

# Hospital Inpatient UB-04

Claim form billing instructions for the  
Department of Human Services

# Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

# MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

# Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

# Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use commercially available versions of the UB-04.

# A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible.
- If possible, submit no more than twenty-two lines of services per claim form. All inpatient charges must be billed on one claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

# Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - Standard Register Company, Forms Division (800-755-6405)

# Services billed on the UB-04

## **Institutional Providers**

- Free Standing Kidney Dialysis
- Home Health
- Hospice
- Hospital

# Services billed on the UB-04

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: [DMAP.providerservices@state.or.us](mailto:DMAP.providerservices@state.or.us)

# Introducing the UB-04

1	2	3a PAT CNTL #	4 TYPE OF BILL
		b. MED REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		c	d
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION UP 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
			18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE
35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE DATE	38 OCCURRENCE DATE
39	40	41	42
a	b	c	d
43	44	45	46
47	48	49	50
51	52	53	54
55	56	57	58
59	60	61	62
63	64	65	66
67	68	69	70
71	72	73	74
75	76	77	78
79	80	81	82
83	84	85	86
87	88	89	90
91	92	93	94
95	96	97	98
99	100	101	102
103	104	105	106
107	108	109	110
111	112	113	114
115	116	117	118
119	120	121	122
123	124	125	126
127	128	129	130
131	132	133	134
135	136	137	138
139	140	141	142
143	144	145	146
147	148	149	150
151	152	153	154
155	156	157	158
159	160	161	162
163	164	165	166
167	168	169	170
171	172	173	174
175	176	177	178
179	180	181	182
183	184	185	186
187	188	189	190
191	192	193	194
195	196	197	198
199	200	201	202
203	204	205	206
207	208	209	210
211	212	213	214
215	216	217	218
219	220	221	222
223	224	225	226
227	228	229	230
231	232	233	234
235	236	237	238
239	240	241	242
243	244	245	246
247	248	249	250
251	252	253	254
255	256	257	258
259	260	261	262
263	264	265	266
267	268	269	270
271	272	273	274
275	276	277	278
279	280	281	282
283	284	285	286
287	288	289	290
291	292	293	294
295	296	297	298
299	300	301	302
303	304	305	306
307	308	309	310
311	312	313	314
315	316	317	318
319	320	321	322
323	324	325	326
327	328	329	330
331	332	333	334
335	336	337	338
339	340	341	342
343	344	345	346
347	348	349	350
351	352	353	354
355	356	357	358
359	360	361	362
363	364	365	366
367	368	369	370
371	372	373	374
375	376	377	378
379	380	381	382
383	384	385	386
387	388	389	390
391	392	393	394
395	396	397	398
399	400	401	402
403	404	405	406
407	408	409	410
411	412	413	414
415	416	417	418
419	420	421	422
423	424	425	426
427	428	429	430
431	432	433	434
435	436	437	438
439	440	441	442
443	444	445	446
447	448	449	450
451	452	453	454
455	456	457	458
459	460	461	462
463	464	465	466
467	468	469	470
471	472	473	474
475	476	477	478
479	480	481	482
483	484	485	486
487	488	489	490
491	492	493	494
495	496	497	498
499	500	501	502
503	504	505	506
507	508	509	510
511	512	513	514
515	516	517	518
519	520	521	522
523	524	525	526
527	528	529	530
531	532	533	534
535	536	537	538
539	540	541	542
543	544	545	546
547	548	549	550
551	552	553	554
555	556	557	558
559	560	561	562
563	564	565	566
567	568	569	570
571	572	573	574
575	576	577	578
579	580	581	582
583	584	585	586
587	588	589	590
591	592	593	594
595	596	597	598
599	600	601	602
603	604	605	606
607	608	609	610
611	612	613	614
615	616	617	618
619	620	621	622
623	624	625	626
627	628	629	630
631	632	633	634
635	636	637	638
639	640	641	642
643	644	645	646
647	648	649	650
651	652	653	654
655	656	657	658
659	660	661	662
663	664	665	666
667	668	669	670
671	672	673	674
675	676	677	678
679	680	681	682
683	684	685	686
687	688	689	690
691	692	693	694
695	696	697	698
699	700	701	702
703	704	705	706
707	708	709	710
711	712	713	714
715	716	717	718
719	720	721	722
723	724	725	726
727	728	729	730
731	732	733	734
735	736	737	738
739	740	741	742
743	744	745	746
747	748	749	750
751	752	753	754
755	756	757	758
759	760	761	762
763	764	765	766
767	768	769	770
771	772	773	774
775	776	777	778
779	780	781	782
783	784	785	786
787	788	789	790
791	792	793	794
795	796	797	798
799	800	801	802
803	804	805	806
807	808	809	810
811	812	813	814
815	816	817	818
819	820	821	822
823	824	825	826
827	828	829	830
831	832	833	834
835	836	837	838
839	840	841	842
843	844	845	846
847	848	849	850
851	852	853	854
855	856	857	858
859	860	861	862
863	864	865	866
867	868	869	870
871	872	873	874
875	876	877	878
879	880	881	882
883	884	885	886
887	888	889	890
891	892	893	894

# UB-04

- Not sure if you are using the correct form?

The bottom left corner will look like this.

UB-04 CMS-1450



# Top section

1										3a PAT. CNTL. #										4 TYPE OF BILL									
										b. MED. REC. #										7									
										5 FED. TAX NO.										STATEMENT COVERS PERIOD FROM THROUGH									
8 PATIENT NAME a					9 PATIENT ADDRESS a																								
b					b					c					d					e									
10 BIRTHDATE		11 SEX	12 DATE		13 HR	14 TYPE	15 SRC	16 DHR		17 STAT	18	19	20	21	CONDITION CODES		22	23	24	25	26	27	28	29 ACDT STATE	30				
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37																	
38										39 CODE VALUE CODES AMOUNT		40 CODE VALUE CODES AMOUNT		41 CODE VALUE CODES AMOUNT															
a										a		a		a															
b										b		b		b															
c										c		c		c															
d										d		d		d															

Red = Required

Yellow = Optional

# Box 1 - Optional

1	<b>Hospital</b>			
	<b>PO Box ###</b>			
	<b>Anytown, OR 97###</b>			

## Billing Provider Information

- Enter the name and address of the Hospital that is requesting to be paid for the services rendered.

# Box 3a - Optional

3a PAT.  
CNTL #

**X123400**

## Patient Account Number

- Enter your recipient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

# Box 4 - Required



## Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
  - 111 - Inpatient (including patients with Medicare Part A only)
  - 121 - Inpatient (including patients with Medicare Part B only)

# Box 6 - Required

6	STATEMENT COVERS PERIOD
	FROM THROUGH
	<b>120108</b>   <b>120708</b>

## Statement Covers Period

- Enter the beginning and ending dates of services covered by this claim.
- This box must list numeric dates of service.
- The from date is the date of admission.
- The through date is the date of discharge, transfer or expiration.

# Box 8b - Required

8 PATIENT NAME	a
b	<b>Patient, Your</b>

## Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use the recipient's last name first.
- Do not use nicknames.

# Box 12 - Required

12	DATE
<b>120108</b>	

## Admission Date

- Enter the actual date of admission, even if the recipient was not eligible on the date admitted.

# Box 13 - Required

13 HR
<b>10</b>

## Admission Hour

- Enter the hour of admission in military time.
- Example:
  - 01 - 1:00 a.m.
  - 10 - 10:00 a.m.
  - 14 - 2:00 p.m.
  - 23 - 11:00 p.m.

# Box 14 - Required

14 TYPE
1

## Admission Type

- Enter the type of admission.
- Example:
  - 1 - Emergent
  - 2 - Urgent
  - 3 - Elective
  - 4 - Newborn

# Box 16 - Required

16 DHA

**15**

## Discharge Hour

- Enter the discharge hour in military time.
- Example:

01 - 1:00 a.m.

10 - 10:00 a.m.

14 - 2:00 p.m.

23 - 11:00 p.m.

# Box 17 - Required

17 STAT

**01**

## Discharge Status

- Enter the recipient discharge status.
- Example:

01 - To home or self care

02 - To another acute care hospital

03 - To skilled nursing facility

04 - To intermediate care facility

05 - To another type of institution

06 - To home under care of Home Health

07 - Left against medical advice

08 - To home under care of Home Enteral/Parenteral

20 - Expired

# Box 31 - Optional

31 CODE	OCCURRENCE DATE

## Accident Occurrence

- If this claim is a result of an accident, enter one of the following codes and the date of the occurrence.

01 - Auto accident

04 - Employment related accident

- Pursue all prior resources first.
- DHS is the payer of last resort.

# Middle section

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
PAGE ____ OF ____		CREATION DATE		TOTALS			23

Red = Required

# Box 42 - Required

42 REV. CD.	
1	120
2	
3	250
4	
5	260
6	
7	270
8	
9	305
10	312
11	
12	636
13	710
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	0001

## Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Use an accommodation day revenue center code if the recipient was admitted, discharged, transferred or expired on the same day.
- Do not use the same revenue center code twice.
- Refer to your Hospital supplemental for a complete list of revenue center codes.





# Total - Required

**TOTALS**  **5,906 80**

## Total Charges

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- Each claim form is a separate document, and is to be totaled as such.

# Bottom section

50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASS. GEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI			
										57 OTHER PRV ID			
58 INSURED'S NAME			59 P. REL.	59 INSURED'S UNIQUE ID			61 GROUP NAME		62 INSURANCE GROUP NO.				
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME					
66 DX	67			A			B			C			
	J			K			L			M			
	N			O			P			Q			
	R			S			T			U			
	V			W			X			Y			
	Z			aa			ab			ac			
69 ADMIT DX	70 PATIENT REASON DX		OTHER PROCEDURE CODE		DATE		71 PPS CODE		72 EQI		73		
76 ATTENDING		NPI		QUAL		75		76 ATTENDING		NPI		QUAL	
LAST		FIRST						LAST		FIRST			
77 OPERATING		NPI		QUAL				77 OPERATING		NPI		QUAL	
LAST		FIRST						LAST		FIRST			
78 OTHER		NPI		QUAL				78 OTHER		NPI		QUAL	
LAST		FIRST						LAST		FIRST			
79 OTHER		NPI		QUAL				79 OTHER		NPI		QUAL	
LAST		FIRST						LAST		FIRST			
80 REMARKS			81CC										
			a										
			b										
			c										
			d										

Red = Required

Yellow = Optional

# Box 50 - Optional

50 PAYER NAME	
A	<b>Primary payer</b>
B	<b>Secondary payer</b>
C	<b>Tertiary payer</b>

## Payer Name

- Enter the names of up to three payer organizations in order.

Example:

If Medicaid is primary, enter on line A.

If Medicaid is secondary, enter on line B.

If Medicaid is tertiary payer, enter on line C.

# Box 54 - Optional

54 PRIOR PAYMENTS

## Prior Payments

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

# Box 56 - Required

56 NPI

#####

## National Provider Identifier (NPI)

- Enter the ten-digit NPI of the Hospital billing for services rendered.

# Box 57 - Required

57	
OTHER	<b># # # # # #</b>
PRV ID	

## Provider Number

- Enter the six (6)-or nine (9)-digit DHS provider number of the Hospital billing for services rendered.
- Do not list other payer provider numbers.
- Correspond the placement number as outlined in box 50 instructions.

# Box 60 - Required

60 INSURED'S UNIQUE ID
<b>XX###X#X</b>

## Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

# Box 63 - Optional

63 TREATMENT AUTHORIZATION CODES	
A	
B	<b># # # # # # # # # #</b>
C	

## Treatment Authorization

- If the service you provided requires prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.
- Correspond the placement as outlined in box 50 instructions.

# Box 66 - Required

66 DX	7993
----------	------

## Diagnosis Code

- Enter the recipient's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for causing this hospitalization.
- You may enter up to five codes if necessary by listing them in box 67 - 67D.
- The diagnosis codes must be carried out to its highest degree of specificity.
- Do not use the decimal point.

# Box 74 - Optional

74	PRINCIPAL PROCEDURE CODE	DATE

## Principal Procedure

- This box is required if a procedure was performed.
- Enter the ICD-9-CM procedure code which best identifies the procedure completed.
- The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

# Box 78 - Optional

78 OTHER	NPI #####	QUAL	#####
----------	-----------	------	-------

## Referring Provider ID

- This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).
- Enter the ten-digit NPI of the referring PCM or PCO.
- Enter the six (6)-or nine (9)-digit DHS provider number of the referring PCM or PCO.
- If the recipient is not referred by the PCM or PCO, leave this box blank.

# Box 80 - Optional

80 REMARKS
<b>NC</b>

## Third Party Resource

- If the recipient has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.
- TPR codes can be found in your provider rulebook supplemental, or on the following slides.

# Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes continued on next slide

# Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAFF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

# Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

# Multiple carrier TPR codes

SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes continued on next slide

# Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

C  
O  
M  
P  
L  
E  
T  
E  
D

1 Hospital PO Box ### Anytown, OR 97###		2		33 PAT CNTL # X123400		4 TYPE OF BILL 111	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 120108		7 THROUGH 120708			
8 PATIENT NAME a Patient, Your				9 PATIENT ADDRESS b			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 120						6 4,200 00	
2 250						29 533 95	
3 260						1 38 35	
4 270						8 260 68	
5 305						2 26 00	
6 312						1 80 00	
7 636						7 167 82	
8 710						8 600 00	
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
00							
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
00							
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72</							

# Resources

# Where to mail your claim

- Mail your UB-04 claim form to:

DMAP

PO Box 14956

Salem, OR 97309-4957

# Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your UB-04 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: [DMAP.providerservices@state.or.us](mailto:DMAP.providerservices@state.or.us)

Thank You!