Provider Bulletin #15-02
Philadelphia Behavioral Health System
Community Behavioral Health

Changes to CMS 1500 (02-12) and UB-04 Required Fields

January 23, 2015

The purpose of this bulletin is to inform our provider organizations about the required field changes for both the CMS 1500 (02-12) and the UB04 which will be enforced on all paper claims received on or after February 23, 2015.

All paper claims received on or after February 23, 2015, must contain the identified required fields for either the CMS 1500 (02-12) or the UB04. Please understand that those paper claims without the required fields will be returned to the provider and not entered into the claims system for adjudication. Also, e**ffective February 23, 2015** Explanation of Benefits **(EOB's)** that are accompanied by a paper claim must have on them the **Claim Adjustment Reason Code (CARC)** and the **Remittance Advice Remark Code (RARC)**. Community Behavioral Health will no longer accept EOB's with Primary Insurance Company proprietary codes for coordination of benefits consideration.

The attached document lists all the required fields for either CMS 1500 (02-12) and UB04.

Item Number	Description for Paper	Usage	Loop ID for EDI	837P Segment / Data Element for EDI	Segment/ Data Element Name for EDI
1	**Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other**	**Required**	2000B	SBR09	Claim Filing Indicator Code
1a	**Insured's ID Number**	**Required**	2010BA	NM109	Subscriber Primary Identifier
2	**Patient's Name**	**Required**	2010CA or 2010BA	NM103	Patient Last Name
				NM104	Patient First Name
				NM105	Patient Middle Name or Initial
				NM107	Patient Name Suffix
3	**Patient's Birth Date, Sex**	**Required**	2010CA or	DMG02	Subscriber Birth Date
				DMG03	Subscriber Gender Code
5	**Patient's Address**	**Required**	2010CA	N302	Patient Address Line
				N401	Patient City Name
				N402	Patient Sate Code
				N403	Patient Postal Zone or ZIP Code
6	**Patient Relationship to Insured**	**Required**	2000B	SBR02	Individual Relationship Code
			2000C	PAT01	Individual Relationship Code
9	**Other Insured's Name**	**Situational, if TPL information present then Required**	2330A	NM103	Other Insured Last Name
				NM104	Other Insured First Name
				NM105	Other Insured Middle Name
				NM107	Other Insured Name Suffix
9a	**Other Insured's Policy or Group Number**	**Situational, if TPL information present then Required**	2320	SBR03	Insured Group or Policy Number
9d	**Insurance Plan Name or Program Name**	**Situational, if TPL information present then Required. You Must use the Carrier Name listed in Appenix A of the CBH Companion Guide**	2320	SBR04	Other Insured Group Name

Item Number	Description for Paper	Usage	Loop ID for EDI	837P Segment / Data Element for EDI	Segment/ Data Element Name for EDI
10a	Is Patient's Condition Related to: Employment	Required	2300	CLM11	Related Cause Code
10b	Is Patient's Condition Related to: Auto Accident	Required	2300	CLM11	Related Cause Code
10c	Is Patient's Condition Related to: Other Accident	Required	2300	CLM11	Related Cause Code
11d	Is there another Health Benefit Plan?	Required			
12	Patient's or Authorized Person's Signature	Required	2300	CLM09	Release of Information Code
13	Insured's or Authorized Persons Signature	Required	2300	CLM08	Benefits Assignment Certification Indicator
17	Name of Referring Provider or Other Source	Required	2310A (referring)	NM103	Referring Provider Last Name
				NM104	Referring Provider First Name
				NM105	Referring Provider Middle Name or Initial
				NM107	Referring Provider Name Suffix
17b	NPI #	Required	2310A (referring)	NM109	Referring Provider Identifier
18	Hospitalization Dates Related to Current Services	Situational	2300	DTP03	Related Hospitalization Admission Date
21	Diagnosis or Nature of Illness or Injury	21A = Required 21B-L = Situational	2300	HI01-2	Diagnosis Code
				HI02-2	Diagnosis Code
				HI03-2	Diagnosis Code
				HI04-2	Diagnosis Code
22	Medicaid Resubmission and/or Original Reference Number	Situational	2300	CLM05-3	Claim Frequency Code
			2300	REF02	Payer Claim Control Number

Item Number	Description for Paper	Usage	Loop ID for EDI	837P Segment / Data Element for EDI	Segment/ Data Element Name for EDI
23	Prior Authorization Number	Required	2300	REF02	Prior Authorization or Blanket Authorization Number
24A	Date(s) of Service	Required	2400	DTP03	Service Date
24B	Place of Service	Required	2300	CLM05-1	Place of Service Code
			2400	SV105	Place of Service Code
24D	Procedures, Services, or Supplies	CPT/HCPCS: Required MODIFIER: Situational	2400	SV101 (2-6)	Product/Service ID and Procedure Modifier
24E	Diagnosis Pointer	Required	2400	SV107 (1-4)	Diagnosis Code Pointer
24F	$ Charges	Required	2400	SV102	Line Item Charge Amount
24G	Days or Units	Required	2400	SV104	Service Unit Count
25	Federal Tax ID Number	Number Field: Required SSN/EIN: Required	2010AA	REF02	Billing Provider Tax Identification Number
				REF02	Billing Provider License and/or UPIN Information
26	Patient's Account No.	Required	2300	CLM01	Patient Control Number
27	Accept Assignment?	Required	2300	CLM07	Assignment or Plan Participation Code
28	Total Charge	Required	2300	CLM02	Total Claim Charge Amount
29	Amount Paid	Situational, if TPL information present then Required	2300	AMT02	Patient Amount Paid
			2320	AMT02	Payer Paid Amount
31	Signature of Physician or Supplier Including Degrees or Credentials and Date	Required	2300	CLM06	Provider or Supplier Signature Indicator
32	Service Facility Location Information	Situational, if laboratory services required	2310C	NM103	Laboratory or Facility Name
				N301	Laboratory or Facility Address Line
				N401	Laboratory or Facility City Name
				N402	Laboratory or Facility State or Province Code

Item Number	Description for Paper	Usage	Loop ID for EDI	837P Segment / Data Element for EDI	Segment/ Data Element Name for EDI
				N403	Laboratory or Facility Postal Zone or ZIP Code
32a	**NPI #**	**Situational, if laboratory services required**	2310C	NM109	Laboratory or Facility Primary Identifier
33	**Billing Provider Info & Ph #**	**Required**	2010AA	NM103	Billing Provider Last or Organizational Name
				NM104	Billing Provider First Name
				NM105	Billing Provider Middle Name or Initial
				NM107	Billing Provider Name Suffix
				N301	Billing Provider Address Line
				N401	Billing Provider City Name
				N402	Billing Provider State or Province Code
				N403	Billing Provider Postal Zone or ZIP Code
				PER04	Communication Number
33a	**NPI #**	**Required**	2010AA	NM109	Billing Provider Identifier
33b	**Other ID #**	**Required**	2000A 2010AA	PRV03	Provider Taxonomy Code
				REF01	Reference Identification Qualifier
				REF02	Billing Provider Tax Identification Number

REGULAR CLAIM

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0123455789

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

3. PATIENT'S BIRTH DATE MM DD YY: 03281945 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 625 DAISY STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

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

CITY: PHILA STATE: PA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 19122 TELEPHONE (Include Area Code): 215 2220000

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) PA

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 X DATE 01/02/2015

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 X

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN JOHN

17a.

17b. NPI 1000000090

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

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. ICD-9-CM

A. 304.03 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 9999999

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 01/02/2015	01/02/2015	52		H0035	UA	A	90.00	5		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 01-2345678 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: LB049C66245A

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

28. TOTAL CHARGE: $ 90.00

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 X DATE 01/07/2015

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: TREATMEN NOW 215-077-0009

1919 WEST STREET

PHILA PA 19101

a. 1123456779 b. 103TC0700X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

LAB CLAIM

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0123455789

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

3. PATIENT'S BIRTH DATE MM DD YY: 03281945 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 625 DAISY STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

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

CITY: PHILA STATE: PA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 19122 TELEPHONE (Include Area Code): (215 2220000

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 [X]

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

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State): PA

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

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 [X] *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 X DATE 01/06/2015

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 X

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TREATMENT NOW

17a.

17b. NPI 1123457789

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

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. ICD-9-CM

A. 304.03 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 9090909

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 01/06/2015	01/06/2015	81		85014		A	75.00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 01-8765432 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 4747474747LB47Y

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

28. TOTAL CHARGE: $ 75.00

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 X DATE 01/07/2015

32. SERVICE FACILITY LOCATION INFORMATION
TREATMENT NOW
1919 WEST STREET
PHILA PA 19101
a. 1123457789 b.

33. BILLING PROVIDER INFO & PH # 215-999-0000
LAB
101 LEFT STREET
PHILA PA 19197
a. 9876543210 b. 293D00000X

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

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

TPL CLAIM

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☒ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ OTHER (ID#) ☐		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0123455789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN LILY	3. PATIENT'S BIRTH DATE MM DD YY: 03281945 SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 625 DAISY STREET	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street):
CITY: PHILA STATE: PA	8. RESERVED FOR NUCC USE	CITY: STATE:
ZIP CODE: 19122 TELEPHONE (Include Area Code): (215) 2220000		ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): BROWN LILY	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: ZXZ0123456789	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): PA	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: KEYSTONE HEALTH PLAN EAST	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 X DATE 01/05/2015		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 X
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN JOHN	17a. 17b. NPI 1000000090	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. ICD-9-CM: A. 304.03 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 9999999

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 01/05/2015	01/05/2015	49		90832		A	275.00	2		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 01-2345678 SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.: LB049C66245	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE: $275.00	29. AMOUNT PAID: $42.75	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 X DATE 01/15/2015	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # (215) 077-0009 TREATMEN NOW 1919 WEST STREET PHILA PA 19101 a. 1123456779 b. 103TC0700X			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form Locator #	Description for Paper	USAGE	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
01	Billing Provider, Name, Address and Telephone Number	REQUIRED		Loop 2010AA, NM1/85/03, N3 segment, N4 segment
02	Pay-to-Name and Address (required when different from form locator 01)	SITUATIONAL		Loop 2010AB, NM1/85/03, N3 segment, N4 segment
03a	Patient Control Number	REQUIRED	It is a requirement that the value submitted MUST be unique for EACH individual claim.	Loop 2300, CLM01
03b	Medical Record Number	SITUATIONAL		Loop 2300, REF/EA/02
04	Type of Bill	REQUIRED	Code values: 0 Non-Payment/Zero 1 Admit through Discharge Claim 2 Interim – First Class 3 Interim – Continuing Claim 4 Interim – Last Claim 8 Void/Cancel of Prior Claim Recommended value is "1" to indicate an "Original" claim unless one of the other codes is more appropriate. *See notes on declaration of Dischareg Time (Loop 2300 DTP03)	Loop 2300, CLM05-1, CLM05-3
05	Federal Tax ID	REQUIRED		Loop 2010AA, NM109, REF/EI/02
06	Statement Covers Period (MMDDYY)	REQUIRED		Loop 2300, DTP/434/03
08b	Patient Name	REQUIRED		Loop 2010BA, NM1/IL/03, 04, 05, 07
09a-d	Patient Address a) State b) City c) State d) ZIP Code	REQUIRED		Loop 2010BA, N301, N401,02,03,04
10	Patient Birth Date	REQUIRED		Loop 2010BA, DMG02
11	Patient's sex	REQUIRED		Loop 2010BA, DMG02
12	Admission/Start of Care Date	REQUIRED		Loop 2300, DTP/435/03
13	Admission Hour	SITUATIONAL		Loop 2300, DTP/435/03
14	Admission Type	SITUATIONAL	See UB-04 Desk Reference for Hospitals	Loop 2300, CL101
15	Source of Admission	REQUIRED	Code Values: 1 Non-Health Care Facility Point of Origin 2 Clinic or Physician's Office 4 Transfer from Hospital (Different Facility) 5 Transfer from Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF) 6 Transfer from Health Care Facility 8 Court/Law Enforcement 9 Information Not Available CBH will ONLY accept numeric values for this data segment.	Loop 2300, CL102
16	Discharge Hour	SITUATIONAL	If Discharge Time is declared then the Type of bill (CLM05-3) value MUST be "1" or "4"	Loop 2300, DTP/096/03
17	Patient Discharge Status	REQUIRED	See UB-04 Desk Reference for Hospitals	Loop 2300, CL103

Form Locator #	Description for Paper	USAGE	837I Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
18-28	Condition Codes	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BG) Loop 2300, HI02-2 (HI02-1=BG) Loop 2300, HI03-2 (HI03-1=BG) Loop 2300, HI04-2 (HI04-1=BG) Loop 2300, HI05-2 (HI05-1=BG) Loop 2300, HI06-2 (HI06-1=BG) Loop 2300, HI07-2 (HI07-1=BG)
29	Accident State	SITUATIONAL		Loop 2300, CLM11-4
31-34	Occurrence Code/Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1= BH) HI01-4 Loop 2300, HI02-2 (HI02-1= BH) HI02-4 Loop 2300, HI03-2 (HI03-1= BH) HI03-4 Loop 2300, HI04-2 (HI04-1= BH) HI04-4 Loop 2300, HI05-2 (HI05-1= BH) HI05-4 Loop 2300, HI06-2 (HI06-2= BH) HI06-4 Loop 2300, HI07-2 (HI07-1= BH) HI07-4 Loop 2300, HI08-2 (HI08-1= BH) HI08-4
35-36	Occurrence Span Code/Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BI) HI01-4 Loop 2300, HI02-2 (HI02-1= BI) HI02-4 Loop 2300, HI03-2 (HI03-1= BI) HI03-4 Loop 2300, HI04-2 (HI04-1= BI) HI04-4
39-41	Value Code/Amount	REQUIRED	Value codes must be entered in numeric sequence, starting in Form Locator 39a through 41a, 39b through 41b, 39c through 41c and 39d through 41d. See UB-04 Desk Reference for Hospitals.	Loop 2300, HI01-2 (HI01-1= BE) HI01-5 Loop 2300, HI02-2 (HI02-1= BE) HI02-5 Loop 2300, HI03-2 (HI03-1= BE) HI03-5 Loop 2300, HI04-2 (HI04-1= BE) HI04-5 Loop 2300, HI05-2 (HI05-1= BE) HI05-5 Loop 2300, HI06-2 (HI06-1= BE) HI06-5 Loop 2300, HI07-2 (HI07-1= BE) HI07-5 Loop 2300, HI08-2 (HI08-1= BE) HI08-5 Loop 2300, HI09-2 (HI09-1= BE) HI09-5 Loop 2300, HI10-2 (HI10-1= BE) HI10-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5 Loop 2300, HI12-2 (HI12-1= BE) HI12-5
42	Revenue Code	REQUIRED	See CBH Schedule A	Loop 2400, SV201
43	Revenue Description	SITUATIONAL		Not Required by Medicare
44	HCPCS/Rate/HIPPS Code	SITUATIONAL		Loop 2400, SV202-2 (SV202-1=HC/HP)
45	Service Date	SITUATIONAL		Loop 2400, DTP/472/03
45 (23)	Creation Date	REQUIRED		
46	Service/Units	REQUIRED		Loop 2400, SV205
47 (23)	Total Charges	REQUIRED		Loop 2400, SV203
50a-c	Payer Name	REQUIRED	Enter the name of each payer organization from which the provider might expect some payment for the bill.	Loop 2330B, NM1/PR/03
51 a-c	Identification Code Other Payer Primary Identifier	REQUIRED		Loop 2330B, NM1/PR/09
52 a-c	Release of Information	REQUIRED		Loop 2300, CLM07
53 a-c	Assignment of Benefits Certification	REQUIRED		Loop 2300, CLM08
54 a-c	Prior Payment Amounts	SITUATIONAL	If coordination of benefits is Involved, then enter the covered charges amount on the EOB (for Medicare, or the other insurance carrier's payment amount).	Loop 2320, AMT/D/02
55a-c	Estimated Amount Due	SITUATIONAL	Enter the estimated amount you expect to be paid by CBH.	Loop 2300, AMT/EAF/02
56	National Provider Identifier (NPI)	REQUIRED		Loop 2010AA, NM1/85/09
57c	Billing Provider Specialty Information	REQUIRED	This information must be sent in all CBH claims for the purpose of adjudication	Loop 2000A, PRV03
58a-c	Insured's Name Other Insured's Name	REQUIRED		Loop 2010BA, NM1/IL/03, 04, 05 Loop 2330A, NM1/IL/03, 04, 05
59a-c	Patient Relationship	REQUIRED		Loop 2000B, SBR02
60a-c	Subscriber Identification Code	REQUIRED	Length of 10.	Loop 2010BA, NM1/IL/09, REF/SY/02
63	Treatment Authorization Codes	REQUIRED		Loop 2300,REF/G1/02
67a-q	Diagnosis	REQUIRED		Loop 2300, HI01-2 (HI01-1=BK)
69	Admitting Dx	REQUIRED		Loop 2300, HI02-2 (HI02-1=BJ)
70a-c	Patient Reason for Visit	SITUATIONAL		Loop 2300, HI02-2 (HI02-1=PR)
71	Diagnosis Related Group (DRG) Code	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=DR)
72a-c	External Cause of Injury Code	SITUATIONAL		Loop 2300, HI03-2 (HI03-1= BN)
74	Principal Procedure Code Principal Procedure Date	SITUATIONAL		Loop 2300, HI01-2 (HI01-1= BR) Loop 2300, HI01-4 (HI01-1=BR)

Form Locator #	Description for Paper	USAGE	837i Companion Guide for EDI	ASC 837I v5010A2 Loop, Segment for EDI
74a-e	Other Procedure Information	SITUATIONAL		Loop 2300, HI01-2 (HI01-1=BQ) Loop 2300, HI01-4 (HI01-1=BQ) Loop 2300, HI02-2 (HI02-1=BQ) Loop 2300, HI02-4 (HI02-1=BQ) Loop 2300, HI03-2 (HI03-1=BQ) Loop 2300, HI03-4 (HI03-1=BQ) Loop 2300, HI04-2 (HI04-1=BQ) Loop 2300, HI04-4 (HI04-1=BQ) Loop 2300, HI05-2 (HI05-1=BQ) Loop 2300, HI05-4 (HI05-1=BQ)
76	Attending Provider Name Attending Provider Secondary ID Attending Provider Last Name Attending Provider First Name	SITUATIONAL		Loop 2310A, NM1/71/09 Loop 2310A, REF02 (REF01= 0B/1G/G2/or LU Loop 2310A, NM1/71/03 Loop 2310A, NM1/71/04

UB-04 Desk Reference for Hospitals

These values are valid for paper claim submission on the UB-04 Claim Form only.

Type of Bill Codes (Form Locator 4)

INPATIENT ONLY:

First Digit
- **1** Type of Facility – Hospital

Second Digit
- **1** Bill Classification – Inpatient

Third Digit
- **0** Non Payment/Zero Claim
- **1** Admit through Discharge Claim
- **2** Interim – First Claim
- **7** Replacement of Prior Claim
- **8** Void/Cancel of Prior Claim

OUTPATIENT ONLY:

First Digit
- **1** Type of Facility – Hospital

Second Digit
- **3** Bill Classification – Outpatient
- **4** Bill Classification – Hospital Special Treatment Room

Third Digit
- **0** Nonpayment/Zero Claim
- **1** Admit through Discharge Claim
- **7** Replacement of Prior Claim
- **8** Void/Cancel of Prior Claim

Admission Type (Form Locator 14)

- **1** Emergency Admission
- **2** Urgent Admission
- **3** Elective Admission
- **4** Newborn Admission
- **5** Trauma Admission (Emergency Admission)

Condition Codes (Form Locators 18–28)

- **02** Condition is Employment Related
- **03** Patient is Covered by Insurance Not Reflected Here
- **05** Lien Has Been Filed
- **60** Day Outlier
- **77** Provider accepts or is obligated/required to a contractual agreement or law to accept payment by primary payer as payment in full
- **A1** EPSDT
- **A4** Family Planning Outpatient
- **AA** Abortion Consent (MA 3) – Rape
- **AB** Abortion Consent (MA 3) – Incest
- **AD** Abortion Consent (MA 3) – Danger to Life
- **AI** Sterilization Patient Consent Form (MA 31)
- **B3** Pregnancy
- **X2** Medicare EOMB on File

Condition Codes (continued)

- **X3** Hysterectomy Acknowledgment Form (MA 30)
- **X4** Medicare Denial on File
- **X5** Third Party Payment on File
- **X6** Restricted Recipient Referral Form
- **X7** Medical Documentation for Hysterectomy
- **Y0** Newborn Eligibility
- **Y3** Copay Not Collected
- **Y6** Third Party Denial on File

Patient Status Codes (Form Locator 17)

- **01** Discharge to home or self-care – Routine Discharge
- **02** Discharged/transferred to another hospital for inpatient care
- **03** Discharged/transferred to a skilled nursing facility
- **04** Discharged/transferred to an intermediate care facility
- **05** Discharged/transferred to another type of institution for inpatient care
- **07** Left against medical advice or discontinued care
- **20** Expired
- **30** Still a patient

Occurrence Codes (Form Locators 31–34)

- **01** Auto Accident
- **02** No Fault Accident
- **03** Accident/Tort Liability
- **04** Accident/Employment Related
- **05** Other Accident
- **06** Crime Victim
- **24** Date Insurance Denied
- **25** Date Benefits Terminated By Primary Payer
- **A3** Benefits Exhausted
- **B3** Benefits Exhausted
- **C3** Benefits Exhausted
- **DR** Disaster Related

Occurrence Span Codes (Form Locator 35–36)

- **71** Prior Stay Dates
- **74** Non-covered Level of Care/Leave of Absence (JCAHO RTF only)
- **MR** Disaster Related

Value Codes (Form Locators 39–41)
06 Medicare Blood Deductible (Paper Claims Only)
14 No Fault, Including Auto/Other
15 Worker's Compensation
16 PHS or Other Federal Agency
38 Medicare Blood Deductible Pints Furnished
39 Medicare Blood Deductible Pints Replaced
47 Any Liability Insurance
66 Patient Pay
73 Sequestration Adjustment Amount
80 Covered Days
81 Non-Covered Days
82 Co-Insurance Days
83 Lifetime Reserve Days, Inpatient Only
A1 Deductible Payer A
A2 Coinsurance and Lifetime Reserve Payer A
A7 Copayment, Payer A
B1 Deductible Payer B
B2 Coinsurance and Lifetime Reserve Payer B
B7 Copayment, Payer B
X0 Medicare Part B

Patient's Relationship to Insured Codes (Form Locator 59)
01 Spouse
04 Grandparent
05 Grandchild
07 Niece/Nephew
10 Foster Child
15 Ward of the Court
17 Step Child
18 Patient is Insured
19 Natural Child/Insured Financial Responsibility
20 Employee
21 Unknown
22 Handicapped Dependent
23 Sponsored Dependent
24 Minor Dependent of a Minor Dependent
29 Significant Other
32 Mother
33 Father
36 Emancipated Minor
39 Organ Donor
40 Cadaver Donor
41 Injured Plaintiff
43 Natural Child/Insured does not have Financial Responsibility
53 Life Partner
G8 Other Relationship
Please note that the Patient's Relationship to Insured Codes are the same codes used electronically in the 837I.

Present on Admission (POA) Indicator Codes (Form Locators 67, 67 A-Q)
INPATIENT ONLY:
Y Yes, present at the time of inpatient admission
N No, not present at the time of inpatient admission
U Unknown, documentation is insufficient to determine if condition was present at time of inpatient admission
W Clinically undetermined, provider is unable to clinically determine whether condition was present at time of inpatient admission or not
1 Exempt from POA reporting

Claims Adjustment Reason Codes (Form Locator 80)
8001 Changing the Patient Control Number
8002 Changing the Covered Dates
8003 Changing the Covered/Non covered Days
8004 Changing the Admission Dates/Time
8005 Changing the Discharge Times
8006 Changing the Status
8007 Changing the Medical Record Number
8008 Changing the Condition Codes (*sometimes to make claim an "outlier" claim*)
8009 Change the Occurrence Codes
8010 Changing the Value Codes
8011 Change the Revenue Codes
8012 Change the Units Billed
8013 Change the Amount Billed
8014 Change the Payer Codes
8015 Change the Prior Payments
8016 Change the Prior Authorization Number
8017 Change the Diagnosis Codes
8018 Change the ICDN Codes and Dates
8019 Change the Phys. ID Numbers
8020 Changed the Billed Date

1 The Hospital
1911 Hospital Way
Philadelphia PA 19101

2 **REGULAR CLAIM**

3a Pat. Cntl #	908771132	4 Type of Bill
b Med. Rec. #		111

5 Fed. Tax No.	6 Statement Covers Period From	Through
111111010	1/1/2015	1/10/2015

8 Patient Name	9 Patient Address				
a	a 20 First Street				
b Doe, John	b Philadelphia	c PA	d 19111	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
2-5-59	M	1/1/15	09	2	1	23	01			

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
						a
						b

38		39 Value Codes Code Amount	40 Value Codes Code Amount	41 Value Codes Code Amount
	a	80 9		
	b			
	c			
	d			

42 Rev cod	43 Description	44 HCPCS/Rate/HIPPS code	45 Serv.	46 Serv. units	47 Total Charges	48 Non-covered charges	49
124	Room and Board			9	67590 00		1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
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							15
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							17
							18
							19
							20
							21
							22
	PAGE ___ OF ___ CREATION DATE		1/12/15	TOTALS	67590 00		23

50 Payer Name	51 Health Plan ID	52 Rel Info		53 Asg. Ben.	54 Prior Payments	55 Est. Amt Due	56 NPI	9876543210	
CBH		Y		Y			57 Other Prv ID	283Q00000X	A B C

58 Insured's Name	59 P. Rel	60 Insured's Unique ID	61 Group Name	62 Insurance Group No.	
Doe, John	18	1023456789			A B C

63 Treatment Authorization Codes	64 Document Control Number	65 Employer Name	
9999998			A B C

66 DX	296.34										68

69 Admit DX	296.34	70 Patient Reason DX				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	

76 Attending	NPI 1001010101	Qual		
Last Good		First Bill		
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			

1 The Other Hospital
21 Trailing Way Court
Philadelphia PA 19127

2

TPL CLAIM

3a Pat. Cntl #	120100121200-1101212	4 Type of Bill
b Med. Rec. #		111
5 Fed. Tax No.	6 Statement Covers Period From	Through
55-5555551	12/1/14	12/31/14

8 Patient Name		9 Patient Address					
a		a	200 First Street				
b Road, Left		b Philadelphia	c PA	d 19111	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
2-5-59		12/1/14	11	2	4	09	01	X2		

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	
															a
															b

38		39 Value Codes Code	Amount		40 Value Codes Code	Amount		41 Value Codes Code	Amount	
	a	A1	1325	00	80	30				
	b									
	c									
	d									

42 Rev cod	43 Description	44 HCPCS/Rate/HIPPS code	45 Serv.	46 Serv. units	47 Total Charges		48 Non-covered charges		49
124	Inpatient			30	1,200,000	00			
	PAGE ___ OF ___	CREATION DATE	1/20/15	TOTALS →	1,200,000	00			

50 Payer Name	51 Health Plan ID	52 Rel Info		53 Asg. Ben.	54 Prior Payments		55 Est. Amt Due		56 NPI	9876543210	
Medicare CBH	123456	y		y	45,000	00	1325	00	57 Other Prv ID	283Q00000X	A B C

58 Insured's Name	59 P. Rel	60 Insured's Unique ID	61 Group Name	62 Insurance Group No.	
Road, Left	18	111456789			A B C

63 Treatment Authorization Codes	64 Document Control Number	65 Employer Name	
90909099			A B C

66 DX	296.34										68
69 Admit DX	296.34	70 Patient Reason DX				71 PPS Code		72 ECI			73

74 Principal Procedure Code	Date	a Other Procedure Code	Date	b Other Procedure Code	Date	75	76 Attending	NPI 1123460889	Qual	
							Last Kavan		First Mui	
c Other Procedure Code	Date	d Other Procedure Code	Date	e Other Procedure Code	Date		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				

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23