim form for Medicare, see Medicare Claims Processing Manual Chapter 26 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf. For private payers, review the instructions provided in manuals or online resources. See the individual payer website for instructions.

Section Review 8.2

1. When two or more diagnoses codes reported in item 21 support a procedure, how many diagnosis codes should the provider report in item 24E for Medicare claims?

   A. 1
   B. 2
   C. 3
   D. Report all diagnosis codes applicable to the procedure.

2. When a provider "accepts assignment" the difference between the charged amount and the allowed amount:

   A. is billed to the patient.
   B. can be submitted again for reconsideration.
   C. is written off as patient hardship.
   D. is considered a contractual write off.

3. What is the appropriate POS code to report services rendered in an urgent care facility?

   A. 23
   B. 17
   C. 24
   D. 20

4. Item 14 Qualifier is used to indicate what information?

   A. Onset of Current Symptoms or Illness
   B. Location of injury
   C. LMP
   D. both a and c

5. Prior authorization is reported in Item 23. What other information can be reported in this area of the CMS-1500 claim form?

   A. Unlisted CPT® code(s)
   B. Mammography pre-certification number
   C. Patient identification number
   D. Patient account number

UB-04 (CMS 1450)

The UB-04 is submitted for inpatient and outpatient hospital, CAHs and CORFs. Each of the form locators will be discussed. Refer to the copy of the UB-04 form (Image 4.C) provided in this chapter to understand each form locator (FL) as it is explained. The electronic version of the UB-04 is the 837I.

EXAMPLE

This is an excerpt of the UB-04 Claim Form Map to the X12 837 Institutional Claim. This excerpt identifies how the item numbers discussed in this chapter relate to the electronic transmission of claims.

Field	Paper UB-04	Electronic 837I
Billing Provider's Service Location 9-digit ZIP Code	1	2010AA loop N403
Billing Provider NPI	56 NPI	2010AA loop NM108 = XX NM109 = NPI
Billing Provider Taxonomy	81CC a or b first box – B3 Qualifier second box – taxonomy code of billing provider	2000A loop PRV02 = ZZ PRV03 = taxonomy code
Billing Provider LPI	57 Prv ID	2010AA loop REF 02 = LPI
Attending Provider NPI	76 Attending	2310A loop NM108 = XX NM109 = NPI

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME	9 PATIENT ADDRESS
10 BIRTHDATE	11 SEX
12 ADMISSION DATE	13 HR
14 TYPE	15 SRC
16 DHR	17 STAT
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	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

	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

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

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				A
B				B
C				C

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

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

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	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	81CC a	b	c	d

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
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. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

Image 4.C

FL 1—Billing Provider Name, Address, and Telephone Number

The minimum entry is the provider name, city, state, and nine-digit ZIP Code. Phone and/or Fax numbers are desirable. This information is in the billing system and does not require keying for each claim.

FL 2—Billing Provider's Designated Pay-to Name, Address, and Secondary Identification FLs. This FL is not required.

FL 3a—Patient Control Number-The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes. This is assigned by the facilities system to help quickly find the patient's account for the date of service billed.

FL 3b—Medical/Health Record Number-The number assigned to the patient's medical/health record by the provider (not FL3a). This number is assigned by the facility.

FL 4—Type of Bill. This four-digit alphanumeric code gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third digit classifies the type of care. The fourth digit indicates the sequence of this bill in this particular episode of care. It is referred to as a frequency code.

Code Structure

2nd Digit-Type of Facility
(CMS will process this as the 1st digit)

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Clinics Only)
(CMS will process this as the 2nd digit)

3rd Digit-Classification (Special Facilities Only)
(CMS will process this as the 2nd digit)

4th Digit-Frequency—Definition (CMS will process this as the 3rd digit)

Bill Type Codes reported by outpatient facilities:

Bill Type Code	
013X	Hospital Outpatient
018X	Hospital Swing Bed
072X	Clinic ESRD
073X	Clinic—Freestanding
074X	Clinic OPT
075X	Clinic CORF
083X	Hospital Outpatient (ASC)
085X	Critical Access Hospital

FL 5—Federal Tax Number. The format is NN-NNNNNNN. This information is stored in the billing system and is not keyed for every claim.

FL 6—Statement Covers Period (From-Through). The facility enters the beginning and ending dates of the period included on this bill in numeric format (MMDDYY).

FL 7—This FL is not used.

FL 8—Patient's Name/ID. The provider enters the patient's last name, first name, middle initial (if applicable), along with patient ID (if different than the subscriber/insured's ID).

FL 9—Patient's Address. The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, state, and ZIP Code. This information is obtained when the patient is admitted. A photocopy of the patient's ID is required to verify the patient's address and identity.

FL 10—Patient's Birth Date. The facility enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits. This information can be confirmed with a copy of the patient's photo ID.

FL 11—Patient's Sex. The provider enters an "M" (male) or "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

FL 12—Admission/Start of Care Date. This FL is required for inpatient, home health, hospice, and outpatient rehab/facility.

FL 13—Admission Hour. This information is not required.

FL 14—Priority (Type) of Admission or Visit. For example, one in this FL indicates an emergency.

FL 15—Point of Origin for Admission or Visit. The provider enters the code indicating the source of the referral for this admission or visit. For example, seven indicates emergency room.

FL 16—Discharge Hour. This is not required.

FL 17—Patient Discharge Status. This code indicates the patient's discharge status as of the through date of the billing period (FL 6).

An example is 01 Discharged to home or self-care. Medicare has identified invalid information in this FL as being one of the top 10 reasons for an electronic claim rejection.

FLs 18-28—Condition Codes. The provider enters the corresponding code (in ascending order, beginning with numbers followed by letters) to describe any conditions or events that apply to the billing period.

For example, condition code 44 is reported when the physician orders inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. In this case, the claim is submitted as outpatient.

FL 29—Accident State. This FL is not used.

FL 30—(Untitled). This FL is not used.

FLs 31, 32, 33, and 34—Occurrence Codes and Dates. The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). Numbered codes are entered before alphabetical codes in the following order: 31A - 34A followed by 31B - 34B. When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

An example of an occurrence code is 04 Accident employment related. This is an indication it is a workers' compensation claim.

FLs 35 and 36—Occurrence Span Code and Dates. This is for inpatient only. Do not complete for outpatient claims.

FL 37—(Untitled). This FL is not used.

FL 38—Responsible Party Name and Address. This FL is not used.

FLs 39, 40, and 41—Value Codes and Amounts. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of the claim. The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line A through line D. The provider uses FLs 39A through 41A before 39B through 41B (for example, it uses the first line before the second). For example, 50 is for physical therapy visits.

FL 42—Revenue Code. The facility enters the appropriate revenue codes to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed Total Line in the charge area. The facility must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the facility must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible. An example of a revenue code is 0450 for emergency department.

FL 43—Revenue Description/IDE Number/Medicaid Drug Rebate. This is not a required FL. The facility can use this form locator to enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43.

FL 44—HCPCS/Rates/HIPPS Rate Codes. For outpatient claims, enter the CPT® and HCPCS Level II codes. The UB-04 accommodates up to four modifiers, two characters each. Medicare has identified invalid information within the HCPCS field as one of the top 10 claims submission errors.

FL 45—Service Date. This is a required FL for outpatient services. Community Mental Health Centers (CMHC) and hospitals (with the exception of CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X, 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012X and 022X). If a service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

FL 46—Units of Service. The entries in this column quantify services by revenue code category (for example, number of days in a particular type of accommodation, pints of blood). When reporting the procedure codes, the units indicate the number of times the procedure was performed.

FL 47—Total Charges. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a CPT® or HCPCS Level II procedure code, where the provider sums the total charges for the billing period for each procedure code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00).

FL 48—Non-covered Charges. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49—(Untitled). This FL is not used.

Note: the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A, B, and C—Payer Identification

If Medicare is the primary payer, the provider must enter Medicare on line A. Entering Medicare indicates that the provider has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.

FL 51A, B, and C—Health Plan ID. Report the NPI.

FLs 52A, B, and C—Release of Information Certification Indicator. A Y code indicates that the provider has on file a signed statement permitting it to release data to other organizations to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA privacy rule by requiring that a signature be collected. An I code indicates informed consent to release medical information for conditions or diagnoses regulated by federal statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA privacy rule by requiring a signature be collected.

FL 53A, B, and C—Assignment of Benefits Certification Indicator. These FLs are not used.

FLs 54A, B, and C—Prior Payments. Situational. For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient towards deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column.

FL 55A, B, and C—Estimated Amount Due from Patient. This is not required.

FL 56—Billing Provider National Provider ID (NPI). Each provider and facility is required to have an NPI. Two of the top 10 reasons Medicare rejects institutional electronic claims is due to the billing provider NPI not being associated with the billing provider's Tax ID or for the billing provider's NPI being invalid.

FL 57—Other Provider ID (primary, secondary, and/or tertiary). This FL is not used.

FLs 58A, B, and C—Insured's Name. The name of the insured is entered here. This information is obtained from the patient's insurance card. The name on the claim must match the beneficiary's name on the Medicare ID card identically. Incomplete or invalid completion of this field is one of the top 10 claim submission errors identified by Medicare.

FL 59A, B, and C—Patient's Relationship to Insured. This is represented by a two-character code for each payer in A-C. This is completed to communicate to the payer the relationship between the insured and the patient. This information is obtained from the patient during registration.

FLs 60A, B, and C—Insured's Unique ID Number (Certificate/Social Security Number/Medicare beneficiary identifier). This is the policy ID assigned by the payer. This information is on the patient's insurance card.

FL 61A, B, and C—Insurance Group Name. Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a Workers' Compensation (WC) or an Employer Group Health Plan (EGHP) is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C—Insurance Group Number. Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63A, B, and C—Treatment Authorization Code. Required when an authorization or referral number is assigned by the payer. Whenever quality improvement organization (QIO) review is performed for outpatient preadmission, pre-procedure, or home intravenous (IV) therapy services, the authorization number is required for all approved admissions or services.

FL 64A, B, and C—Document Control Number (DCN). The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65A, B, and C—Employer Name (of the Insured). Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides healthcare coverage for the individual identified on the same line in FL 58.

FL 66—Diagnosis and Procedure Code Qualifier (ICD Version Indicator). The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9—Ninth Revision, 0—Tenth Revision.

FL 67—Principal Diagnosis Code. The hospital enters the ICD-10-CM (or ICD-9-CM if the payer does not accept ICD-10-CM) code for the principal diagnosis, which is the main reason for the encounter.

FLs 67A-67Q—Other Diagnosis Codes. Report as many ICD-10-CM codes as necessary to report the diagnoses of the patient.

FL 68—Reserved. This FL is not used.

FL 69—Admitting Diagnosis. This is required for inpatient claims.

FL70A–70C—Patient's Reason for Visit. This FL is required for Medicare institutional claims processing on Type of Bill 013x and 085x when; a) Form Locator 14 (priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.

If the Patient's Reason for Visit is not required, it may be reported on other 013x and 085x bill types that fail to meet the criteria in a) or b) above at the sender's discretion when this information substantiates the medical necessity of services

The ICD-10-CM codes to identify the reason for the patient's visit are entered here.

FL71—Prospective Payment System (PPS) Code. This FL is not used.

FL72—External Cause of Injury (ECI) Codes. Usually this FL is not used unless the payer requires external cause codes, which identify the external cause of an injury (for example, fall or car accident).

FL 73—Reserved. This FL is not used.

FL 74—Principal Procedure Code and Date. This FL is required for inpatient claims. ICD-10-PCS codes are reported for inpatient procedures.

FL 74A–74E—Other Procedure Codes and Dates. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.

FL 75—Reserved. This FL is not used.

FL 76—Attending Provider Name and Identifiers (including NPI). Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported for the encounter. A common reason for Medicare rejecting an electronic claim is for invalid or missing information in the attending physician field.

Secondary Identifier Qualifiers:

0B—State License Number

1G—Provider UPIN Number

G2—Provider Commercial Number

FL 77—Operating Provider Name and Identifiers (including NPI). Required when a surgical procedure code is listed on the claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s) is listed here.

Secondary Identifier Qualifiers:

0B—State License Number

1G—Provider UPIN Number

G2—Provider Commercial Number

FLs 78 and 79—Other Provider Name and Identifiers (including NPI). The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

DN—Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. If not required by the payer, do not send.

ZZ—Other Operating Physician. An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. If not required by the payer, do not send.

Secondary Identifier Qualifiers:

0B—State License Number

1G—Provider UPIN Number

G2—Provider Commercial Number

FL 80—Remarks. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but is necessary for proper payment.

FL 81—Code-Code FL. Used to report additional codes related to a FL or to report external code list approved by the NUBC for inclusion to the institutional data set.

For complete instructions for proper UB-04 completion see Medicare Claims Processing Manual chapter 25. For private payers, review the instructions provided in manuals or online resources. See the individual payer website for instructions.

Section Review 8.3

1. The abbreviation FL refers to:

   A. Fill line
   B. Form line
   C. Form locator
   D. Fill locator

2. What is the type of bill code that is reported for a free-standing clinic?

   A. 073X
   B. 074X
   C. 085X
   D. 075X

3. Guidelines for proper completion of claim forms can be found by referencing:

   A. The back of the paper claim form
   B. Private payer website and policy manual
   C. Medicare Claims Processing Manual
   D. Both b and c

4. When reporting procedure codes on the UB-04 claim form, FL46- Units of Service:

   A. indicates the number of days the patient was in the facility.
   B. indicates the number of times the procedure was performed.
   C. indicates the order in which the procedure was performed, i.e. first, second, third, etc.
   D. is not a required field.

5. A patient is admitted to the hospital with pneumonia. Which FL would be used to report the patient's admitting diagnosis?

   A. FL 68
   B. FL 70
   C. FL 65
   D. FL 69

Glossary

Adjudication—Determination of the insurer's payment amount after the member's insurance benefits have been applied

Claim Form—Used to report the procedures performed and the reason the procedures were performed to the insurance carrier to obtain payment for those services.

Edit—A tool used in the electronic claims process that checks and evaluates claims data received against payer's predefined criteria.

Electronic Data Interchange (EDI)—computer to computer exchange of business documents in a standard format, between business partners.

Ordering Provider—The physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident-to that physician's or non-physician practitioner's service.

Referring Provider—The provider who requests an item or service for the beneficiary.

Supervising Provider—The provider who provided oversight of the rendering provider and the care being reported.

Important Links:

Fact Sheet for Medicare Billing: 837I and Form CMS-1450

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

Fact Sheet for Medicare Billing: 837P and Form CMS-1500

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

Medicare Claims Processing Manual

https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html