Tips for Completing the UB04 (CMS-1450) Claim Form

As a Carelonfacility partner, we value the services you provide and it is important to us that you are reimbursed for the work you do. To assure your claim is not rejected or denied, we provide the tips below for accurately completing the UB04 (CMS-1450) claim form.

Field	Field description	Field type	Instructions
1	Facility name, Address, Telephone Number, and Country Code	Required	This field contains the complete servicing address (the address where the services are being performed/rendered) and telephone and/or fax number. This must be a street address. Please enter this to match the name and address submitted to Carelonon your credentialing documents.
2	Pay-to Name and Address	Situational	This field contains the address to which payment should be sent if different from the information in field 1. Please be sure this matches what you submitted on your credentialing documents.
3a	Patient Control Number	Required	Complete this field with the patient account number assigned by the provider that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.
3b	Medical/Health Record Number	Situational	In this field, report the patient's medical record number as assigned by the provider.
4	Type of Bill	Required	This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The second digit is the type of facility. The third digit classifies the type of care being billed. The fourth digit indicates the sequence of the bill for a specific episode of care.
5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). The format is NN-NNNNNNN.
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.
7	Reserved for Assignment by the NUBC	Not Required	N/A
8a	Patient Identifier	Situational	This field is for the patient's identification number. Only required if the patient's ID on their identification card is different than the subscriber's.
8b	Patient Name	Required	This field is for the patient's last, middle initial, and first name.
9a	Patient Address	Required	This field is for entering the patient's street address. Please comply with US Postal service guidelines for all addresses.

9b	(unlabeled field)	Required	This field is for entering the patient's city.
9c	(unlabeled field)	Required	This field is for entering the patient's state code as defined by the US Postal Service.
9d	(unlabeled field)	Required	This field is for entering the patient's ZIP code.
9e	(unlabeled field)	Required	This field is for entering the patient's Country Code.
10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Sex	Required	Use this field to identify the sex of the patient.
12	Admission Date/Start of Care Date	Situational	Required for inpatient and home health claims. The hospital enters the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.
13	Admission Hour	Situational	Required for most accounts including all inpatient and Medicaid claims. Enter the hour in which the patient is admitted for inpatient or outpatient care. **NOTE**: Enter using Military Standard Time (00–23) in top-of-the-hour times only.
14	Priority (Type) of Admission/Visit	Required	Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.
15	Source of Referral for Admission or Visit	Required	This field contains a code that identifies the point of patient origin for this admission or visit. See valid codes at the end of this section.
16	Discharge Hour	Situational	If the type of bill (field 4) ends in "1" or "4," discharge hour is required If the "begin" and "end" service dates (field 6) are the same, discharge hour must be later then admission hour (field 13) **NOTE**: Enter using Military Standard Time (00–23) in top-of-the-hour times only.
17	Patient Discharge Status	Required	Use this field to report the status of the patient upon discharge. See valid codes at the end of this section.
18–28	Condition Codes	Situational	Use these fields to report conditions or events related to the bill that may affect the processing of it.
29	Accident State	Situational	When appropriate, assign the two-digit abbreviation of the state in which an accident occurred.
30	Reserved for Assignment by the NUBC	Not Required	N/A
31–34	Occurrence Codes and Dates	Situational	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.). If you enter an occurrence code, the dates must be populated.

35–36	Occurrence Span Codes and Dates	Situational	This field is for reporting the beginning and end dates of the specific event related to the bill. If you enter an occurrence code, the dates must be populated.
37	Reserved for Assignment by the NUBC	Not Required	N/A
38	Responsible Party Name and Address	Not required	N/A
39–41	Value Codes and Amounts	Situational	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is qualified by all payers. If a code is present, the amount should be included.
42	Revenue code	Required	Use this field to report the appropriate *HIPAA* compliant numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/or ancillary service.
43	Revenue Description	Optional	This field contains a narrative description or standard abbreviation for each revenue code category reported on this claim.
44	HCPCS/Rate/HIPPS Code	Situational	Some revenue codes require a HCPCS code. This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.
45	Service Date	Situational	Required for outpatient services. Indicates the date the service was rendered using the six-digit format (MMDDYY).
46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.
47	Total Charges	Required	This field reports the total charges–covered and non-covered–related to the current billing period.
48	Non-Covered Charges	Situational	This field indicates charges that are non-covered charges by the payer as related to the revenue code.
49	Reserved for Assignment by the NUBC	Not Required	N/A
50a, b, c	Payer Name	Situational	If more than one payer is responsible for this claim, enter the name(s) of primary, secondary, and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification Number	Not Required	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.
52a, b, c	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement from the patient or the patient's legal representative to release information. Refer to Attachment B for valid codes.

53a, b, c	Assignment of Benefits Certification Indicator	Situational	Not required for Careloncontracted providers. Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.
54a, b, c	Prior Payments	Situational	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.
55a, b, c	Estimated Amount Due	Not required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.
56	National Provider Identifier–Billing Provider	Required	This field is for reporting the unique provider identifier assigned to the provider.
57	Other Provider Identifier–Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field. When populated, the qualifier is required.
58a, b, c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial. THIS MUST MATCH THE NAME ON THE *MEMBER*'S IDENTIFICATION CARD
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a, b, c	Insured's Unique Identification	Required	This is the unique number the health plan assigns to the insured individual. THIS MUST MATCH THE ID ON THE *MEMBER*'S IDENTIFICATION CARD.
61a, b, c	Group Name	Situational	Enter the group or plan name of the primary, secondary, and tertiary payer through which the coverage is provided to the member.
62a, b, c	Insurance Group Number	Situational	Enter the plan or group number for the primary, secondary, and tertiary payer through which the coverage is provided to the member.
63a, b, c	Treatment *Authorization* Codes	Situational	Enter the *authorization* number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized.
64a, b, c	Document Control Number	Not Required from the Provider	This number is assigned by the health plan to the bill for their internal control. Also used to indicate the DCN on any claim adjustment being requested.
65a, b, c	Employer Name (of the Insured)	Situational	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58.
66	*Diagnosis* and Procedure Code Qualifier (*ICD* Version Indicator)	Required	This qualifier is used to indicate the version of *ICD* used. A "9" is used for the 9th version and a "0" for *ICD*-10.
67	Principal Diagnosis Code	Required when applicable	Enter the valid ICD diagnosis to the highest level of specificity for services rendered.
67 a–q	Other *Diagnosis Codes*/Present on	Situational	This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment

	Admission Indicator (POA)		of the patient or the length of stay. The ICD completed to its fullest character must be used. The present on admission (POA) indicator applies to diagnosis codes (e.g., principal, secondary, and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code.
68	Reserved for Assignment by the NUBC	Not Required	N/A
69	Admitting *Diagnosis*	Situational	Required for inpatient claims. Enter a valid ICD diagnosis code to its highest level of specificity for services rendered that describes the diagnosis of the patient at the time of admission.
70 a–c	Patient's Reason for *Visit*	Situational	The ICD codes that report the reason for the patient's outpatient visit is reported here.
71	Prospective Payment System (PPS) Code	Not required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan using DRG codes.
72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse effects, the appropriate ICD diagnosis code is reported in this field.
73	Reserved for Assignment by the NUBC	Not Required	N/A
74	Principal Procedure Code and Date	Situational	Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
74 a–e	Other Procedure Codes and Dates	Not Required	N/A
75	Reserved for Assignment by the NUBC	Not Required	N/A
76	Attending Provider Names and Identifiers	Required	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim.
77	Operating Physician Name and Identifiers	Situational	Report the name and identification number of the physician responsible for performing surgical procedure in this field.
78–79	Other Provider Names and Identifiers	Situational	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.
80	Remarks	Not Required	This field is used to report additional information necessary to process the claim.
81 a–d	Code–Code	Situational	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set. Taxonomy codes should be reported in these fields using a qualifier of B3.

UB04 (*CMS*-1450) REFERENCE MATERIAL[1]

Type of Bill Codes (Field 4)

This is a four-digit code; each digit is defined below.

First Digit–Leading Zero	
0XXX	

Second Digit–Type of Facility	Description of Second Digit
01XX	Hospital
02XX	Skilled Nursing
03XX	Home Health Facility
04XX	Religious Non-medical Health Care Institutions (RNHCI)–Hospital Inpatient
05XX	Reserved for National Assignment by the NUBC
06XX	Intermediate Care (not used for Medicare)
07XX	Clinic or Hospital Based Renal Dialysis Facility (Requires Special Reporting for the Third Digit)
08XX	Special Facility or ASC Surgery (Requires Special Reporting for the Third Digit)
09XX	Reserved for National Assignment by the NUBC

Third Digit–Bill Classification	Description of Third Digit Except for Clinics and Special Facilities
0X**1**X	Inpatient (Including Medicare Part A)
0X**2**X	Inpatient (Medicare Part B Only) (Includes HHA *Visits* Under a Part B Plan of Treatment)
0X**3**X	Outpatient (Includes HHA *Visits* Under a Part A Plan of Treatment Including DME Under Part A)
0X**4**X	Other (Part B)
0X**5**X	Intermediate Care Level 1
0X**6**X	Intermediate Care Level II
0X**7**X	Reserved for National Assignment by NUBC

[1] Ingenix® *Uniform Billing Editor, March, 2015*

0X**8**X	Swing Beds
0X**9**X	Reserved for National Assignment by NUBC

Third Digit–Bill Classification	Description of Third Digit Classification for Clinics Only
0X**1**X	Rural Health Clinic
0X**2**X	Clinic–Hospital Based or Independent Renal Dialysis Center
0X**3**X	Freestanding
0X**4**X	Other Rehabilitation Facility (ORF)
0X**5**X	Comprehensive Outpatient Rehabilitation Facility (CORF)
0X**6**X	Community Mental Health Center (CMHC)
0X**7**X	Reserved for National Assignment by NUBC
0X**8**X	Reserved for National Assignment by NUBC
0X**9**X	Other

Third Digit–Bill Classification	Description of Third Digit Classification for Special Facility Only
0X**1**X	Hospice (Non-hospital based)
0X**2**X	Hospice (Hospital based)
0X**3**X	Ambulatory Surgery Center
0X**4**X	Freestanding Birthing Center
0X**5**X	Critical Access Hospital
0X**6**X	Reserved for National Assignment by NUBC
0X**7**X	Reserved for National Assignment by NUBC
0X**8**X	Reserved for National Assignment by NUBC
0X**9**X	Other
Fourth Digit–Frequency of the Bill	**Description of Fourth Digit Frequency of the Bill**
0XX**0**	Nonpayment/Zero Claim

0XX**1**	Admit through Discharge Claim
0XX**2**	Interim–First Claim
0XX**3**	Interim–Continuing Claim (Not valid for Medicare PPS Claims)
0XX**4**	Interim–Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
0XX**5**	Late Charges Only Claim
0XX**6**	Reserved for National Assignment by NUBC
0XX**7**	Replacement of Prior Claim
0XX**8**	Void/Cancel of a Prior Claim
0XX**9**	Final Claim for a Home Health PPS Episode

Sex Codes (Field 11)

Code	Definition
M	Male
F	Female
U	Unknown

Type of Admission Codes (Field 14)

Code	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma
6–8	Reserved for National Assignment
9	Information Not Available

Source of Admission Codes Except Newborns (Field 15)

Code	Definition
1	Physician Referral
2	Clinic Referral

3	Managed Care Plan Referral
4	Transfer From a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility or Intermediate Care Facility or Assisted Living Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital (CAH)
B	Transfer From Another Home Health Agency
C	Readmission to Same Home Health Agency
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
E-Z	Reserved for National Assignment

Additional Source of Admission Codes for Newborns (Field 15)

Code	Definition
1–4	Discontinued
5	Born Inside this Hospital
6	Born Outside this Hospital
7–9	Reserved for National Assignment

Patient Status (Field 17)

Code	Definition
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to a SNF with Medicare Certification in Anticipation of Skilled Care
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list.
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care

07	Left Against Medical Advice or Discontinued Care
08	Reserved for Assignment by the NUBC
09	Admitted as an Inpatient to This Hospital
10–19	Reserved for Assignment by the NUBC
20	Expired
21–29	Reserved for Assignment by the NUBC
30	Still a Patient
31-39	Reserved for Assignment by the NUBC
40	Expired at Home
41	Expired in a Medical Facility such as a Hospital, SNF, ICF or Free-Standing Hospice
42	Expired, Place Unknown
43	Discharged/Transferred to a Federal Health Care Facility
44–49	Reserved for Assignment by the NUBC
50	Discharged to Hospice, Home
51	Discharged to Hospice, Medical Facility (Certified) Providing Hospice Level of Care
52–60	Reserved for Assignment by the NUBC
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	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital
67–69	Reserved for Assignment by the NUBC

Release of Information Indicator Codes (Field 52)

Code	Definition
I	Informed consent to release medical information for conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Member's Relationship to the Insured Codes for UB04 Only (Field 59, 837I, version 5010)

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Valid Taxonomy Codes

Taxonomy codes are established by the National Uniform Claim Committee (NUCC) and published on their website under Code Sets/Provider Taxonomy. Taxonomy codes are self-selected. Choose the code that best identifies the provider. Reimbursement is based on provider's licensure identified by the selected taxonomy.

Additional helpful tips:

- **DIAGNOSIS CODE:** Place the diagnosis code as far left as possible within the box.
- **REFERRING PROVIDER:** If referring provider is an individual, use last name, first name, and middle initial. Middle initial is optional. If referring provider is a facility, provide the facility's full name.
- **PATIENT RELATIONSHIP TO INSURED:** When insured is different from patient and "Self" has been selected as the relationship, the system will change the insured's name to the patient's name.
- **INSURED'S ID:** This field should contain insured's ID and no additional information.
- **RED & WHITE FORMS:** Submitting claims in red and white forms, instead of black and white forms, ensures better scanning quality.

If you have questions about a specific claim rejection, contact the customer service department based on the member's benefit plan.