CLAIM FORM INSTRUCTIONS – UB-04/CMS 1450 (2/12)

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Iowa Total Care. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The Following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 Claim Form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Iowa Total Care or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c	d	e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	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
	a						
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE ____ OF ____	CREATION DATE		TOTALS			

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

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	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	a	b	c	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	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided. Not required (NR) fields are optional.

NOTE: Claims with missing or invalid required (R) field information will be rejected or denied.

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
1	UNLABELED FIELD · Name · Address · Telephone Number	**Line 1:** Enter the complete provider's name. **Line 2:** Enter the complete mailing address. **Line 3:** Enter the city, state, and zip code (zip+4) is required for paper and EDI claims. **Line 4:** Enter the area code and phone number.	R
2	UNLABELED FIELD Billing Provider's Designated Pay-to Address	Enter the Pay-to Name and Address	NR
3A	PATIENT CONTROL NO.	Enter the facility patient account/control number.	NR
3B	MEDICAL/HEALTH RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: **1st Digit:** indicating the type of facility. **2nd Digit:** indicating the type of care. **3rd Digit:** indicating the bill sequence (frequency code) 7 = Corrected Claim Submission 8 = Void	R
5	FEDERAL TAX NUMBER	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD (From – Through Dates)	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Reserved	NR

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
8	PATIENT NAME / IDENTIFIER	8a –Enter the first 9-digit identification number on the enrollee's Health Plan ID card. 8b –Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card. • Use a comma or space to separate the last and first names. • Titles: (Mr., Mrs., etc.) should not be reported in this field. • Prefix: No space should be left after the prefix of a name. (e.g. McKendrick. H). • Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). • Suffix: a space should separate a last name and suffix.	NR
9	PATIENT ADDRESS	Enter the patient's complete mailing address. A - Street address B - City C - State D - Zip Code E - Country Code (NOT REQUIRED)	R (Except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION / START OF CARE DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims.	NR
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the hour of inpatient admission or time of treatment for outpatient services. **EXAMPLES:** 12:15 a.m. use 0015 11:30 a.m. use 1130 12:45 p.m. use 1245 11:59 p.m. use 2359	R
14	ADMISSION TYPE	**REQUIRED** for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of admission using the following codes: 1 - Emergency 2 - Urgent 3 - Elective 4 - Newborn 5 - Trauma	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
15	ADMISSION SOURCE	**REQUIRED** for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. **For Type of Admission 1, 2, 3, or 5:** 1 - Clinic/Physician Referral 2 - Health Maintenance Referral (HMO) 3 - Transfer from hospital 4 - Transfer from Skilled Nursing Facility 5 - Transfer from another health care facility 6 - Emergency Room 7 - Court/Law Enforcement 8 - Information not available **For Type of Admission 4 (newborn):** 1 - Normal Delivery 2 - Premature Delivery 3 - Sick Baby 4 - Extramural Birth 5 - Information not available	R
16	DISCHARGE HOUR	Enter the time using 2-digit military time (00-23) for the hour of inpatient admission or time of treatment for outpatient services. **EXAMPLES:** 12:15 a.m. use 0015 11:30 a.m. use 1130 12:45 p.m. use 1245 11:59 p.m. use 2359	R
17	PATIENT DISCHARGE STATUS	**REQUIRED** for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6, using one of the following codes. 01 - Routine Discharge 02 - Discharged to another short-term general hospital 03 - Discharged to SNF 04 - Discharged to ICF 05 - Discharged to another type of institution 06 - Discharged to care of home health service Organization 07 - Left against medical advice 08 - Discharged/transferred to home under care of a Home IV provider. 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 - Expired or did not recover 30 - Still patient (to be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 - Expired at home (hospice use only) 41 - Expired in medical facility (hospice use only) 42 - Expired – place unknown (hospice use only)	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
17 (cont.)		43 - Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 - Hospice – Home 51 - Hospice – Medical Facility 61 - Discharged/Transferred within this institution to a hospital-based Medicare approved swing bed 62 - Discharged/Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 - Discharged/Transferred to a Medicare certified long-term care hospital (LTCH) 64 - Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 - Discharge/Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 - Discharged/Transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	**REQUIRED:** when applicable. • Condition Codes are used to identify conditions relating to the bill that may affect payor processing. • Each field (18-24) allows entry of a 2-character code. • Codes should be entered in alpha-numeric sequence (numbered codes precede alpha-numeric codes.) • For a list of codes and additional instructions, prefer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE	Two-character state abbreviation	NR
30	UNLABELED FIELD	Reserved	NR
31-34	OCCURRENCE CODES and DATES	Occurance Code: **REQUIRED** when applicable. • Occurrence codes are used to identify events relating to the bill that may affect payor processing. • Each field (31-34a) allows for entry of a 2-character code. • Codes should be entered in alphanumeric sequence (numbered codes precede alpha-numeric codes). • For a list of codes and additional instructions, refer to the NUBC UB04 Uniform Billing Manual Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Codes is present on the same line (31a-34a). • Enter the date for the associated Occurrence Code in MMDDYYYY format.	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
35-36	OCCURRENCE SPAN CODES and DATES	Occurance Span Code: **REQUIRED** when applicable. • Occurrence Codes are used to identify events relating to the bill that may affect payor processing. • Each field (35-36a) allows for entry of a 2-character code. Codes should be entered in alpha-numeric sequence (numbered codes precede alpha-numeric codes). • For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present in the same line (35a-36a). • Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	UNLABELED FIELD	**REQUIRED** for re-submissions or adjustments. • Enter the Document Control Number (DCN) of the original claim.	C
38	RESPONSIBLE PARTY NAME and ADDRESS (Claim Addressee)	Used for patient parent or guardian, for minors, or the actual patient.	NR
39-41	VALUE CODES and AMOUNTS	**REQUIRED Value Codes when applicable.** • Value Codes are used to identify events relating to the bill that may affect payor processing. • Each field (39-41) allows for entry of a 2-character code. • Codes should be entered in alpha-numeric sequence (numbered codes precede alpha-numeric codes.) • Up to 12 codes can be entered. • All “a” fields must be completed before using “b” fields. • All “b” fields must be completed before using “c” fields. • All “c” fields must be completed before using “d” fields. • For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual. **REQUIRED Value Amounts when applicable or when a Value Code is entered.** • Enter the dollar amount for the associated value code. • Dollar amounts to the left of the vertical line should be right justified. • Up to eight characters are allowed (i.e. 199,999.99). • Do not enter a dollar sign ($) or a decimal. • A decimal is implied. • If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42 – 47: • A total of 22 services lines available for claim detail information. • Fields 42, 43, 45, 47, and 48 include separate instructions for the completion of lines 1 – 22 and line 23.	R
42 Lines 1-22	REV CD	• Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. o Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. • Enter accommodation revenue codes first, followed by ancillary revenue codes. o Enter codes in ascending numerical value	R
42 Line 23	REV CD	Enter 0001 for total charges	R
43 Lines 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	R
43 Line 23	PAGE __OF __	Enter the number of pages. • Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. o Enter a “1” in both fields if only one claim form is submitted. (i.e. PAGE “1” OF “1”) o Limited to 4 pages per claim.	C
44	HCPCS / ACCOMMODATION RATES	**REQUIRED** for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. • The field allows up to 9 characters. • Only 1 CPT/HCPC and up to 2 modifiers are accepted. • Do not use spaces, commas, or dashes between the CPT/HCPC and Modifiers. • Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. • Please refer to your current provider contract.	C
45 Lines 1-22	SERVICE / ASSESSMENT DATE	**REQUIRED** on all outpatient claims. • Enter the date of service for each service line billed (MMDDYY). • Multiple dates of service may not be combined for outpatient claims	C
45 Line 23		Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. • A value of at least "1" must be entered. • For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Lines 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Lines 1-22	NON-COVERED CHARGES	Enter the non-covered chares included in field 47 for the Revenue Code listed in field 42 of the service line. • Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all services lines.	C
49	UNLABELED FIELD	Reserved	NR
50	PAYOR NAME	Enter the name of each payor from which reimbursement is being sought, in the order of the payor liability. • Line A refers to the primary payor. • Line B refers to the secondary payor. • Line C, tertiary.	R
51	HEALTH PLAN IDENTIFICATION NUMBER		NR
52	REL INFO Release of Information Certification Indicator	**REQUIRED** for each line (A, B, C) completed in field 50. • Release of Information Certification Indicator Enter 'Y' (yes) or 'N' (no). • Providers are expected to have necessary release of information on file. • It is expected that all released invoices contain 'Y'.	R
53	ASG BEN Assignment of Benefits Certification Indicator	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payor directly to the provider for services.	R
54	PRIOR PAYMENTS – Payor	Enter the amount received from the primary payor on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST AMOUNT DUE		NR
56	NPI – National Provider Identified-Billing Provider	**REQUIRED:** Enter provider's 10-character NPI	R
57	OTHER PRV ID Other (Billing) Provider Identifier	• Enter the numeric provider identification number. • Enter the TPI number (non-NPI number) of the billing provider.	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. • In most cases this will be the patient's name. • Enter the name as last name, first name, Middle initial.	R
59	P REL-Patient Relationship		NR
60	INSURED'S UNIQUE ID	**REQUIRED:** Enter the patient's Insurance ID exactly as it appears on the patient's ID card. • Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME – Insured's Group Name		NR
62	INSURANCE GROUP NO. Insured's Group Number		NR
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim, when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50.	C
65	EMPLOYER NAME of INSURED		NR
66	DX - Diagnoses and Procedure Code Qualifier (ICD Revision Indicator)		NR
67	PRINCIPAL DIAGNOSIS CODE and PRESENT ON ADMISSIOM INDICATOR	Enter the principal/primary diagnosis or condition using the appropriate release/updated of ICD-9/10 Volume 1 & 3 for the date of service. • Services requiring a diagnosis for payment, (example: Emergent Diagnosis, IHAWP sleep apnea claims), the diagnosis must be in the principal diagnosis position.	R
67 A-Q	OTHER DIAGNOSIS CODE and PRESENT ON ADMISSIOM INDICATOR	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service. • Diagnosis codes submitted must be valid ICD-0/10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit. • 'E' and most 'V' codes are **NOT** acceptable as a primary diagnosis. **NOTE:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	UNLABELED FIELD	Reserved	NR

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
69	ADMIT DX Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10 Volume 1 & 3 for the date of service. • Diagnosis codes submitted must be valid ICD-0/10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit. • 'E' and most 'V' codes are **NOT** acceptable as a primary diagnosis. **NOTE:** Claims with incomplete or invalid diagnosis codes will be denied.	R
70 A-C	PATIENT REASON DX Patient's Reason for Visit	• Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. ○ Field 70a requires entry ○ Fields 70b-70c are conditional • Diagnosis codes submitted must be valid ICD-0/10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit. • 'E' and most 'V' codes are **NOT** acceptable as a primary diagnosis. **NOTE:** Claims with incomplete or invalid diagnosis codes will be denied.	R
71	PPS CODE Prospective Payment System (PPS) Code		NR
72 A-C	ECI CODE and PRESENT ON ADMISSION External Cause of Injury (ECI)		NR
73	UNLABELED	Reserved	NR
74	PRINCIPAL PROCEDURE – CODE & DATE	**CODE:** Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. **DATE:** Enter the date the principal procedure was performed (MMDDYY).	C
74 A-E	OTHER PROCEDURE – CODES & DATES	**REQUIRED** on inpatient claims when a procedure is performed during the date span of the bill. **CODE:** Enter the ICD-9/10 Procedure Code(s) that identifies the significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-0/10 Procedure Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. **DATE:** Enter the date the principal procedure was performed (MMDDYY).	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
75	UNLABELED	Reserved	NR
76	ATTENDING Provider Name and Identifiers	Enter the NPI and name of the physician in charge of the patient's care. • NPI: Enter the attending physicians 10-character NPI. • Taxonomy Code: Enter valid taxonomy Code. • QUAL: Enter of the following qualifier and ID Number ○ 0B – State License #. ○ 1G – Provider UPIN. ○ G2 – Provider Commercial #. ○ B3 – Taxonomy Code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name.	R
77	OPERATING Physician Name and Identifiers	**REQUIRED** when a surgical procedure is performed. Enter the NPI and name of the Operating physician in charge of the patient's care. • NPI: Enter the Operating Physician's 10-character NPI. • Hospice Providers billing for room and board (revenue code 658) can use box 77 for the nursing facility NPI (required). • Taxonomy Code: Enter valid taxonomy Code. • QUAL: Enter of the following qualifier and ID Number ○ 0B – State License #. ○ 1G – Provider UPIN. ○ G2 – Provider Commercial #. ○ B3 – Taxonomy Code.	C
78 – 79	OTHER Provider (Individual) Name and Identifiers	Enter the Provider Type qualifier, NPI, and name of the physician in charge of patient's care. • (Blank Field): Enter one of the following Provider Type Qualifiers: ○ DN – Referring Provider. ○ ZZ – Other Operating MD. ○ 82 – Rendering Provider • NPI: Enter the other physician 10-character NPI. • QUAL: Enter of the following qualifier and ID Number ○ 0B – State License #. ○ 1G – Provider UPIN. ○ G2 – Provider Commercial #.	C
80	REMARKS		NR
81	CC Code-Code Field	A: Taxonomy of billing provider. User B3 qualifier	R