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, effective 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
				NM103	Patient Last Name
			2010CA	NM104	Patient First Name
2	Patient's Name	Required	or 2010BA	NM105	Patient Middle Name or Initial
				NM107	Patient Name Suffix
3	Patient's Birth Date, Sex	Required	2010CA	DMG02	Subscriber Birth Date
3	Patient's Birth Date, Sex	Required	or	DMG03	Subscriber Gender Code
				N302	Patient Address Line
			l	N401	Patient City Name
5	Patient's Address	Required	2010CA	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
				NM103	Other Insured Last Name
				NM104	Other Insured First Name
9	Other Insured's Name	Situational, if TPL information present then Required	2330A	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

ltem 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
				NM103	Referring Provider Last Name
	Name of Referring Provider or		2310A (referring)	NM104	Referring Provider First Name
17	Other Source	Required		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
				HI01-2	Diagnosis Code
				H102-2	Diagnosis Code
21	Diagnosis or Nature of Illness or Injury	21A = Required 21B-L = Situational	2300	HI03-2	Diagnosis Code
				HI04-2	Diagnosis Code
			2300	CLM05-3	Claim Frequency Code
22	Medicaid Resubmission and/or Original Reference Number	Situational	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
	2010(0) 0. 00.000		2300	CLM05-1	Place of Service Code
24B	Place of Service	Required	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	2010AA	REF02	Billing Provider Tax Identification Number
25	rederal rax ID Number	SSN/EIN: Required	2020711	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
			2300	AMT02	Patient Amount Paid
29	Amount Paid	Situational, if TPL information present then Required	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
				NM103	Laboratory or Facility Name
				N301	Laboratory or Facility Address Line
32	Service Facility Location Information	Situational, if laboratory services required	2310C	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
				NM103	Billing Provider Last or Organizational Name
				NM104	Billing Provider First Name
				NM105	Billing Provider Middle Name or Initial
				NM107	Billing Provider Name Suffix
33	Billing Provider Info & Ph #	Required	2010AA	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
			2000A	PRV03	Provider Taxonomy Code
33b	Other ID #	Required	2010AA	REF01	Reference Identification Qualifier
				REF02	Billing Provider Tax Identification Number



REGULAR CLAIM

	SURANCE C														90
	NAL UNIFORM CLAIM	COMMITT	EE (NUC	CC) 02/12										PICA [T	
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	ast Name, First Name, M	vliddle Initial				га дінтн од 281945	YE M	SEX F	4. INSURED'S NAM	dE (Last Name	First Na	ame, Middle	Initial)		
5. PATIENT'S ADDRES					6. PATIEN	T RELATION:	SHIP TO INS		7, INSURED'S ADD	PESS (No., SI	reel)				
625 DAISY ST	TREET				Self	Spouse	Child	Ollrer							
CITY PHILA				PA STATE	8. RESERV	/ED FOR NU	CC USE		CITY		O.F.			STATE	Š
ZIP CODE 19122		NE (Include 22000 (ode)					ZIP CODE		TELE (PHONE (In	clude Area (Code)	NOTAMOORIA
9. OTHER INSURED'S	3 NAME (Last Name, Fi	rst Name, k	Aiddle In	itial)	10. IS PATI	ENT'S COND	OITION RELA	TED TO:	11, INSURED'S PO	OLICY GROUP	OR FE	CA NUMBI	ER		
a, OTHER INSURED'S	3 POLICY OR GROUP	NUMBER			в. EMPLOY	MENT? (Curr			a, INSURED'S DA	TE OF BIRTH		м	SEX	гП	0100
b. RESERVED FOR N	JUCC USE				b. AUTO A		-	PLACE (State)	b_OTHER CLAIM	! ID (Designated	d by NU			· 🗀	A CIAR
c, RESERVED FOR N	UCC USE		_		c. OTHER	ACCIDENT?		PA_	c, INSURANCE PL	AN NAME OF	PROG	FIAM NAME	=====		FINE
d. INSURANCE PLAN	NAME OF PROGRAM	NAME			10d. CLAIN	YES (De	esignated by h		d. IS THERE ANO	A 4					FVC
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SIGNED X						ATE 0	1/0 2/20	15	SIGNED	<					
14. DATE OF CURRE	NT ILLNESS, INJURY,	or PREGNA	NCY (L	MP) 15. C	THER DAT	E MM	DD	YY	16, DATES PATIE	NT NABLE T	O WOR		RENT OCCU	PATION	٦,
17 NAME OF PEEER	QUAL.	OTHER SOL	IRCE	QUA 17a.					18, HOSPITALIZAT	ION DATES RE	ELATED	TO CURRE	NT SERVIC	ES	-
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LAB CLAIM

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1a. INSURED'S LD. NUMBER CHAMPVA (For Program in Item 1) MEDICARE MEDICAID GROUP HEALTH PLAN HLK LUNG 0123455789 (10#) (Medicare#) X (Medicald#) (ID#/DoD#) (Member ID#) 3. PATIENT'S BIRTH DATE 0328 1945 4_INSURED'S NAME (Last Name, First Name, Middle Initial) 2 PATIENT'S NAME (Last Name, First Name, Middle Initial) SEX BROWN LILY 6. PATIENT RELATIONSHIP TO INSURED 7. (NSURED'S ADDRESS (No., Street) 5, PATIENT'S ADDRESS (No., Street) Self X Spouse Child 625 DAISY STREET B. RESERVED FOR NUCC USE INSURED INFORMATION PHILA PA ZIP CODE ZIP CODE TELEPHONE (Include Area Code) 215 2220000 19122 11 INSURED'S POLICY GROUP OR FECA NUMBER 10. IS PATIENT'S CONDITION RELATED TO: P. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 8. OTHER INSURED'S POLICY OR GROUP NUMBER a, EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH No YES b, AUTO ACCIDENT? b. RESERVED FOR NUCC USE b, OTHER CLAIM ID (Designated by NUCC) PATIENT AND PLACE (State) YES NO PA C. INSURANCE PLAN NAME OF PROGRAM NAME C BESERVED FOR NUCC USE c. OTHER ACCIDENT? YES d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 10d, CLAIM CODES (Designated by NUCC) d. INSURANCE PLAN NAME OR PROGRAM NAME If yes, complete Items 9, 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE | 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. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I Bulhorize payment of medical benefits to the undersigned physician or supplier for services described below. 01/06/2015 SIGNED X DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT 14, DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE DD OLIAL. FROM то 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 18 HOSPITAL PATION DATES RELATED TO CURRENT SERVICES 1123457789 TREATMENT NOW FROM TΩ 20, OUTSIDE LAB? 19, ADDITIONAL CLAIM INFORMATION (Designated by NUCC) YES 22. RESUBMISSION 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. ICD-9-CM ORIGINAL REF. NO. A 304.03 n 1 29 PRIOR ALITHORIZATION NUMBER E. 1 F. 1 G. L н. 1 9090909 B. ACE O D. PROCEDURES, SERVICES, OR SUPPLIES SUPPLIER INFORMATION From RENDERING DIAGNOSIS ID. (Explain Unusual Circumstances) PONTER PROVIDER ID. # CPT/HCPCS MODIFIER DD DD BEFFVICE EMG 75.00 01/06/2015 01/06/2015 85014 2 NPI 3 NPI OB NP PHYSICIAN 5 NPI 6 NPI 29. AMOUNT PAID 30. Rsvd for NUCC Use 27. ACCEPT ASSIGNMENT? 26. PATIENT'S ACCOUNT NO. 25, FEDERAL TAX LD, NUMBER SSN EIN 01-8765432 4747474747LB47Y YES s 75.00 3 BLLING PROVIDER INFO & PH # 31 SIGNATURE OF PHYSICIAN OR SUPPLIER TREATMENT NOW INFORMATION 215-999-0000 INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the rowted apply to this bill and are made a part thereof.) 1919 WEST STREET 101 LEFT STREET PHILA 19197 PHILA PA 19101

01/07/2015

a. 1123457789

a.9876543210



TPL CLAIM

HEALTH INSUF	RANCE C	LAIM	FOF	RM										
APPROVED BY NATIONAL (UNIFORM CLAIM	COMMIT	TEE (NI	JCC) (12/12										PICA I I I
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1. MEDICARE MEDI (Medicare#) (Medicare#)		CARE (/DoD#)		CHAMPVA (Member ID	GRO	LTH PLAN	FECA BLK LUNG (ID#)		0123455789	NUMBER		1	Por integral in in	i lielli i)
2 PATIENT'S NAME (Last Na BROWN		viddle Initi	ial)			8 1945	E S	EX F	4. INSURED'S NAME	(Last Nam	e, First N	lame, Midd	le Initial)	
5, PATIENT'S ADDRESS (No					6. PATIENT	RELATIONSH			7. INSURED'S ADDR	ESS (No.,	Street)			_
625 DAISY STRE	ET				Self			Other					- 1,	STATE
CITY PHILA				PA	8. RESERV	ED FOR NUCC	USE		CITY					
ZIP CODE 19122	215 2			Code)					ZIP CODE		TEL	EPHONE (nclude Area C	ode)
D. OTHER INSURED'S NAM BROWN	IE (Last Name, Fi	rst Name	Middle	Initial)	10, IS PATII	ENT'S CONDIT	TON RELAT	ED TO:	11, INSURED'S POL	ICY GRO	JP OR F	ECA NUM	BER	
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19, ADDITIONAL CLAIM IN	FORMATION (De	signated i	by NUCC	C)					20. OUTSIDE LAB?	7 _{NO} 1		\$ CHA	RGES	
21. DIAGNOSIS OR NATURI	É OF ILLNESS OF	NURY	Relate /	-L to service	line below (24	E) ICE	Ind. ICD	-9-CM	22, RESUBMISSION CODE		- ACIO	MALAL FACE	NO	
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31. SIGNATURE OF PHYSI		IER				ATION INFORI	MATION		TREATMEN	WON	PH#	215-0	7-0009)
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orm Locator	Resoription for Paper	USAGE	8371 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	SITUATIONAL		Loop 2010AB, NM1/85/03, N3 segment, N4 segment
03a	different from form locator 01) 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	unique for EACH materials claim	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	LISAGE	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, HI08-2 (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, HI03-2 (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) HI06-5 Loop 2300, HI05-2 (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, HI09-2 (HI10-1= BE) HI10-5 Loop 2300, HI10-2 (HI11-1= BE) HI11-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5
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 45 (23)	Service Date Creation Date	REQUIRED		Loop 2400, DTP/472/03
46		REQUIRED		Loop 2400, SV205
40	Service/Units	REGOINED		100p 8 100p 0 100p
47 (23)	Total Charges	REQUIRED	Enter the name of each payer organization from which	Loop 2400, SV203
50a-c	Payer Name	REQUIRED	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 Loop 2300, CLM08
53 a-c	Assignment of Benefits Certification 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	This information must be sent in all CBH claims for the	Loop 2010AA, NM1/85/09
57c	Billing Provider Specialty Information Insured's Name	REQUIRED	purpose of adjudication	Loop 2000A, PRV03 Loop 2010BA, NM1/IL/03, 04, 05
58a-c	Other Insured's Name	REQUIRED		Loop 2330A, NM1/IL/03, 04, 05 Loop 2000B, SBR02
59a-c	Patient Relationship	REQUIRED	Length of 10	Loop 2010BA, NM1/IL/09, REF/SY/02
60a-c	Subscriber Identification Code	REQUIRED	Length of 10.	
63 67a-0	Treatment Authorization Codes	REQUIRED		Loop 2300, REF/G1/02 Loop 2300, HI01-2 (HI01-1=BK)
67a-q 69	Diagnosis 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) Loop 2300, HI03-2 (HI03-1= BN)
		DATACIONAL		ACCIONA ASSET PRICES APPRICA DE PINA
72a-c 74	External Cause of Injury Code Principal Procedure Code	SITUATIONAL		Loop 2300, HI01-2 (HI01-1= BR)

Form Locator	Description for Paper	USAGE	837i Companion Guide for HD1	ASC 837I v5010A2 Loop, Segment for EDI
74а-ө	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, HI04-2 (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

- O 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

- O 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
- YO 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:

- Yes, present at the time of inpatient admission
- No, not present at the time of inpatient admission
- 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
- 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

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