

UB-04 Overview

Sponsored by the Maine
Chapter of AAHAM

Presented by the
State of Maine Uniform Billing
Committee

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Agenda

- Background
 - NUBC
 - HIPAA
 - NPI
- UB04
 - Implementation
 - Form Locators & Crosswalk
 - Payer examples

Background

NUBC
National Uniform Billing
Committee

UB Process - NUBC

- The NUBC was formed in 1975 to develop a single healthcare claim billing form and standard data set for use nationwide by all institutional providers and payers.
 - Includes participation by all major national provider and payer organizations
 - Strives to balance the need for information against the burden of providing that information.
 - Applies administrative simplification principles as mandated by HIPAA (1966)
- The UB82 was the first uniform data set approved
 - To assist with implementation of the UB82, State Uniform Billing Committees were formed (SUBC).

UB Process – Oversight and Changes

- The UB92 evolved as NUBC/SUBC improved on the institutional data-set.
- Ongoing changes and revisions are achieved through the NUBC and the individual SUBCs
 - As change requests are submitted for consideration, the NUBC meets, comments, and passes minutes to the SUBC.
 - SUBCs comment, NUBC reviews, and change requests are revised, rejected, and implemented.
- UB04 is necessary to further implement requirements of HIPAA regulations.

Health Insurance Portability and Accountability Act

HIPAA

HIPAA

- HIPAA supports privacy, security, insurability, and establishes electronic standards for health care providers and payers
- The Federal Dept of Health and Human Services is responsible for HIPAA oversight
 - HIPAA privacy (PHI) and security regulations are familiar topics
 - *Claims and remittance advices used by payers and providers who communicate electronically are also affected by this law*

HIPAA Goals

- Goals are to establish a generic methodology for health insurance related patient/recipient billing, payment reports, inquiries about eligibility, and requests for claim status
 - Eliminates proprietary methods of electronic billing
- A common systematic language/format, ANSI, (American National Standards Institute) was selected for use to create these electronic communication queries



HIPAA Electronic Standards

- There are 4 core standard electronic transactions that support the needs of payers and providers
 - ***ANSI 837- the claim***
 - ANSI 835- the remittance advice
 - ANSI 270/271- patient eligibility information request and response
 - ANSI 276/277- insurance claim status and reply
- ***UB92 needed revisions to comply with the ANSI 837***

HIPAA Content Standards

Congress also established data content standards within the HIPAA regulation

- Some have been defined and are being implemented
 - National Provider Identifiers (NPI)
 - Taxonomy
- More to come in future months
 - National Payer Codes
- These data content standards are mandated by HIPAA for all payers/providers who trade information electronically

National Provider Identifier (NPI)

The first initiative associated with data content standardization is NPI conversion

NPI Definition

- Standard unique identifier for health care providers
 - 10 characters, intelligence free, numeric identifier
 - Replaces current provider identifiers such as PIN, UPIN, Payer specific provider ID number
 - Will never change; provider will carry it regardless of change in status or location
 - Unlike prior payer specific provider identifiers!

NPI - Who needs it ?

- Individuals (Entity type 1)
 - Physicians, nurse practitioners, psychologists, etc
- Organizations (Entity type 2)
 - Hospitals, home health agencies, clinics, nursing homes, group practices
 - Sub-Parts
 - Components of the parent company, who conduct their own separate HIPAA standard transaction, may be certified separately from the parent by the State, such as swing bed, psychiatric distinct part unit, rural health clinic

NPI - How to apply?

FOX Systems was selected to enumerate and process applications for the NPI

- Paper application

- <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

- Online application

- <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

- Electronic File Interchange

- http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp#TopOfPage

NPI ENUMERATION ISSUES

- May 2007 – CMS will be performing maintenance and implementing changes to the National Plan and Provider Enumeration System (NPPES)
- The upcoming changes in NPPES will impact the Electronic File Interchange (EFI) XML Schema.
- EFI process in NPPES will not be available for EFI file submission from April 20 – May 7, 2007.

NPI ENUMERATION ISSUES

- Once the NPPES changes have been completed (May 7th), EFI files can be submitted using the new EFI XML Schema (EFI schema version 5/07/2007).
- After May 7th, any EFI files received with the old EFI XML Schema will be rejected.

NPI ENUMERATION ISSUES

- The inability to submit EFI files containing NPI application data from April 20-May 7 could cause providers problems in their abilities to meet the compliance date.
- The web-based NPPES application process is available now, and will be available during the April 20 – May 7 period when the EFI capability will not.

NPI National Implementation Timeline

- May 23, 2005 - January 2, 2006
 - Providers use existing Medicare provider number
- January 3, 2006 - October 1, 2006
 - Providers may use NPI but Legacy also required
- October 2, 2006 - May 22, 2007
 - Providers may use NPI and/or Legacy numbers
 - ***Recommendation: Continue submission of Legacy***
- May 23, 2007 - NPI only: **Contingency Plans**
 - ***Recommendation: Continue submission of Legacy***
- May 2008
 - Non HIPAA entities (small providers)

CMS

NPI Contingency
Announcement

CMS NPI Contingency Announcement

On April 2, 2007 CMS announced that:

“...it is implementing a contingency for covered entities (other than small health plans) who will not meet the May 23, 2007 deadline for compliance with the National Plan Identifier.....”

CMS NPI Contingency Announcement

“Covered entities that have been making a **good faith effort to comply** with the NPI provisions may, for up to 12 months, implement contingency plans that could **include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flow**”

CMS Press Release April 2, 2007

CMS NPI Contingency

Good Faith Efforts are comprised of:

Sustained Actions

Demonstrable Progress

CMS NPI Contingency

In determining whether a good faith effort has been made, CMS will place strong emphasis on:

- sustained actions and
- demonstrable progress.

A covered entity may end its contingency plan before May 23, 2008 but it cannot extend it beyond that date.

CMS NPI Contingency

Indications of Good Faith:

- Increased external testing with trading partners
- Lack of availability of, or refusal by, the trading partner(s) prior to May 23, 2007 for health plans (other than small health plans) to test the transaction(s) with the covered entity whose compliance is at issue.
- In the case of such a health plan, concerted efforts in advance of May 23, 2007 and continued efforts afterwards to conduct outreach and make testing available to its provider community.
- For a health care provider, having obtained an NPI and having the ability to use it on HIPAA transaction

CMS NPI Contingency

Examples of good faith efforts to comply:

1. Internal NPI Plans
2. Internal NPI Registry (credentialing)
3. Medical Staff By Law changes
4. IT NPI Discussions, Sales Presentations, etc
5. Correspondence to trading partners/providers
6. Minutes – Board Meetings
 - Department Heads
 - Quality Assurance
 - Medical Staff
 - Internal Education Programs
 - External Education Programs i.e. NHIC, WEDI, etc.
7. Newsletters – Ones you subscribe
 - Ones you produce

NPI CONTINGENCY GUIDANCE

Organizational Contingency Plan
should address three transaction
scenarios:

1. Legacy Only Transactions
2. Legacy and NPI (dual use) Transactions
3. NPI Only Transactions

NPI COMPLIANCE GUIDANCE

1. Immediate establish intent of major payers re: their contingency plan(s)
2. Determine organizational contingency plan
3. Review and/or revise organizational NPI plan
4. Formally assess organizational NPI compliance

NPI COMPLIANCE GUIDANCE

5. Inventory trading partner NPI status
6. Create organizational NPI contingency plan;
Emphasize failure to comply consequences
7. Obtain governing body ratification
8. Implement

CMS NPI Contingency

- Each covered entity will determine the specifics of its contingency plan
- Contingency plans may not extend beyond May 23, 2008 but entities may elect to end their contingency plan sooner
- CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance

NPI Data Dissemination

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions. CMS plans to make data available from the NPPES system that will assist covered entities in developing these “crosswalks.”

CMS NPI Contingency Press Release
April 2, 2007

CMS NPI Contingency

The Contingency Plan enforcement process “**is complaint driven** and will allow covered entities to demonstrate good faith efforts and employ contingency plans.

If a complaint is filed against a covered entity, CMS will evaluate the entity’s “**Good faith efforts**” to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues.”

CMS Press Release April 2, 2007

CMS NPI Contingency

- CMS will focus on voluntary compliance and use a complaint driven approach for enforcement.
- When CMS receives a complaint about a covered entity that appears to allege a failure to comply with a non-privacy administration simplification provision of HIPAA , it will notify the entity in writing that a complaint has been filed.

CMS NPI Contingency

Following notification from CMS, the Entity will have the opportunity to

1. Demonstrate compliance
2. Document its good faith efforts to comply with the standards
3. Submit a corrective action plan

Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule After the May 23,2007 Implementation Deadline

CMS NPI Contingency

“HHS may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period.”

Section 1176(b) of the Social Security Act

Guidance on Compliance with the HIPAA National
Provider Identifier
(NPI) Rule After the May 23, 2007 Implementation
Deadline

CMS NPI Contingency

“HHS has the authority under the statute (Section 1176(b)) to extend the period within which a covered entity may cure the noncompliance “based on the nature and extent of the failure to comply”

Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule After the May 23, 2007 Implementation Deadline

CMS NPI Contingency

For a 12 month period after the compliance date
(i.e. through May 23, 2008)

CMS will not impose penalties on covered entities
that deploy contingency plans

(in order to ensure the smooth flow of payments)

if they have made reasonable and diligent efforts
to become compliant and,

In the case of health plans

(that are not small health plans)

to facilitate the compliance of their trading partners.

CMS NPI Contingency

Specifically as long as a health plan (that is not a small health plan) can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers .

CMS Fee For Service Contingency Plan

CMS will allow legacy ID's for primary payers (billing, pay to and rendering) until a sufficient level of primary payer NPI compliance enables rejecting claims without primary payer NPI's.

CMS will assess NPI primary payer compliance during May and June and notify contractors, providers and others when NPI's are required for processing.

CMS Fee For Service Contingency Plan

For all other Secondary providers (referring, ordering, supervising, facility, care plan oversight, purchase service, attending and operating and “other” providers legacy numbers will be acceptable until May 23, 2008.

CMS Fee For Service Contingency Plan

NPI and legacy claims accepted through
May 23, 2008.

After May 23, 2008 only NPI claims

NPI SHARING

Entity to Entity Sharing

Health plans and other health care industry entities may disclose health care providers' NPIs in directories and listings for dissemination to other health industry entities for purposes of using the NPIs in HIPAA standard transactions.

NPI SHARING

Entity to Entity Sharing

While disclosures of health care providers' NPIs by health care industry entities to other health care industry entities for purposes of using NPIs in HIPAA standard transactions do not appear to violate any Federal laws, the entities making such disclosures should ensure that such disclosures do not violate any State laws.

NPI SHARING

Entity to Entity Sharing

CMS encourages health care industry entities who plan to make disclosures described above to ensure that the affected health care providers are aware, beforehand, of these plans and that the affected health care providers do not object to such disclosures.

NPI SHARING

Entity to Entity Sharing

If disclosures are made without the affected health care providers' knowledge or consent, the entities making the disclosures could be faced with adversarial actions on the part of any or all of the affected health care providers.

CMS NPI Contingency

“CMS Recognizes that transactions often require the participation of two covered entities, each of whom is required to comply with HIPAA, and that non compliance one covered entity may put the second entity in a difficult position.”

Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule After the May 23,2007 Implementation Deadline

UB04

UB04 - New form to replace the UB92

■ Transitory period

- March 1, 2007 through May 22, 2007
- Crosswalk of UB92 to UB04 available
- CMS publications
 - CR 5072 published by Medicare – 7/28/06
 - MedLearn MM5072
- Interim instruction:
 - <http://www.cms.hhs.gov/transmittals/downloads/R1018CP.pdf>

UB-04 *Factoids*

■ Form changes

- Current ANSI 837 implementation guide supports most data reporting requirements of the UB 04 (data content) so...
- Paper form has major changes
 - Vendor updates to billing software

■ Testing

- Claims submission testing is needed
 - Providers should test internally to ensure that all fields are accurately dropping to claims database.

UB-04 Form Locator Changes

Form Locators have been:

- Eliminated
- Moved
- Expanded

UB-92: What FL's are gone?

Form Locator (FL):

- 07 08 09 10
- 16
- 57
- 64
- 66
- 85 86

UB-92: Form Locators that have been moved or significantly revamped:

- 23
- 37 a b c
- Charge section...line 23
- 51 and 56
- 67 thru 77
- 79
- 82 & 83
- 84

UB-04: What's new

- FL 02: Pay-to address
- FL 3 b: Medical record number
- FL 4: Type of Bill is four characters
- FL 8a: National patient identifier
- FL 29: Auto accident state
- FL 18 thru 41: Expanded
- Charge Section, Line 23:
 - Page numbering
 - Claim creation date
 - 0001 and Total Charges

UB-04 More New FL's:

- Payer section-No more ESC codes or Employer location
 - FL 51: Health plan ID
 - FL 56: NPI
 - FL 57: Other provider ID
 - FL 64: DCNs
- FL 66: ICD 9 or 10?
- FL 67 A thru Q and 72: Expanded; POA indicator
- FL 70: Patients reason for visit
- FL 71: PPS code
- FL 76 thru 79: NPIs and Qualifiers
- FL 80 & 81: Defined fields, overflow codes

UB 04 – Field and Layout Changes

- New Fields or new Layouts
 - FL 02 Pay to-
 - Name, address, State
 - FL 24 Condition Codes
 - Additional fields
 - FL 29 Accident State
 - State where Auto accident occurred
 - FL 45 Creation Date – line 23 multiple bills
 - FL 70 – Patient reason for visit
 - For unscheduled OP (includes ED)
 - FL 66 DX version code (ICD9 or ICD10)

UB 04 - New Fields or Layouts – con't

- FL 67 A thru Q Diagnosis fields (added and expanded)
 - Medicare reads A-I
 - Allows for present on admission flag
- FL 71 PPS Code
- FL 72 External Cause of Injury Code
 - Additional fields
- Fl 76 thru 79 NPI/Qualifying ID
 - New layout – includes taxonomy
 - New fields added

UB 04 Moved or Deleted Data Fields

■ Moved

- FL 03 a thru b
 - Patient control number
 - Medical record number
- FL 37 ICN/DCN
 - Moved to FL 64
- FL 82-83 Attending, Other physician
 - Moved to FL 76-79

■ Deleted

- FL 07 Covered days (use value code 80)
- Fl 08 Non covered days (use value code 81)
- Fl 09 /10 Coins and LTR days (use value codes 82 and 83)
- Fl 16 Marital status
- Fl 23 Med record number (moved to FL 3b)
- FL 79 Proc Coding method
- FL 85 Pt rep signature
- FL 86 Date bill submitted

UB 04 Expanded Data Fields

- Expanded
 - Fl 04 Bill Type
 - FL 44 HCPCS/CPT codes 9 to 14 bytes
 - Fl 74 a thru d procedure codes w/dates

1										2										3a PAT. CNTL #				4 TYPE OF BILL										
																				b. MED. REC. #														
																				5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH								
8 PATIENT NAME										9 PATIENT ADDRESS																								
d										b										c				d		e								
10 BIRTHDATE			11 SEX	12 DATE			ADMISSION 13 HR		14 TYPE	15 SRC		16 CHR	17 STAT	18	19	20	21	CONDITION CODES								22	23	24	25	26	27	28	29 ACCT STATE	30
31 OCCURRENCE CODE			DATE	32 OCCURRENCE CODE			DATE	33 OCCURRENCE CODE		DATE	34 OCCURRENCE CODE		DATE	35 OCCURRENCE SPAN CODE		FROM	THROUGH		36 OCCURRENCE SPAN CODE		FROM	THROUGH		37										
38										39 VALUE CODES CODE				AMOUNT				40 VALUE CODES CODE				AMOUNT				41 VALUE CODES CODE		AMOUNT						
										a				:				:				:		:										
										b				:				:				:		:										
										c				:				:				:		:										
										d				:				:				:		:										

UB 04 - Top

UB 92

- FL1: Provider
- FL 2: Unlabeled
- FL 3: Patient Control
- FL 4: Type of Bill
- FL5: Federal tax ID
- FL 6: Statement covers period
- FL 7: Covered Days

UB 04

- FL 1: Provider
- FL 2: Pay to Name
- FL 3a: Pt Control Number
- FL 3b: Medical Record No.
- FL 4: Type of bill
- FL 5: Tax ID #
- FL 6: Stmt covers period
- FL 7: Reserved for future use

UB 04 - Patient

UB-92

- FL 8: NonCovered Days
- FL 9: Coinsurance Days
- UB04 uses Value codes
 - 80=Covered days
 - 81=Non-covered days
 - 82=Coinsurance days
 - 83=Lifetime reserve days

UB-04

- FL 8a: Patient Identifier
- FL 8b: Patient name
- FL 9a: Street address
- FL 9b: City
- FL 9c: State
- FL 9d: Zip (9 not required)
- FL 9e: Country code if not USA

UB 04 – FL 10 thru 12

UB-92

- FL 10: Lifetime Reserve Days
- FL 11: Unlabeled
- FL 12: Patient Name

UB-04

- FL 10: Patient Birth Date
- FL 11: Patient Sex Code
- FL 12: Admission date

UB 04 – FL 13 thru 15

UB-92

- FL 13: Patient Address
- FL 14: Patient Birth Date
- FL 15: Patient Sex

UB-04

- FL 13: Admission Hour
- FL 14: Admission Type
- FL 15: Admission Source

UB 04 – FL 16 and 17

UB-92

- FL16: Marital status
- FL17: Admission date

UB-04

- FL 16: Discharge Hour
- FL 17: Discharge Status

UB 04 Condition codes

UB-92

- FL 18: Admission Hour
- FL 19: Type of admission
- FL 20: Source of admission
- FL 21: Discharge hour
- FL 22: Discharge status
- FL 23: Medical Record Number
- FL 24 – 30: Condition codes

UB-04

- FL 18 thru 28:
Condition codes

UB 04 Accident State thru Occurrence Span codes

UB-92

- FL 24-30: Condition Codes
- FL 31: Unlabeled
- FL 32a b – 35a b:
Occurrence codes & dates
- FL 36a b: Occurrence span
codes and dates

UB-04

- FL 29: Accident State
- FL 30: Reserved for future
NUBC use
- FL 31 a b – 34 a b:
Occurrence codes & dates
- FL 35 a b – FL 36 a b:
Occurrence span codes and
dates

UB 04 FL 27 thru Value codes

UB-92

- FL 37: ICN/DCN
- FL 38: Payer name/address
- FL 39a b c d – 41a b c d:
Value codes and amounts

UB-04

- FL 37: Reserved for future NUBC use
- FL 38: Payer name/address
- FL 39a b c d -41a b c d:
Value codes and amounts

UB04 – Charge section

UB-92:

- FL 42: Revenue code
- FL 43: Description
- FL 44: HCPCS/ Rate/
HIPPS Code
- FL 45: Service date
- FL 46: Service units
- FL 47: Total charges
- FL 48: Noncovered chgs
- FL 49: Reserved

UB-04 – on Line 23:

- FL 42: 0001 on last page only
- FL 43: Page __ of __
- FL 44: Creation Date printed
on form
- FL 45: Date claim created
- FL 46: TOTALS pre-printed
- FL 47: Total on last page only
- FL 48: Total on last page only
- FL 49: Reserved

50 PAYER NAME	51 HEALTH PLAN ID		52 REL INFO	53 ASS GEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
					:	:	ST	
					:	:	OTHER	
					:	:	PRV ID	
58 INSURED'S NAME		59 REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		

UB 04 – Payer section, Lines a b c

UB-92

- FL 50: Payer name
- FL 51: Provider number
- FL 52: Release of Information
- FL 53: Assignment of benefits
- FL 54: Prior payments
- FL 55: Estimated amount due
- FL 56: Unlabeled
- FL 57: Unlabeled/Due from patient

UB-04

- FL 50: Payer name
- FL 51: Health Plan ID (NEIC code)
- FL 52: Release of information
- FL 53: Assignment of benefits
- FL 54: Prior payments
- FL 55: Estimated amount due
- FL 56: NPI
- FL 57: Other Provider ID (Legacy number)

Payer section, continued:

- FL 58: Insureds name
 - FL 59: Patient relationship to insured
 - FL 60: Policy number
 - FL 61: Group name
 - FL 62: Insurance group number
- FL 58: Insureds name
 - FL 59: Patient relationship to insured
 - FL 60: Policy number
 - FL 61: Group name
 - FL 62: Insurance group number

Payer section, FL 63-65

- FL 63: Treatment auth codes
- FL 64: Employer Status code
- FL 65: Employer name
- FL 66: Employer location
- FL 63: Treatment auth codes
- FL 64: Document Control Number
- FL 65: Employer name

66 DX	67	A	B	C	D	E	F	G	H	68		
	I	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	d.	OTHER PROCEDURE CODE	DATE	b.	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL	
										LAST	FIRST	
										77 OPERATING NPI	QUAL	
										LAST	FIRST	
										78 OTHER NPI	QUAL	
										LAST	FIRST	
80 REMARKS			81 CC a							79 OTHER NPI	QUAL	
			b							LAST	FIRST	
			c							79 OTHER NPI	QUAL	
			d							LAST	FIRST	

UB-04 CMS-1450

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB 04 – Diagnosis code section

UB-92

- FL 66: Employer location
- FL 67: Principal diagnosis code
- FL 68 – 75 Additional dx codes
- FL 76: Admitting dx code
- FL 77: E code
- FL 78: Reserved

UB-04

- FL 66: Dx and Procedure Code qualifier
- FL 67: Principal dx code with POA indicator
- FL 67 A – Q: Additional dx codes with POA indicator
- FL 68: Reserved
- FL 69: Admitting dx
- FL 70: Patient reason for visit
- FL 71: PPS code
- FL 72: E codes
- FL 73: reserved

UB 04 – Procedure codes

UB-92

- FL 68 – 75 Additional dx codes
- FL 76: Admitting dx code
- FL 77: E code
- FL 78: Reserved

UB-04

- FL 74: Principal Procedure Code/Date
- FL 74 a thru e: Other procedure codes and dates
- FL 75: Reserved

UB 04 – Attending and Operating

UB-92

- FL 76: Admitting
Diagnosis Code
- FL 77: E Code

UB04

- FL 76: Attending
Physician NPI, Name,
Qualifier and Legacy ID
- FL77: Operating
Physician NPI, Name,
Qualifier and Legacy ID

UB 04 – Other providers

UB-92

- FL 78: Unlabeled
- FL 79: Principal Coding method

UB-04

- FL 78: Other Provider Qualifier, NPI, Name and Qualifier and Legacy ID
- FL 79: Other Provider Qualifier, NPI, Name and Qualifier and Legacy ID

UB 04

UB-92

- FL 80: Principal Procedure Code/Date
- FL 81 A thru E: Other Procedure Code/Date

UB-04

- FL 80: Remarks
- FL 81: Code Code field

...the end...

UB 04

UB-92

- FL 82: Attending Physician ID
- FL 83: Other Physician ID
- FL 84: Remarks
- FL 85: Provider Rep Signature
- FL 86: Date

UB-04

- FL 82: Eliminated
- FL 83: Eliminated
- FL 84: Eliminated
- FL 85: Eliminated
- FL 86: Eliminated

1		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM THROUGH			
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ADOT	
30 STATE		31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE	
34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE	
38		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES	
39 CODE		AMOUNT		40 CODE		AMOUNT	
41 CODE		AMOUNT		42 REV. CD.		43 DESCRIPTION	
44 HCPCS / RATE / HPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
48 NON-COVERED CHARGES		49		50 PAYER NAME		51 HEALTH PLAN ID	
52 REL. PFD		53 ASL. SKN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	
56 INSURED'S NAME		57 OTHER PRV ID		58 INSURED'S UNIQUE ID		59 NPI	
60 GROUP NAME		61 INSURANCE GROUP NO.		62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER	
64 EMPLOYER NAME		65		66		67	
68		69		70		71	
72		73		74		75	
76 ATTENDING		NPI		QUAL		77 OPERATING	
LAST		FIRST		QUAL		LAST	
78 OTHER		NPI		QUAL		79 OTHER	
LAST		FIRST		QUAL		LAST	
80 REMARKS		81CC		82		83	
84		85		86		87	
88		89		90		91	

PAGE ___ OF ___ CREATION DATE TOTALS

UB-94 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF NUBC