UB-04 Billing Instructions for Hospital Claims

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	**Expanded to 20 characters from 16 characters.**
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	**Expanded to 24 characters from 16 characters.**
4	Type of Bill	**Required.** Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: a. First digit-type facility 1 = Hospital b. Second digit-classification 1 = Inpatient Medicaid and/or Medicare Part A or Parts A & B 2 = Inpatient Medicaid and Medicare Part B only 3 = Outpatient or Ambulatory Surgical Center c. Third digit-frequency 0 = Non-Payment claim 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	

Locator #	Description	Instructions	Alerts
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates	
7	Unlabeled	**Optional.** State Assigned. **Note: Hospitals billing for services associated with moderate to high level emergency physician care (99283, 99284, 99285) should place a '3' in Form Locater 7 on the UB-04.** **Hospitals billing for services associated with low level emergency physician care (99281, 99282) should place a '1" in Form Locator 7 on the UB-04.**	**The CommunityCARE emergency indicator was formerly entered in UB-92 Form Locator 11.** **If providers do not use the emergency indicator correctly, the claim will deny with a 104 error edit.** **Covered days are now reported in the value code field (39-41) as value code 80.**
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	**Formerly entered in UB-92 Form Locator 12.**
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	**Formerly entered in UB-92 Form Locator 13.**
10	Patient's Birthdate	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 14.**

Locator #	Description	Instructions	Alerts
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	**Formerly entered in UB-92 Form Locator 15.**
12	Admission Date	**Required for Hospital Services.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	**Formerly entered in UB-92 Form Locator 17.**
13	Admission Hour	**Required for Hospital Services.** Enter the 2-digit code which corresponds to the hour the patient was admitted for care as: <u>Code Time</u> 00 = 12:00 - 12:59 midnight 01 = 01:00 - 01:59 A.M. 02 = 02:00 - 02:59 03 = 03:00 - 03:59 04 = 04:00 - 04:59 05 = 05:00 - 05:59 06 = 06:00 - 06:59 07 = 07:00 - 07:59 08 = 08:00 - 08:59 09 = 09:00 - 09:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 noon 13 = 01:00 - 01:59 P.M. 14 = 02:00 - 02:59 15 = 03:00 - 03:59 16 = 04:00 - 04:59 17 = 05:00 - 05:59 18 = 06:00 - 06:59 19 = 07:00 - 07:59 20 = 08:00 - 08:59 21 = 09:00 - 09:59 22 = 10:00 - 10:59 23 = 11:00 - 11:59	**Formerly entered in UB-92 Form Locator 18.**

Locator #	Description	Instructions	Alerts
14	Type Admission	**Required for Hospital Services.** Enter one of the appropriate codes indicating the priority of this admission. 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn	**Formerly entered in UB-92 Form Locator 19.**
15	Source of Admission	**Required for Hospital Services.** Enter the appropriate code from the list of "Code Structure for Adult and Pediatrics: shown below. * Newborn coding structure must be used when the type of admission code in Form Locator 14 is "4" <u>Valid codes if type of admission is 1, 2, or 3</u> 1 = Physician Referral 2 = Clinic Referral 3 = HMO Referral 4 = Transfer from a Hospital 5 = Transfer from a Skilled Nursing Facility 6 = Transfer from Another Health Care Facility 7 = Emergency Room <u>Valid codes if type of admission is 4</u> 1 = Normal Delivery 2 = Premature Delivery 3 = Sick Baby 4 = Extramural Birth	**Formerly entered in UB-92 Form Locator 20.**
16	Discharge Hour	**Required for Hospital Services.** Enter the two-digit code which corresponds to the hour the patient was discharged. See Form Locator 13.	**Formerly entered in Form Locator 21.**

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required for Hospital Services.** Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are: 01 = Discharged (routine) 02 = Discharged to another short-term general hospital 03 = Discharged to Skilled Nursing Facility 04 = Discharged to Intermediate Care Facility 05 = Discharged to another type of institution 06 = Discharged/transferred to home under care of home health service organization 07 = Left against medical advice 20 = Expired 30 = Still Patient	**Formerly entered in UB-92 Form Locator 22.** **Patient Status Code 08 (Discharge/Transfer to home care of Home IV provider) is no longer valid. Use Patient Status Code 01 instead.**
18-28	Condition Codes	**Required for Hospital Services.** Enter C1 in Form Locator 18 for inpatient claims. <u>PRO Approval</u> C1 Approved as billed **Optional.** Must be a valid code if entered. Valid codes are listed as follows: <u>Insurance</u> 01 = Military service related 02 = Condition is employment related 03 = Patient is covered by insurance not reflected here 04 = Information only bill 05 = Lien has been filed 06 = End stage renal disease in first 30 months of entitlement covered by employer group insurance <u>Accommodations</u> 38 = Semi-private room not available 39 = Private room medically	**Formerly entered in UB-92 Form Locator 24-30.**

Locator #	Description	Instructions	Alerts
		necessary 40 = Same day transfer <u>Special Program Indicators</u> A1 = EPSDT/CHAP A2 = Physically Handicapped Children's Program A4 = Family Planning	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Situational.** Enter, if applicable. Each code must be two position numeric and have an associated date. Dates must be valid and in MMDDYY format. Valid codes are listed as follows: 01 = Accident/Medical Coverage 02 = Auto accident/no fault 03 = Accident/tort liability 04 = Accident/employment related 05 = Accident/No Medical Coverage 06 = Crime victim 24 = Date insurance denied 25 = Date benefits terminated by primary payer 27 = Date of Hospice certification or recertification 42 = Date of discharge when "Through" date in Form Locator 6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill. A3, B3, C3 = Benefits exhausted	**Formerly entered in UB-92 Form Locator 32-35.**

Locator #	Description	Instructions	Alerts
35-36	Occurrence Spans (Code and Dates)	**Situational.** Enter, if applicable, a code and related dates that identity an event that relates to the payment of the claim. Code and date must be valid. Date must be (MMDDYY) format. Valid codes are listed as follows: 72 = First/Last visit 74 = Non-covered Level of Care	**Formerly entered in UB-92 Form Locator 36.**
37	Unlabeled	**Leave Blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields. 02 = Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 = Medicare blood deductible 08 = Medicare lifetime reserve first CY 09 = Medicare coinsurance first CY 10 = Medicare lifetime reserve second year 11 = Coinsurance amount second year 12 = Working Aged Recipient/Spouse with employer group health plan 13 = ESRD (End Stage Renal Disease) Recipient in the 12-month coordination period with an employer's group health plan 14 = Automobile, no fault or any liability insurance 15 = Worker's Compensation	**Value Code 80 must be used to report covered days, which was formerly reported in Form Locator 7.** **Value Code 81 must be used to report non-covered days, which was formerly reported in Form Locator 8.** **Value Code 82 must be used to report co-insurance days, which was formerly reported in Form Locator 9.** **Value Code 83 must be used to report lifetime reserve days, which was formerly reported in Form Locator 10.**

Locator #	Description	Instructions	Alerts
		including Black Lung 16 = VA, PHS, or other Federal Agency 30 = Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 = Pints blood furnished 38 = Blood not replaced - deductible is patient's responsibility 39 = Blood pints replaced *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) A1,B1,C1 = Deductible A2,B2,C2 = Co-insurance *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	**Please read the instructions carefully for entering the new number of days information in the Value Code fields.**
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies a specific accommodation and ancillary service. Accommodation codes require a rate in Form Locator 44. Revenue Codes 300-319 and 490 for outpatient require a CPT/HCPCS procedure code in Form Locator 44. Specific revenue codes should be selected if at all possible (i.e. 258 = IV Solutions, 305 = Lab /	**Revenue Codes 89x (other donor bank) are now unassigned. Use Revenue Codes 81x instead.**

Locator #	Description	Instructions	Alerts
		Hematology, etc.) See Revenue Codes listing that follows these instructions. The amount charged must be present in Form Locator 47. Codes must be valid and entered in ascending order, except for the final entry for total charges. **Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.**	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42. Two page claims are accepted for inpatient hospital **ONLY**. Use "Page ___ of ___" on line 23 as needed for two-page claims. Enter "Page 1 of 2" or "Page 2 of 2" as appropriate.	**Instructions for two-page claims have been added.**
44	HCPCS/Rates HIPPS Code HCPCS/CPT Code (Outpatient DX Lab)	**Required for inpatient services.** Enter the accommodation rate for any accommodation Revenue Codes indicated in Form Locator 42. If present, the accommodation rate must be numeric. **Situational.** When Revenue Codes 300-319 (Lab) or 490 (Ambulatory Surgery) are indicated in Form Locator 42, entry of the appropriate CPT/HCPC Codes in Form Locator 44 is **required**.	

Locator #	Description	Instructions	Alerts
45	Service Date	**Required for outpatient services.** Enter the appropriate service date (MMDDYY) on each line indicating a Revenue Code. **Required.** Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature (Form Locator 86 on the UB-92).**
46	Units of Service	**Required.** Enter the appropriate unit(s) of service by Revenue Code.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes.	
48	Non-Covered Charges	**Situational.** Indicate charges included in Form Locator 47 which are not payable under the Medicaid Program.	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	

Locator #	Description	Instructions	Alerts
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	**The 7-digit Medicaid ID number is now located in Form Locator 57.**
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field. If the patient has Medicare Part B only, enter the amount **billed** to Medicare Part B.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number previously entered in the UB-92 Form Locator 51 must be entered here.**

Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Spouse 04 = Grandfather or Grandmother 05 = Grandson or Granddaughter 07 = Nephew or Niece 10 = Foster child 15 = Ward (Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order) 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 32 = Mother 33 = Father 39 = Organ Donor 41 = Injured Plaintiff 43 = Child where insured has no financial responsibility	

Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Situational.** If the services on the claim require prior authorization or pre-certification, enter the prior authorization or pre-certification number in 63A. If the services require a CommunityCARE PCP referral authorization number, enter the PCP 7-digit Medicaid referral authorization number or the unique electronic 9-digit referral authorization number (assigned through e-RA) in 63C, as appropriate.	**The CommunityCARE Referral Authorization Number was formerly entered in Form Locator 83A of the UB-92.**

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment and void data was formerly entered in Form Locator 84 on the UB-92.** **To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Optional.** Enter the diagnosis/procedure code version qualifier of "9."	**The diagnosis/procedure code version qualifier was formerly entered in Form Locator 79 of the UB-92.**

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if is has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	**The Diagnosis Codes were formerly entered in Form Locators 68 through 75 of the UB-92.**
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Situational.** If the claim is for inpatient services, enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Optional.** Enter the appropriate Diagnosis Code indicating the patient's presenting symptom.	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank**.	
74 74 a - e	Principal Procedure Code / Date Other Procedure Code / Date	**Required for inpatient services**. Enter a valid current ICD-9-CM procedure code. **Required for inpatient services.** Enter valid current ICD-9-CM procedure codes as appropriate.	
75	Unlabeled	**Leave blank.**	

Locator #	Description	Instructions	Alerts
76	Attending	**Required**. Enter the name and/or number of the attending physician.	**Attending physician name and/or number was formerly entered in Form Locator 82 of the UB-92.**
77	Operating	**Situational**. If applicable, enter the name and/or number of the operating physician. **Note**: **For sterilization procedures, the surgeon's name must appear in Form Locator 77**.	**Operating physician name and/or number is new to the UB-04.** **Operating physician name for sterilization procedures was formerly entered in Form Locator 82.**
78	Other	**Situational.** If applicable, enter the name and/or number of any other physician.	**CommunityCARE referral authorization number, formerly entered in 83A (Other Physician) of the UB-92, has been moved to Form Locator 63C of the UB-04.**
79	Other	**Situational**. If applicable, enter the name and/or number of any other physician.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	**Any special handling instructions formerly required on UB-92 Form Locator 84 are now required in UB-04 Form Locator 80.** **Adjustments and Voids, formerly entered in Form Locator 84 of the UB-92, have been moved to Form Locator 64 A B C of the UB-04.**

Locator #	Description	Instructions	Alerts
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.