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				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME a				9 PATIENT ADDRESS a			
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT	
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26		27		28		29 ACCT STATE 30	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE	
35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE		38 OCCURRENCE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42 VALUE CODES	
AMOUNT		AMOUNT		AMOUNT		AMOUNT	
a		b		c		d	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
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UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the form locator (FL) information.

FL 1	Provider name, physical address and telephone number required	FL 37	Not required
FL 2	Pay-to name and address required	FL 38	Responsible party name and address
FL 3a	Patient control number	FLs 39–41	Value codes and amounts
FL 3b	Medical/health record number	FL 42	Revenue code
FL 4	Type of bill (<i>three-character alphanumeric identifier</i>)	FL 43	Revenue description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.
FL 5	Federal Tax Identification (ID) number	FL 44	HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.
FL 6	Statement covers period (<i>from–through</i>). The beginning and ending dates of the period included on the bill are shown in numeric fields (<i>MM-DD-YY</i>).	FL 45	Service date. If submitting claims for outpatient services, report a separate date for each day of service.
FL 7	Not required	FL 46	Service units. The entries in this column quantify services by revenue category (<i>e.g., number of days, a particular type of accommodation, pints of blood</i>). Up to seven digits may be entered.
FL 8a-b	Patient's name (<i>surname first, first name, and middle initial, if any</i>). Enter the patient's Social Security number (SSN) in field "a." Enter the patient's name in field "b."	FL 47	Total charges
FL 9a-e	Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable.	FL 48	Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.
FL 10	Patient's birth date (<i>MM-DD-YYYY</i>). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.	FL 49	Not required
FL 11	Patient's sex. This item is used in conjunction with FLs 66–69 (<i>diagnoses</i>) and FL 74 a–e (<i>surgical procedures</i>) to identify inconsistencies.	FLs 50A–C	Payer identification. Enter the primary payer on line A.
FL 12	Admission date	FLs 51A–C	Health plan ID number
FL 13	Admission hour	FLs 52A–C	Release of information. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.
FL 14	Type of admission. This code indicates priority of the admission.	FLs 53A–C	Assignment of benefits certification indicator
FL 15	Source of Admission. This code indicates the source of admission or outpatient registration.	FLs 54A–C	Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (<i>last</i>) line of this column.
FL 16	Discharge hour	FLs 55A–C	Not required
FL 17	Patient status. This code indicates the patient's status as of the "Through" date of the billing period (<i>FL 6</i>).		
FLs 18–28	Condition codes		
FL 29	Accident state		
FL 30	Not required		
FLs 31–34	Occurrence codes and dates		
FLs 35–36	Occurrence span code and dates		

FL 56 National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.

FLs 57A–C Other provider identifier number

FLs 58A–C Insured’s name

FLs 59A–C Patient’s relationship to insured

FLs 60A–C Insured unique ID/SSN/health insurance claim/ID number

FLs 61A–C Group name. Indicate the name of the insurance group or plan.

FLs 62A–C Insurance group number

FLs 63A–C Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.

FLs 64A–C Document Control Number (DCN). Original DCN number of the claim to be adjusted.

FLs 65A–C Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.

FLs 66 Diagnosis and procedure code qualifier (*ICD Version Indicator*)

FLs 67 Principal diagnosis code. HCFA only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.

FLs 67A–Q Other diagnosis codes

FL 68 Not required

FL 69 Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.

FLs 70a–c Patient’s reason for visit

FL 71 Prospective payment system (PPS) code

FLs 72a–c External cause of injury (ECI) code

FL 73 Not required

FL 74 Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

FLs 74a–e Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (*which is shown in FL 74*). The date of each procedure is shown in the date portion of Item 74, as applicable (*MM-DD-YY*).

FL 75 Not required

FL 76 Attending/referring physician ID

FL 77 Operating physician name and identifiers

FLs 78–79 Other physician ID

FL 80 Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.

FLs 81a–d Code field

Condition Codes

02 Condition is employment related

03 Patient covered by insurance not reflected here

06 End-stage renal disease (ESRD) patient in first 30 months of entitlement covered by employer group health insurance

08 Beneficiary would not provide information concerning other insurance coverage

18 Maiden name retained

19 Child retains mother’s name

31 Patient is student (*full time—day*)

33 Patient is student (*full time—night*)

34 Patient is student (*part time*)

36 General care patient in a special unit

38 Semiprivate room not available

39 Private room medically necessary

- 40 Same-day transfer
- 41 Partial hospitalization
- 46 Nonavailability statement on file
- 48 Psychiatric residential treatment centers for children and adolescents
- 55 SNF bed not available
- 56 Medical appropriateness
- 60 Day outlier
- 61 Cost outlier
- 67 Beneficiary elects not to use lifetime reserve days
- A0 TRICARE External Partnership Program
- A2 Physically Handicapped Children's Program
- C1 Approved as billed
- C2 Automatic approval as billed based on focused review
- C3 Partial approval
- C4 Admission/services denied
- C5 Post-payment review applicable
- C6 Admission pre-authorization
- C7 Extended authorization
- G0 Distinct medical visit (*OPPS*)

Occurrence Span Codes

- 01 Auto accident
- 02 No-fault insurance involved—including auto accident/other
- 03 Accident/tort liability
- 04 Accident/employment related
- 05 Accident/no medical or liability coverage
- 06 Crime victim
- 21 Date UR notice received
- 22 Date active care ended
- 24 Date insurance denied
- 25 Date benefits terminated by primary payer
- 26 Date SNF bed became available
- 27 Date of hospice certification or recertification
- 28 Date comprehensive outpatient rehabilitation plan established or last reviewed
- 29 Date outpatient physical therapy plan established or last reviewed
- 30 Date outpatient speech pathology plan established or last reviewed
- 31 Date beneficiary notified of intent to bill (*accommodations*)
- 32 Date beneficiary notified of intent to bill (*procedures or treatments*)

- 33 First day of the Medicare Coordination Period for ESRD beneficiaries covered by Employer Group Health Plan (EGHP)

Value Codes and Amounts

- 01 Most common semiprivate rate
- 02 Hospital has no semiprivate rooms
- 05 Professional component included in charges and also billed separate to carrier
- 30 Preadmission testing
- 31 Patient liability amount
- 37 Pints of blood furnished
- 46 Number of grace days