UB-04 Claim Form Instructions

June 2013

Topics

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- Multi-page claims
- Proper billing order
- Multiple payer types
- Voiding a claim
- Adjusting a claim
- Field requirement table
- Claims mailing address

Introduction

- These instructions address Nevada Medicaid *paper* claim requirements.
- If you submit electronic claims through a clearinghouse, please contact the clearinghouse directly if you have a question specific to submitting a claim or receiving an electronic remittance advice.
- To register to submit electronic claims to Medicaid, see the "Electronic Claims/EDI" webpage online at http://www.medicaid.nv.gov. The EDI webpage contains EDI enrollment forms, announcements and companion guides.

Field Requirements

Required

Fields marked *Required* in the UB-04 claim form instructions are required on all paper claim submissions. The claim may be denied or returned if a *required* field is incomplete. For example, the recipient's last name, first name and middle initial as indicated on the Medicaid ID card must be entered in Field 8b.

Situational

Fields marked *Situational* are required when they apply to the claim. For example, for claims with Third Party Liability (TPL), enter an occurrence code and associated date in Fields 31-34.

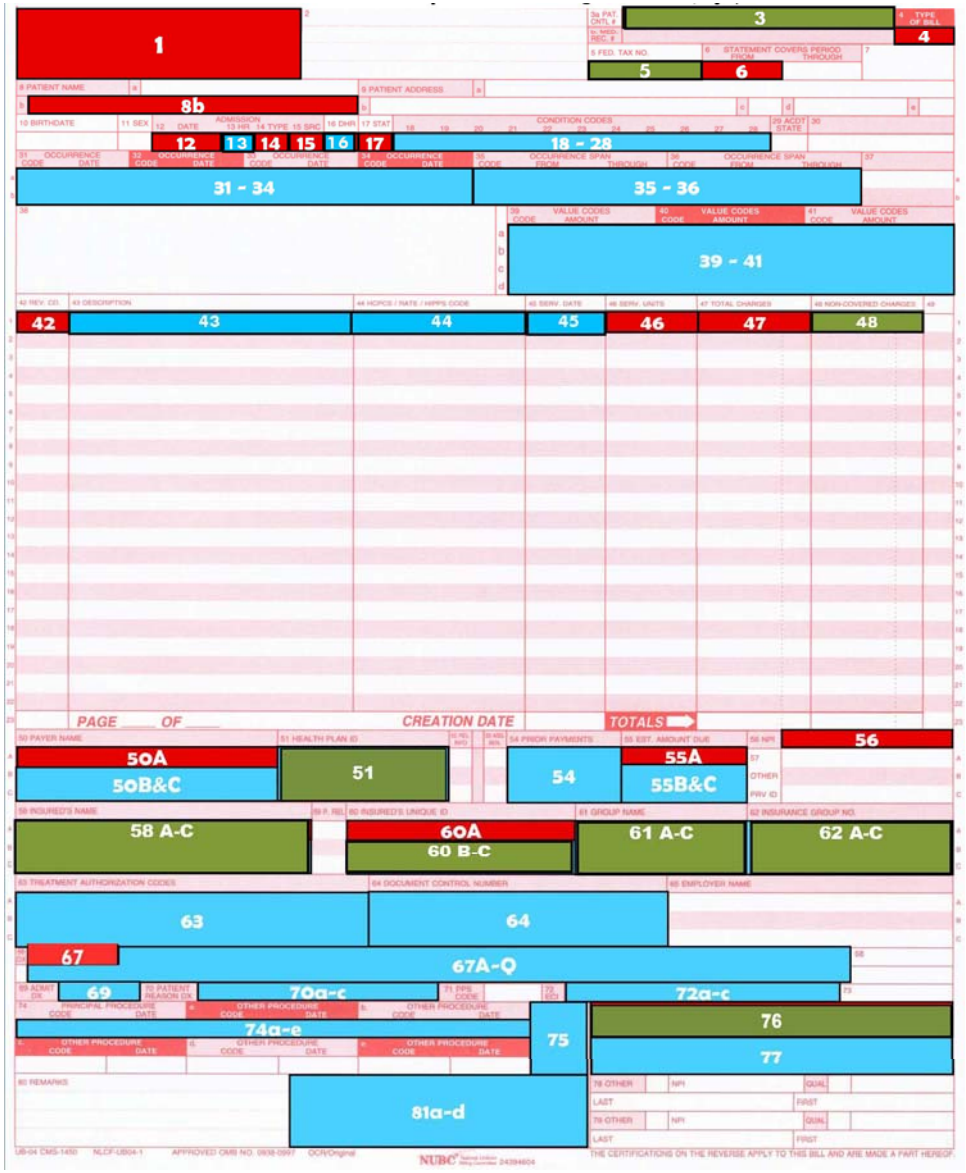
Recommended

Fields marked *Recommended* are not required, but are accepted. For example, it is recommended to enter your patient control number in Field 3a to assist you in reconciling your claim records.

Not Required

Fields marked *Not Required* are not used when processing Nevada Medicaid and Nevada Check Up claims. For example, providers may use Fields 9a-e to enter the recipient's address, but the data will not be used to adjudicate the claim.

UB-04 Claim Form Color Guide



Multi-Page Claims

Limitations

- Paper claims are limited to **5 pages (110 service lines)** per claim.

Proper Billing Order

Using lines A, B, C and D correctly

- Some fields have multiple lines. Lines are labeled with alpha characters *A-C*. Line *d* is not used on Nevada Medicaid and Nevada Check Up claims.
- Whenever a field has more than one line, enter primary insurance information on line A (a), secondary insurance information on line B (b), and tertiary insurance information on line C (c). Ensure this rule is followed throughout all fields that have more than one line marked with an alpha character.

More Than Three Payers

- A claim may have more than three payers. In these circumstances:
  - *Line A*: Enter primary insurance information in Fields 50 and 54.
  - *Line B*: Enter words *Multiple Policies* in Field 50. In Field 54, enter the sum of the prior payments from other carriers (excluding the primary carrier listed on Line A). Do not complete any other fields on this line.
  - *Line C*: Enter Medicaid information in Fields 50 and 55.
- Attach an EOB to the claim to show *each* prior payment.
- *When mailing, write on the envelope: Attn: Customer Service*

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	NPI	
A	Name of Primary Carrier	Primary Carrier Code			Primary Pymt		57	Primary ID	A
B	"Multiple Policies"				Other Pymts		OTHER		B
C	Medicaid				Legal Oblig.		PAY ID	NPI	C

Voiding A Claim

- A claim void may be submitted when a previously *paid* claim should not have been paid. The reversal of the claim will appear on the remittance advice.
- To void a claim, complete the following claim form fields:
  - Field 4: Use *8* as the last digit in the Type of Bill code.
  - Field 64: Enter the claim's *last paid* Internal Control Number (ICN).
  - Field 75: Include the most appropriate void reason code from the table below.

Void Codes

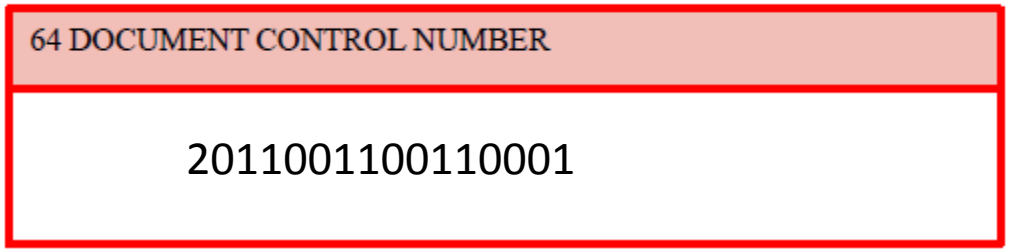
Code	Description
1044	Wrong provider identifier used
1045	Wrong Recipient ID used
1047	Duplicate payment
1048	Primary carrier has paid full charges
1052	Miscellaneous
1060	Other insurance is available

Adjusting A Claim

- A claim adjustment may be submitted when a previously *paid* claim is found to be incorrect. An adjustment will void the original claim and create a new claim with the corrected information. Both the reversal of the original claim and the payment for the new claim will appear on the remittance advice. Timely filing limits apply. To submit a claim adjustment, complete the claim form fields below.
- Field 4: Use *7* as the last digit in the Type of Bill code.

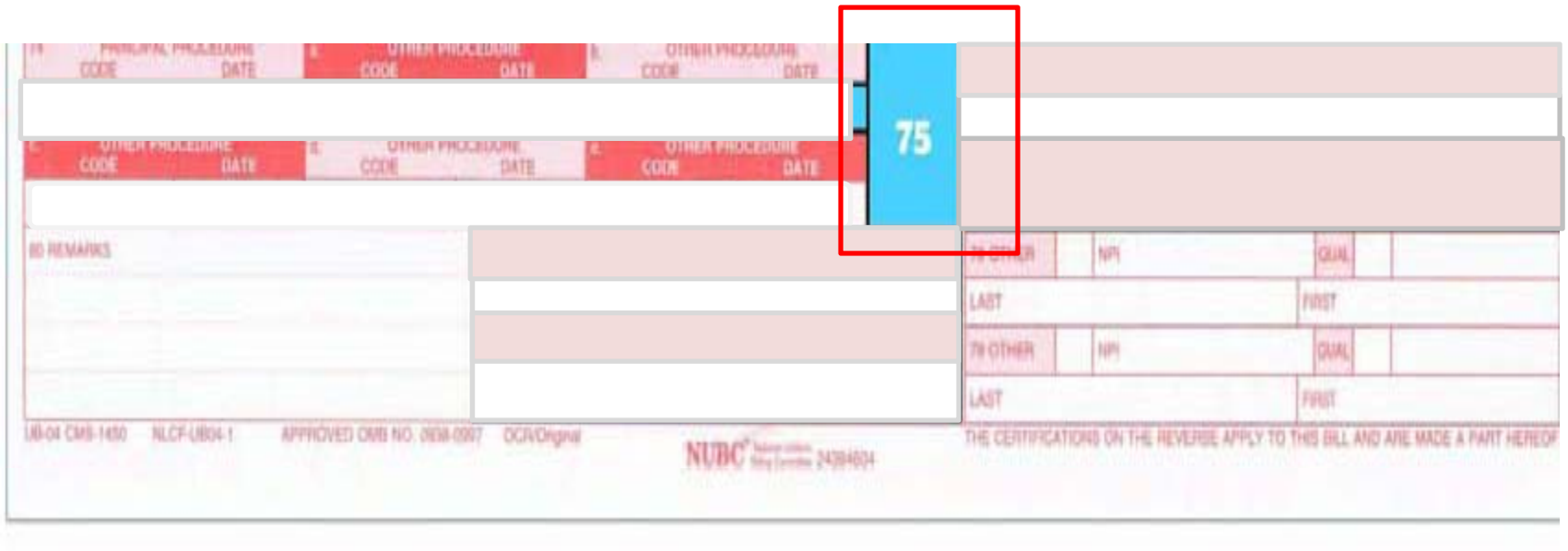
Adjusting A Claim

- Field 64: Enter the claim's *last paid* Internal Control Number (ICN).



Adjusting A Claim

- Field 75: Include the most appropriate adjustment reason code from the table on the following slide.



Adjustment Codes

Code	Definition
1021	Late charges received by facility business office
1023	Primary carrier has made additional payment
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units, visits or studies
1034	Correcting quantity dispensed
1035	Correcting drug code
1041	Incorrect amount paid for original claim
1042	Original claim has multiple incorrect items
1053	Adjustment (miscellaneous)

Instructions For Completing The UB-04 Form

Fields Marked With an Asterisk: In the Field column of the table below, some field numbers are preceded with an asterisk (*). In these fields, use HIPAA-compliant codes that are current for the date(s) of service on the claim.

Field	Requirement	Field Name and Instructions for UB-04 Form
1	**Required**	**Billing provider name and address:** Enter the name and address of the billing provider.
2	Not required	Pay-to name and address (unlabeled on form)
3a	**Recommended**	**Patient control number:** Although not required, you can use this field to enter the recipient's unique control number assigned by the provider (internal patient account number). **If your patient control number is on the claim, HP Enterprise Services will also list it on the remittance advice. We *recommend* completing this field as it may assist you in reconciling your claim records.**
3b	Not required	Medical/Health record number
***4**	**Required**	**Type of bill:** Enter the appropriate type of bill code. • **Adjustments:** Use *7* for the last digit in your Type of Bill code. • **Voids:** Use *8* for the last digit in your Type of Bill code.
5	**Recommended**	**Federal tax number:** Enter the provider's number assigned by the federal government for tax reporting purposes (also known as a tax identification number (TIN) or employer identification number (EIN)).
6	**Required**	**Statement covers period:** Enter the beginning service date in the *From* area and the last service date in the *Through* area of this field. **For services received on a single day, use the same *From* and *Through* dates.**
7	Not required	Reserved for assignment by the NUBC
8a	Not required	Patient name identifier (a):
8b	**Required**	**Patient name:** Enter the recipient's last name, first name and middle initial as indicated on the Medicaid ID card.
9a-e	Not required	Patient address
10	Not required	Patient birth date
11	Not required	Patient sex
12	**Required**	**Admission/start of care date:** Enter the **start date for this episode** of care. For inpatient services, this is the date of admission. For other services (e.g., home health), enter the date the episode of care began.
***13**	**Situational**	**Admission hour (if applicable):** If inpatient, indicate the hour during which the recipient was admitted. If outpatient, enter the hour the episode of care began.

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
***14**	**Required**	**Priority (type) of visit:** Indicate the priority of this admission/visit.
***15**	**Required**	**Source of referral for admission or visit:** Indicate the source of referral for this admission or visit.
***16**	**Situational**	**Discharge hour (if applicable):** If inpatient, indicate the hour in which the recipient was discharged from inpatient care. If outpatient, enter the hour the episode of care concluded.
***17**	**Required**	**Patient discharge status:** Indicate the recipient's disposition or **discharge status** at the end of service for the period covered on this bill, as reported in Field 6, Statement Covers Period.
***18-28**	**Situational**	**Condition codes:** If applicable, indicate **conditions or events** relating to this claim.
29	**Situational**	**Accident state:** If services reported on this claim relate to an auto **accident**, enter the two-digit state/province abbreviation where the accident occurred.
30	Not required	Reserved for assignment by the NUBC
***31-34**	**Situational**	**Occurrence codes and dates:** For claims with **TPL**, enter an occurrence code and associated date on Lines a and b according to proper billing order. • *Code 25:* If other insurance **terminated benefits**, use occurrence code *25* and enter the date the other coverage terminated. If it was Medicare, contact the TPL specialist at TPL@dhcfp.nv.gov. For commercial carriers, contact Emdeon at (855) 528-2596 or TPL-NV@emdeon.com to request an update to the recipient's TPL file. • *Code 24:* If other insurance **denied the claim**, use occurrence code *24* and enter the date the claim was denied. The attached EOB must show the *reason* for the denial. • *Code A3, B3 or C3:* If **benefits have been exhausted** for the primary, secondary or tertiary insurance, enter occurrence code A3, B3 or C3, respectively, and the date on which benefits were exhausted. The attached EOB must show that *benefits have exhausted* with this carrier.
***35-36**	**Situational**	**Occurrence span codes and dates:** If applicable, enter an *occurrence span code* and corresponding dates. (Complete all fields in *Line a* before using the *Line b* fields.)
37	Not required	Reserved for assignment by the NUBC
38	Not required	Responsible party name and address: **Although not required, the claims mailing address can be entered into this field when mailing claims in a window envelope. The address is: HP Enterprise Services, Attn: Claims, P.O. Box 30042, Reno NV 89520-3042.**

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
***39-41**	**Situational**	**Value codes and amounts:** On claims for **home health services**, refer to special instructions in the Home Health Agency Billing Guide. On claims with Medicare **TPL**, enter up to 3 value codes and amounts on the Medicare line. • **Report deductible when Medicare is primary:** Enter code *A1* in the *Code* area **on Line a**, followed by the amount that will apply to the deductible. • **Report co-insurance when Medicare is primary:** Enter value code *A2* in the *Code* area **on Line a**, followed by the amount that will apply to the co-insurance. • **Report deductible when Medicare is secondary:** Enter value code *B1* in the *Code* area **on Line b**, followed by the amount that will apply to the deductible. • **Report co-insurance when Medicare is secondary:** Enter value code *B2* in the *Code* area **on Line b**, followed by the amount that will apply to the co-insurance.
***42**	**Required**	**Revenue code:** Enter up to one revenue code per line as needed in lines 1-22. Do not skip lines. The revenue code must be current for the date(s) of service on the claim. **Each procedure, service, supply and drug must be listed on its own claim line, e.g., do not use the same claim line to bill for an office visit and an outpatient facility administered drug.**
***43**	**Situational**	**Description:** In this field, enter **qualifier N4** followed immediately by the drug's **11-digit NDC** followed by **a space** and then the **NDC quantity** (not HCPCS units) of the drug. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. Therefore, you **must add leading zeros** to one or more sections of the NDC if the container label does not display: • 5 digits in the first section of the NDC • 4 digits in the second section of the NDC • 2 digits in the third section of the NDC *Continued on the next page*

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
***43**	**Situational**	*Continued from the previous page* **For example**, using the 5-4-2 model described above: • 34-73-1 on the container label is expressed as 00034007301 on the claim • 654-3773-22 on the container label is expressed as 00654377322 on the claim • 1645-222-65 on the container label is expressed as 16457022265 on the claim • 12345-6-7 on the container label is expressed as 12345000607 on the claim • 86541-4885-77 on the container label is expressed as 86541488577 on the claim For **multi-ingredient compounds**, list each component separately, on its own claim line with the NDC and NDC quantity is this field. For more information and examples on billing outpatient facility administered drugs, see the *NDC Billing Reference* on the HP Enterprise Services website.
***44**	**Situational**	**HCPCS/Accommodation Rates/HIPPS Rate Codes:** *Outpatient services:* Enter the appropriate procedure code (HCPCS or CPT) and up to four modifiers. **Note:** On the 23rd line of **each** page (including the first and last pages), enter the page number and total number of pages.
45	**Situational**	**Service date:** *Inpatient claims:* Leave this field blank. *Outpatient claims:* Enter the date the service was provided. Note: The date in Field 45 must be within the date range indicated in Field 6.
46	**Required**	**Service units:** *Inpatient and outpatient services:* Enter the applicable **quantitative measure** of services (e.g., number of accommodation days, miles, pints of blood, renal dialysis treatments). *Outpatient facility administered drugs:* Leave this field blank.
47	**Required**	**Total charges:** *Inpatient claims:* Enter charges per line for **covered and non-covered** services during the billing period shown in Field 6. *Outpatient claims or outpatient facility administered drugs:* Enter the charges on this line for **covered and non-covered** services/drugs on the billing date shown in Field 45. Note: The date in Field 45 must be within the date range indicated in Field 6.
48	**Recommended**	**Non-covered charges:** Enter the charge for non-covered Medicaid services. Include charges incurred during non-covered days.
49	Not required	Reserved for assignment by the NUBC

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
50A-C	**Line A required, Lines B & C situational**	**Payer name:** As applicable, enter the name of the recipient's primary, secondary and tertiary insurance on Lines A, B and C, respectively. On claims with no TPL, Medicaid information is entered on Line A. **If the recipient has Medicare coverage** (primary, secondary *or* tertiary), enter the word *Medicare* followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus).
51A-C	**Lines A, B & C recommended**	**Health plan ID:** As applicable, enter the **carrier code** for the recipient's TPL on Lines A and B, according to *proper billing order*.
52A-C	Not required	Release of Information Certification Indicator (REL INFO)
53A-C	Not required	Assignment of Benefits Certification Indicator (ASG BEN)
54A-C	**Situational**	**Prior payments:** Enter **payment received** from other insurance according to *proper billing order*. Do not include write-off or contractual adjustment amounts. Do not enter an amount on the line that lists the payer, *Medicaid*. If the claim has TPL, complete Field 54 on the first page. This information is not necessary on any other page of the claim.
55A-C	**Line A required, Lines B & C situational**	**Estimated amount due:** *Single page claims/First page of multi-page claims:* If Medicaid is primary; enter the amount of **covered charges for all pages** on Line A. If there is **TPL**, enter the recipient's legal obligation to pay on the line that lists Medicaid. Do not include write-off or contractual adjustment amounts. If the claim has TPL, complete Field 55 on the first page. This information is not necessary on any other page of the claim.
56	**Required**	**National Provider Identifier – Billing Provider (NPI):** Enter an NPI in Field 56.
57A-C	Not required	Other (Billing) provider identifier
58A-C	**Lines A, B & C recommended**	**Insured's name:** As applicable, enter the insured's name for the primary, secondary and tertiary insurance on Lines A, B and C, according to *proper billing order*. On the line that shows payer, *Medicaid,* enter the **recipient's name** exactly as shown on their Medicaid card.
59A-C	Not required	Patient's Relationship to Insured (P. REL)
60A-C	**Line A required, Lines B & C recommended**	**Insured's unique identifier:** As applicable, enter the insured's unique identifier for the primary, secondary and tertiary insurance on Lines A, B and C according to *proper billing order*. On the line that shows payer, *Medicaid,* enter the 11-digit **Recipient ID** as shown on the recipient's Medicaid card. Do not include spaces or hyphens. Clarification: Medicaid payer line is required; the other lines are recommended.
61A-C	**Recommended**	**Insured's group name:** If the claim has **TPL**, enter the insurance group name according to *proper billing order*. Do not enter a group name on the line that shows payer, *Medicaid*.
62A-C	**Recommended**	**Insured's group number:** If the claim has **TPL**, enter the group number of the recipient's insurance according to *proper billing order*. Do not enter a group number on the line that shows payer, *Medicaid*.

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
63A-C	**Situational**	**Treatment authorization code:** If you obtained an 11-digit Authorization Number from Medicaid for the service/item, enter it on the line that shows payer, *Medicaid*. Only one Authorization Number may be entered per claim.
64A-C	**Situational**	**Document control number:** When **adjusting or voiding** a previously paid claim, enter the claim's last paid Internal Control Number (ICN) on the line that shows payer, *Medicaid*. Only *one* ICN may be entered per claim.
65A-C	Not required	Employer name (of the insured)
66	Not required	Diagnosis and procedure code qualifier (ICD Version Indicator)
67	**Required**	**Principal Diagnosis Code and Present on Admission Indicator:** Enter the **diagnosis code** for the recipient's primary condition.
67A-Q	**Situational**	**Other diagnosis codes:** Enter a **diagnosis code** for each condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.
68	Not required	Reserved for assignment by the NUBC
69	**Situational**	**Admitting diagnosis code:** Enter the **diagnosis code** describing the recipient's reason for admission. This is required on inpatient claims only.
70a-c	**Situational**	**Patient's reason for visit:** Enter up to three **diagnosis codes** to describe the patient's reason for the visit at the time of outpatient registration.
71	Not required	Prospective Payment System (PPS) Code
72a-c	**Situational**	**External Cause of Injury (ECI) Code:** Enter up to three **diagnosis codes**. This is required when a diagnosis describes an injury, poisoning or adverse effect.
73	Not required	Reserved for assignment by the NUBC
74	**Situational**	**Principal procedure code and date:** Enter a claim level diagnosis code that identifies the **principal inpatient procedure** and the date on which the procedure was performed. This is only required on inpatient claims when a procedure was performed (not required on an outpatient claim).
74a-e	**Situational**	**Other procedure codes and dates:** Enter **diagnosis codes** to identify all significant procedures (other than the principal) and the dates on which each procedure was performed. This field is required on inpatient claims when additional procedures must be reported (not required on an outpatient claim).
75	**Situational**	To **adjust or void** a claim, enter the appropriate 4-digit *reason code* in this Field. See also instructions for Fields 4 and 64.
76	**Recommended**	**Attending provider name and identifiers:** Enter servicing (rendering) provider's **NPI**.

Instructions For Completing The UB-04 Form *continued*

Field	Requirement	Field Name and Instructions for UB-04 Form
77	**Situational**	**Operating physician name and identifiers:** If a **surgery** was performed, enter the surgeon's NPI. In this field, **Hospice, Long Term Care** (Provider Type 65) claims, must enter the NPI of the nursing facility from which the recipient was transferred.
78	Not required	Other provider (individual) names and identifiers
79	Not required	Other provider (individual) names and identifiers
80	Not required	Remarks field
81a-d	**Situational**	**Code-code field:** Use this field to report additional **value codes** and/or **taxonomy codes** if applicable.

Claims Mailing Address

HP Enterprise Services
PO Box 30042
Reno, NV 89520-3042

Adjustments, voids and any other written correspondence may also be sent to this address.

Contact Information

Customer Service Center
Claim inquiries and general information
Phone: (877) 638-3472

Automated Response System (ARS)
Phone: (800) 942-6511

Assistance with Prior Authorizations
Phone: (800) 525-2395

Requests for Provider Training
Email: NevadaProviderTraining@hp.com

Questions?

Thank you for your attention

Please complete the course evaluation before leaving class

Enjoy the remainder of your day