

# Filing Claims

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## Direct and Timely Billing

As a Regence BCBSO and Regence Life and Health participating physician, other health care professional or facility, you have agreed to bill us directly for covered services provided to your Regence BCBSO or Regence Life and Health patients within one year of the date of service. Once coverage is verified, patients should not be asked for full payment at the time of service, although asking for copayments is appropriate. After services are rendered, the patient should only be billed for deductible, copayment and/or coinsurance amounts not collected and non-covered services.

## Use Your Identification Number

All electronically submitted claims must include the National Provider Identifier (NPI) along with the required tax identification number. Until further notice an electronically submitted claim may also include the appropriate Regence BCBSO provider identification number.

The NPI is not required for paper claim submissions, though we strongly recommend you apply for and use an NPI. Paper claim submissions can continue to be submitted using the Regence BCBSO provider identifier with or without an NPI. If you are unsure of your provider identification number, please contact your provider relations representative.

## Filing Claims Electronically

Electronic billing through Availity L.L.C. or Office Ally is available for all Regence BCBSO, Regence Life and Health and BlueCard<sup>®</sup> out-of-area claims. Electronic claims submission offers the following advantages:

- Single submission point for all electronic claims
- Faster claims turnaround time
- Automated claims payment for clean claims
- Detailed online submission and error reports
- Online real-time editing
- No per-claim submission charge for Regence claims if you submit directly through Availity L.L.C. or Office Ally.

If you already submit claims electronically, the following reminders are for you:

- Always enter the patient's information exactly as it appears on their member card. This will help avoid misrouting and processing delays.
- Use your online reports to help research claims processing.
- All claims for out-of-area members with alpha prefixes can and should be billed electronically to expedite their processing.

- Only claims for Medicare adjustments should be billed on paper.

To find out more about submitting claims electronically through Availity LLC contact their EDI Support Center by phone at 1(800) 282-4548. For information about submitting claims through Office Ally contact them via email at **info@officeally.com** or by phone at (949) 464-9129.

## File rejection reports

If you need help with an electronic rejection report that is not from Availity or your clearinghouse, contact Regence EDI Support Center 1 (800) 713-1693 or email **EDIsupport@regence.com**.

## Filing Claims Manually

Regence requires paper claims to be submitted on an original, standard *CMS 1500 08/05* claim form. Instructions for completing this form begin on the next page, and are followed by a sample of the form. Once received, paper claims are scanned and converted into electronic images that are viewed and processed online by our claims analysts. Please observe the following guidelines to ensure your claims are successfully imaged:

- Key or type all information onto your claims. Handwriting and stamps are not always dark or legible enough to be captured by our imaging equipment. Centers for Medicare & Medicaid Services (CMS) no longer accept signature stamps.
- Do not use highlighters on your claims. The imaging equipment ‘blacks out’ the portions of your claims that are highlighted, making the information unreadable.

## Where to Send Original Paper Claims

The mailing addresses for filing paper claims are shown below.

All Claims (except FEP)	FEP Claims Only
Regence BCBSO P.O. Box 30805 Salt Lake City, UT 84130-0805	Regence BCBSO P.O. Box 31105 Salt Lake City, UT 84131-0105

# Resubmitting Claims

## Corrected Claims

Claims with changes or corrections to charges, procedure codes, diagnostic codes or other information should be resubmitted as soon as possible. To help us identify and process these resubmissions more efficiently, label your corrected claims as follows.

Claim Type	Labeling the Corrected Claim
Electronic	Enter <b>CORRECTED CLAIM</b> in the narrative record (NSF Record HA0) of the first service detail line.
Paper	Indicate <b>CORRECTED CLAIM</b> in Block 24 of your <i>CMS-1500</i> form. Mail to: Regence BCBSO P.O. Box 1271 Portland, OR 97201-1271

## Coordination of Benefits (COB)

Coordination of Benefits (COB) enables your patients to receive benefits from all health insurance plans they are covered under, while ensuring that the total combined payment from all sources is not more than the total charge for the services provided.

When your patient has coverage under two or more insurance plans, the *primary plan* will pay benefits first, with **secondary** and **tertiary plans** considering any remaining unpaid, eligible balances. **When Regence BCBSO or Regence Life and Health is the secondary or tertiary plan, you should file the claim with the primary plan first.** When you have received a claims processing voucher from the *primary plan*, you should file the claim and a copy of the voucher with Regence, **identifying all insurance coverage information on each claim.**

### Electronic submission of COB information

Regence BCBSO can accept electronic submission of Coordination of Benefits (COB) claims using standard Health Insurance Portability and Accountability Act (HIPAA), American National Standards Institute (ANSI) formats for both institutional and professional COB claims. This applies to all Regence products, including the Federal Employee Program (FEP) with the exception of Regence MedAdvantage claims.

If you are interested in submission COB claims electronically, please verify with your practice management software vendor that your billing program has the capacity to do so. The information submitted on the secondary claim should include the amount the other carrier approved, the amount paid and the patient balance.

If you have questions about submitting electronic COB claims, please contact your software vendor. Vendors or clearinghouses with questions may contact our Electronic Data Interchange (EDI) Support Center at 1 (800) 713-1693 or via email at [EDIsupport@regence.com](mailto:EDIsupport@regence.com).

## Maintenance of Benefits (MOB)

Maintenance of Benefits (MOB) lets your patients receive benefits from all health insurance plans they are covered under, while maintaining the patient's responsibility for coinsurance and/or copayment amounts on these coverages and ensuring that the total combined payment from all sources is never more than the total charge for the services.

With MOB processing, secondary payers only allow benefits up to their own maximum allowable for the specific service(s). If the primary carrier's payment is equal to or more than what the secondary carrier's payment would have been as primary, no additional benefits will be remitted. This can result in members having out-of-pocket expenses, something not usually seen with COB processing.

## Other Party Liability for Blue Plans

Other Party Liability (OPL) is a department that recovers money when primary responsibility is not the insurer's because of the involvement of another group health plan or contractual exclusions. OPL includes worker's compensation, subrogation and no-fault auto insurance.

In cases where another Blue Plan is involved as a third party, submit OPL information with the Blue Plan claim to Regence BCBSO. Upon receipt, Regence BCBSO will electronically route the claim to the member's Blue Plan. The member's Blue Plan will then process the claim and approve any payment based on the member's benefits. Regence BCBSO will reimburse you accordingly and provide information on your payment voucher.

## Medicare Crossover Claims

If you accept Medicare assignment and render services to members from other Blue Plans, please note the following.

**Medicare is primary:** When Medicare is the primary payer for an out-of-area Blue Plan member (e.g., Medigap plans), follow these procedures:

1. Submit claims to your local Medicare contractor first. **Do not file with Medicare and the supplemental insurer simultaneously.** Be sure to include the:
  - Complete Health Insurance Claim Number (HICN),
  - The patient's complete member number, and
  - Patient's name as it appears on the card

- Other carrier's name and address (OCNA) number. If you include this information, make sure it is the correct OCNA for the member's Blue Plan.
2. After you receive the *Explanation of Medical Benefits* (EOMB) or payment advice from Medicare, determine if the claim was automatically crossed over to the supplemental insurer:
- **Crossed over:** If the indicator on the EOMB or payment advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. You do not need to file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you, if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.
  - **Not crossed over:** If the indicator on the EOMB or payment advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim as you do today to Regence BCBSO along with the payment advice. Regence BCBSO or the member's Blue Plan will pay you the Medicare supplemental benefits. If you did not accept Medicare assignment, the member will be paid and you will need to bill the member.

**Blue Plan is primary:** When a Blue Plan is the primary payer (e.g., Medicare Advantage), submit claims to Regence BCBSO. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Based on the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a physician, other health care professional or facility who accepts Medicare assignment and renders service to Medicare Advantage members from other Blue Plans, you will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than your charge amount. CMS regulations state that the Medicare allowable amount is considered payment in full.

*Note:* Medicare Advantage Private Fee for Service (PFFS) reimbursement is paid at the Home plan contracted rate or Medicare rate, depending on the member contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill.

# Prompt Payment

Senate Bill 894, is a prompt payment law requiring insurance carriers to pay interest on certain claims not paid within specified timeframes. The following information is intended to help you understand components of the law, where you can find information on claims submission, changes to your payment vouchers and other impacts Senate Bill 894 may have on your office.

## Components of the law

- This law includes claims received from contracted and non-contracted medical, vision and alternative care providers.
- The following types of claims are **excluded from Senate Bill 894**:
  - ✓ Dental
  - ✓ Pharmacy
  - ✓ BlueCard<sup>®</sup>
  - ✓ Federal Employee Program
  - ✓ Oregon Medical Insurance Pool (OMIP)
  - ✓ Self-insured groups
  - ✓ Claims paid to the member
  - ✓ Regence MedAdvantage
- We must pay or deny a “clean claim” no later than 30 days after date of receipt.
- The following Medicare definition of “clean claim” is being applied to this law:  
*A claim that has no defect or impropriety, including lack of required substantiating documentation...or particular circumstances requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare...A claim is clean even though the organization refers it to a medical specialist within the organization for examination. If additional substantiating documentation (e.g., the medical record) involves a source outside the organization, the claim is not considered ‘clean’.*
- “Clean claims” not paid within 30 days of receipt (interest payable from day 31 on) must include an interest payment of 12% per annum on the amount due to the provider. Interest must be paid at the time the claim is paid.
- There is no requirement to pay interest in the amount of two dollars or less on any claim.
- If we require additional information (e.g., medical records, accident report) in order to process a claim, we must **notify the enrollee and the provider in writing**, within the initial 30 days, of the additional information needed to process the claim. Once the information is received, we have 30 days from that date to pay or deny the claim. If we don’t meet the 30 days, the above rules on interest apply.

## **Where to find information regarding claims submission**

General information on claims submission can be found in this section and on our *Provider Web Site* at [www.or.regence.com/provider](http://www.or.regence.com/provider). If we require additional documentation beyond the claim form in order to process a particular service, you will receive a request from us for the additional information. A description of the additional documentation (e.g., operative reports or chart notes) may be found on our *Provider Web Site* in the Claims & Billing section, under Supporting Documentation.

## **Where to find information regarding medical and reimbursement policy**

Reimbursement and medical policy can be found on the *Provider Web Site* in the Provider Library section, under Policies. We make every effort to notify you if we make a change to billing guidelines or administrative, medical or reimbursement policies. In most cases notification will be via *The Connection Online*<sup>SM</sup> newsletter.

## **Important information about claims and payment vouchers**

- Interest will be reported on your annual 1099 form for tax reporting purposes
- We have created the following new voucher messages:
  - ✓ Interest of two dollars or less: “OR SB 894 interest \$2 and under not payable”
  - ✓ Interest payments: “OR SB 894 interest payment”
  - ✓ Excluded groups: “Self-funded ERISA group not subject to OR SB 894”

# CMS 1500 Claim Form Instructions

To complete this form, follow the instructions below. **Each field on the form has a corresponding number. Claims submitted with missing or invalid required fields may be rejected and/or returned for correction and resubmission.**

Requirements	Field	Description
	1:	Type of Health Insurance Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
<b>Required</b>	<b>1A:</b>	<b>Insured's Identification Number</b> Enter the three-digit alpha prefix and identification number of the insured <i>exactly as shown on the member card</i> .
<b>Required</b>	<b>2:</b>	<b>Patient's Name</b> Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the member card. <i>Do not use nicknames</i> .
<b>Required</b>	<b>3:</b>	<b>Patient's Birth Date and Sex</b> Enter the eight-digit month, day, century, and year of the patient's birth (MMDDCCYY). Check the appropriate box to identify patient's gender.
<b>Required</b>	<b>4:</b>	<b>Insured's Name</b> Enter the last name, first name, and middle initial of the insured as shown on the member card. If the patient is the insured, enter the word "same".
<b>Required</b>	<b>5:</b>	<b>Patient's Address</b> Enter the patient's complete address.
<b>Required</b>	<b>6:</b>	<b>Patient's Relationship to Insured</b> Check self, spouse, child or other.
	7:	Insured's Address Complete if the patient <i>is not</i> the insured.
	8:	Patient Status Check the appropriate box.
<b>Recommended</b>	<b>9:</b>	<b>Other Insured's Name</b> Enter the name of the insured with other insurance company.
<b>Recommended</b>	<b>9A:</b>	<b>Other Insured's Policy or Group Number</b> Enter the policy and/or group number of the other insurance coverage.
<b>Recommended</b>	<b>9B:</b>	<b>Other Insured's Date of Birth</b> Enter the information available to you in eight-digit format (MMDDCCYY).
	9C:	Employer's Name or School Name Enter the complete name.
	9D:	Insurance Plan Name or Program Name Enter the name of the insurance plan.
<b>Required</b>	<b>10:</b>	<b>Is Patient's Condition Related to</b> Check the correct boxes in a., b. and c.

Requirements	Field	Description
	10D:	Reserved for Local Use Leave blank.
<b>Required</b>	<b>11:</b>	<b>Insured's Policy or FECA Number</b> Enter the group number of the insured as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
<b>Recommended</b>	<b>11A:</b>	<b>Insured's Date of Birth</b> Use eight-digit date format if submitting.
	11B:	Employer's Name or School Name
	11C:	Insurance Plan Name or Program Name
	11D:	Additional Benefit Plans
	12:	Patient's or Authorized Person's Signature Have patient sign if your office requires it.
	13:	Insured's or Authorized Person's Signature May be left blank.
<b>Required for accidents or injuries</b>  <b>Recommended for all other</b>	14:	<b>Date of Current illness, Injury, Pregnancy</b> Enter the date of the current illness, injury or pregnancy.
	15:	If Patient has had Same or Similar illness Enter the date the patient first consulted you for this condition.
	16:	Dates Patient Unable to Work in Current Occupation Leave blank.
	17:	Name of Referring Provider or Other Source List the name of the referring, ordering or supervising physician or other health care professional.
	17A:	Other ID # Enter the assigned Regence provider number if submitting a paper claim and the physician or other health care professional listed in field 17.
	17B:	NPI # Enter the assigned NPI of the physician or other health care professional listed in field 17 for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
<b>Recommended</b>	<b>18:</b>	<b>Hospitalization Dates Related to Current Services</b>
	19:	Reserved for Local Use Leave blank.

Requirements	Field	Description
	20:	Outside Lab If your patient had lab work done, check the correct box <i>even if you are not billing for the lab work</i> . Do not list charges in this field.
<b>Required</b>	<b>21:</b>	<b>Diagnosis or Nature of illness or Injury</b> Identify the patient's condition(s) by entering up to four ICD-9-CM codes in order of relevance. <b>Codes must be carried out to the highest possible (4th or 5th) digit. Non-specific diagnoses, such as 780, may result in denials.</b>
	22:	Medicaid Resubmission Leave blank.
	23:	Prior Authorization Number Leave blank.
<b>Recommended</b>	<b>24A:</b>	<b>Shaded Area – National Drug Code (NDC)</b> In the shaded area above "Date(s) of Service", enter the two digit Product ID Qualifier "N4" identifying the type of number being provided. Enter the NDC number after the Product ID Qualifier.
<b>Required</b>	<b>24A:</b>	<b>Date(s) of Service</b> Enter the date(s) of service. If only one service is provided, the date can be entered as a "from date" or a "to date".
<b>Required</b>	<b>24B:</b>	<b>Place of Services</b> Indicate where services were provided by entering the appropriate two-digit place of service code. Valid codes are as follows: 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance (land) 42 Ambulance (air or water) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Facility 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility

Requirements	Field	Description
	24C:	Emergency Indicator (EMG) Leave blank.
Recommended	24D:	<p><b>Shaded Area – NDC Unit of Measure and Numeric Quantity Administered</b> In the shaded area above “Field 24D Procedures, Services, or Supplies”, enter the two digit NDC Unit of Measurement Qualifier followed by the numeric quantity administered to the patient, which is a full 10-digit number. The 10 digits consist of seven digits for the whole number, followed by the three-digit decimal portion of the number.</p> <p><b>Valid Unit of Measurement Qualifiers are:</b> F2 – International unit GR – Gram ML – Milliliter UN – Unit</p> <p>The HCPCS code should be entered in Field 24D “Procedures, Services, or Supplies”, the charges in Field 24F and the units in Field 24G.</p>
Required	24D:	<p><b>Procedures, Services, or Supplies: CPT/HCPCS, Modifier</b> Enter a valid procedure code best describing each service or supply. Explain unusual services or situations with procedure code modifiers. If a CPT and a HCPCS code describe the same service, use the CPT code. <b>Claims with an invalid or missing procedure code may be denied or returned for correction and resubmission.</b></p>
Required	24E:	<p><b>Diagnosis Pointer</b> Enter one diagnosis code reference number per claim line (i.e., up to four ICD-9-CM codes) as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis.</p>
Required	24F:	<p><b>Charges</b> Enter your charge for each listed service.</p>
Required	24G:	<p><b>Days or Units</b> Enter the number of services billed on the line. For anesthesia services, report time and modifier units on separate lines.</p>
	24H:	EPSDT Family Plan Leave blank.
Required if applicable	24I:	<p><b>ID Qualifier</b> If entering an individual Regence provider number in 24J, ID Qualifier Code ‘1B’ is required.</p>

Requirements	Field	Description
Required if applicable	24J:	<p><b>Rendering Provider ID # (split field)</b> The individual performing/rendering the service. <b>The rendering provider ID # is required when different than the billing provider found in Field 33.</b> Please submit only one provider per claim.</p> <p><b>Unlabeled Field</b> – Enter your individual Regence provider number if submitting paper claim.</p> <p><b>NPI Field</b> – Enter your Type 1 individual NPI number for electronic claims submission. If submitting a paper claim the NPI may be included, if known.</p>
Required	25:	<p><b>Federal Tax ID Number</b> Enter the provider's tax identification number as given by the Internal Revenue Service.</p>
Recommended	26:	<p><b>Patient's Account Number</b> If you use patient account numbers, enter the number for this patient.</p>
Required for Medicare only	27:	<p><b>Accept Assignment</b> Please check applicable box.</p>
Required	28:	<p><b>Total Charge</b> Enter the total of all charges submitted on this claim.</p>
Recommended	29:	<p><b>Amount Paid</b> Enter the exact amount the patient and/or other insurance carrier has paid to you for these services. Entering the words 'patient paid' without indicating the exact amount may cause claims delays and inaccurate processing.</p>
	30:	<p><b>Balance Due</b> Enter the difference between Field 28 and Field 29.</p>
Required	31:	<p><b>Signature of Physician or Supplier</b> Sign and date the form. Stamped and preprinted signatures that include the degree are acceptable for all products except Regence MedAdvantage. Claims for this product must be signed or have a preprinted signature including degree.</p>
Required if applicable	32:	<p><b>Service Facility Location Information</b> Enter name and address of the location where the services were rendered.</p>
Required if applicable	32A:	<p><b>NPI #</b> Enter the service facility NPI number (Type 2) of the service facility location, if known.</p>
Required if applicable	32B:	<p><b>Other ID</b> Enter the two digit ID qualifier '1B' and the service facility Regence provider number of the service facility location if submitting a paper claim.</p>
Required	33:	<p><b>Billing Provider Information and Phone #</b> Enter the billing provider's name, address, zip code, and telephone number.</p>

Requirements	Field	Description
Required for electronic claim submissions	33A:	<p><b>NPI #</b> Enter the NPI number (Type 1 or 2) of the billing provider.</p> <p>The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.</p>
Required for paper claims submissions if not submitting an NPI	33B:	<p><b>Other ID</b> Enter the two digit ID qualifier '1B' and the Regence provider number of the billing provider. <b>Other ID is required if submitting a paper claim and 33A does not include an NPI.</b></p>

# Sample CMS-1500 (08-05) claim form

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																					
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPUS <input type="checkbox"/> (Member ID#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																											
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																											
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																																											
ZIP CODE					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ( )																																																											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																											
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME																																																											
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																											
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																											
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I 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 authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																					
SIGNED _____ DATE _____										SIGNED _____																																																																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																											
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										23. PRIOR AUTHORIZATION NUMBER _____																																																																					
1. _____										3. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. ICD-9-CM (Family Plan)					I. ID. QUAL.					J. RENDERING PROVIDER ID. #									
2. _____										4. _____										NPI _____										NPI _____										NPI _____										NPI _____										NPI _____										NPI _____									
25. FEDERAL TAX I.D. NUMBER										SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ _____					29. AMOUNT PAID \$ _____					30. BALANCE DUE \$ _____																																												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )																																																											
SIGNED _____ DATE _____										a. NPI _____					b. _____					a. NPI _____					b. _____																																																						

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

# UB-04 Paper Claim Form Instructions

All hospitals participating with Regence are required to submit *UB-04* claims in electronic format except for Type of Bill XX7. Following are instructions for completing a paper *UB-04* claim.

Requirements	Form Locator	Description
Required	1:	<b>Provider Name and Address, and Telephone Number</b> Enter provider's name, address, ZIP code and phone number.
	2:	Pay-to Name, Address, and Secondary Identification Fields Leave blank.
Required	3:	<b>Patient Control Number</b> Enter patient's control number or patient account number.
Required	4:	<b>Type of Bill (TOB)</b> Enter type of bill code. <b>Valid type of bill codes:</b> Hospital – Inpatient            11X 12X 18X Hospital – Outpatient            13X 14X Skilled Nursing – Inpatient    21X 22X Skilled Nursing – Outpatient   23X Home Health                        32X 33X 34X Clinic                                 71X 72X 73X 74X 75X 76X 79X Special Facility                    81X 82X 83X 85X  <b>Valid third digit codes:</b> Admit through discharge claim   1 Interim - First claim                2 Interim - Continuing claim        3 Interim - Last claim                 4 Late charges only claim            5 Replacement of prior claim       7 (submit on paper) Void/cancel prior claim            8 (submit on paper)
Required	5:	<b>Federal Tax Number</b> Enter your federal tax identification number.
Required	6:	<b>Statement Covers Period (From-Through)</b> Enter statement covers from and through date. Must be in CCYYMMDD format.
	7:	Untitled Not used
Required	8:	<b>Patient's Name</b> Enter patient's last name, first name and middle initial.

<b>Requirements</b>	<b>Form Locator</b>	<b>Description</b>
<b>Required</b>	<b>9:</b>	<b>Patient Address</b> Enter patient's full mailing address including street number, city, state and zip code.
<b>Required</b>	<b>10:</b>	<b>Patient Birth Date</b> Enter patient's date of birth. Must be in MMDDCCYY format.
<b>Required</b>	<b>11:</b>	<b>Patient Sex</b> Enter "M" (male) or "F" (female).
<b>Required</b>	<b>12:</b>	<b>Admission Date</b> Enter date patient is admitted for this stay. Must be in MMDDCCYY format.
<b>Required for inpatient claims</b>	<b>13:</b>	<b>Admission Hour</b> Enter the admission hour code.  <b>Valid Admission Hour Codes.</b> 00 = 12:00-12:59 midnight    12 = 12:00-12:59 noon 01 = 01:00-01:59                13 = 01:00-01:59 02 = 02:00-02:59                14 = 02:00-02:59 03 = 03:00-03:59                15 = 03:00-03:59 04 = 04:00-04:59                16 = 04:00-04:59 05 = 05:00-05:59                17 = 05:00-05:59 06 = 06:00-06:59                18 = 06:00-06:59 07 = 07:00-07:59                19 = 07:00-07:59 08 = 08:00-08:59                20 = 08:00-08:59 09 = 09:00-09:59                21 = 09:00-09:59 10 = 10:00-10:59                22 = 10:00-10:59 11 = 11:00-11:59                23 = 11:00-11:59 99 = Unknown
<b>Required for inpatient claims</b>	<b>14:</b>	<b>Type of Admission/Visit</b> Enter the type of admission code. This code indicates the priority of this admission.  <b>Valid type of admission codes:</b> 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not available

Requirements	Form Locator	Description
Required	15:	<p><b>Point of Origin for Admission or Visit</b> Enter the code indicating the source of the referral for this admission or visit.</p> <p><b>Valid source of admission codes:</b>  1 = Non-Health Care Facility  2 = Clinic  3 = Reserved for national assignment  4 = Transfer from a hospital (different facility)  5 = Transfer from a skilled nursing facility or Intermediate Care Facility  6 = Transfer from another health care facility  8 = Court/Law enforcement  9 = Information not available  D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer  E = Transfer from ambulatory surgery center</p>
Required for inpatient claims	16:	<p><b>Discharge Hour</b> Enter the discharge hour code.</p> <p><b>Valid Discharge Hour Codes.</b>  00 = 12:00-12:59 midnight    12 = 12:00-12:59 noon  01 = 01:00-01:59            13 = 01:00-01:59  02 = 02:00-02:59            14 = 02:00-02:59  03 = 03:00-03:59            15 = 03:00-03:59  04 = 04:00-04:59            16 = 04:00-04:59  05 = 05:00-05:59            17 = 05:00-05:59  06 = 06:00-06:59            18 = 06:00-06:59  07 = 07:00-07:59            19 = 07:00-07:59  08 = 08:00-08:59            20 = 08:00-08:59  09 = 09:00-09:59            21 = 09:00-09:59  10 = 10:00-10:59            22 = 10:00-10:59  11 = 11:00-11:59            23 = 11:00-11:59  99 = Unknown</p>

Requirements	Form Locator	Description
Required for inpatient claims	17:	<p><b>Patient Status</b>            Required for outpatient claims if the patient status code is other than 01. Enter patient status code.</p> <p><b>Valid Patient Status Codes:</b>            01 = Discharged to home or self-care (routine discharge)            02 = Discharged/transferred to another acute short-term general hospital for inpatient care            03 = Discharged/transferred to a SNF            04 = Discharged/transferred to an ICF            05 = Discharged/transferred to another type of institution not defined elsewhere in this code list            06 = Discharged/transferred to home under care organized home health service organization            07 = Left against medical advice or discontinued care            08 = Reserved for National Assignment            09 = Admitted as an inpatient to this hospital            20 = Expired            30 = Still patient or expected to return for outpatient services</p> <p><b>The following are used only on hospice claims:</b>            40 = Expired at home            41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice            42 = Expired – place unknown            43 = Discharged/transferred to a federal health care facility            50 = Discharged/transferred to Hospice – home            51 = Discharged/transferred to Hospice – medical facility            61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed            62 = Discharges/transferred to <u>an</u> inpatient rehabilitation facility including distinct part units of a “hospital”            63 = Discharge/transferred to long term care hospital            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</p>

<b>Recommended</b>	<b>18 – 28:</b>	<p>Condition Codes  Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. We can only accept up to 10 condition codes.</p>
		<p>Valid Condition Codes  02 = Condition is Employment Related  03 = Patient Covered by Insurance Not Reflected  04 = Information Only Bill  05 = Lien Has Been  06 = ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance  07 = Treatment of Non-terminal Condition for Hospice Patient  08 = Beneficiary Would Not Provide Information Concerning Other Insurance Coverage.  09 = Neither Patient Nor Spouse is Employed  10 = Patient and/or Spouse is Employed but no EGHP Coverage  11 = Disabled Beneficiary But no Large Group Health Plan  12-14 = Payer codes reserved for internal use only by third party payers.  17 = Patient is Homeless  18 = Maiden Name Retained  19 = Child Retains Mother's Name  20 = Beneficiary Requested  21 = Billing for Denial Notice  26 = VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility  27 = Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test (Sole Community Hospitals only).  28 = Patient and/or Spouse's EGHP is Secondary to Medicare  29 = Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare  30 = Qualifying Clinical Trials</p> <p>Student Status  31 = Patient is a Student (Full-Time - Day)  32 = Patient is a Student (Cooperative/Work Study Program)  33 = Patient is a Student (Full-Time - Night)  34 = Patient is a Student (Part-Time)</p> <p>Accommodation  36 = General Care Patient in a Special Unit (Not used by hospitals under PPS)</p>

		<p>37 = Ward Accommodation at Patient's Request (Not used by hospitals under PPS.)</p> <p>38 = Semi-private Room Not Available (Not used by hospitals under PPS)</p> <p>39 = Private Room Medically Necessary (Not used by hospitals under PPS)</p> <p>40 = Same Day Transfer</p> <p>41 = Partial Hospitalization</p> <p>42 = Continuing Care Not Related to Inpatient Admission</p> <p>43 = Continuing Care Not Provided Within Prescribed Post Discharge Window</p> <p>44 = Inpatient Admission Changed to Outpatient</p> <p>46 = Non-Availability Statement on File</p> <p>47 = Reserved for TRICARE</p> <p>48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)</p> <p>49 = Product replacement within product</p> <p>Skilled Nursing Facility Information</p> <p>55 = SNF Bed Not Available</p> <p>56 = Medical Appropriateness</p> <p>57 = SNF Readmission</p> <p>58 = Terminated Managed Care Organization Enrollee</p> <p>59 = Non-primary ESRD Facility</p> <p>67 = Beneficiary Elects Not to Use Lifetime Reserve (LTR)</p> <p>69 = IME/DGME/N&amp;A Payment Only</p> <p>Renal Dialysis Setting</p> <p>71 = Full Care in Unit</p> <p>72 = Self-Care in Unit</p> <p>73 = Self-Care Training</p> <p>74 = Home</p> <p>75 = Home 100-percent</p> <p>76 = Back-up In-Facility Dialysis</p> <p>77 = Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full</p> <p>78 = New Coverage Not Implemented by Managed Care Plan</p> <p>79 = CORF Services Provided Off-Site</p> <p>80 = Home Dialysis-Nursing Facility</p> <p>A9 = Second Opinion Surgery</p> <p>AA = Abortion Performed due to Rape</p> <p>AB = Abortion Performed due to Incest</p> <p>AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality</p>
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		<p>AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself</p> <p>AE = Abortion Performed due to Physical Health of Mother that is not Life Endangering</p> <p>AF = Abortion Performed due to Emotional/psychological Health of the Mother</p> <p>AG = Abortion Performed due to Social Economic Reasons</p> <p>AH = Elective Abortion Self</p> <p>AI = Sterilization Self-explanatory</p> <p>AJ = Payer Responsible for Copayment</p> <p>AK = Air Ambulance</p> <p>AL = Specialized Treatment/bed Unavailable</p> <p>AM = Non-emergency Medically Necessary Stretcher Transport Required</p> <p>AN = Preadmission Screening Not Required</p> <p>B1 = Beneficiary is Ineligible for Demonstration Program</p> <p>B2 = Critical Access Hospital Ambulance Attestation</p> <p>B3 = Pregnancy Indicator</p> <p>B4 = Admission Unrelated to Discharge</p> <p>Quality Improvement Organization (QIO)</p> <p>C1 = Approved as Billed</p> <p>C3 = Partial Approval</p> <p>C4 = Admission Denied</p> <p>C5 = Post-payment Review Applicable</p> <p>C6 = Preadmission/Pre-procedure</p> <p>C7 = Extended Authorization</p> <p>D0 = Changes to Service Dates</p> <p>D1 = Changes to Charges</p> <p>D2 = Changes to Revenue Codes/HCPCS/HIPPS Rate Code</p> <p>D3 = Second or Subsequent Interim PPS Bill</p> <p>D4 = Changes In ICD-9-CM Diagnosis and/or Procedure Code</p> <p>D5 = Cancel to Correct HICN or Provider ID</p> <p>D6 = Cancel Only to Repay a Duplicate or OIG Overpayment</p> <p>D7 = Change to Make Medicare the Secondary Payer</p> <p>D8 = Change to Make Medicare the Primary Payer</p> <p>D9 = Any Other Change</p> <p>DR = Disaster related</p> <p>E0 = Change in Patient Status</p> <p>G0 = Distinct Medical Visit</p> <p>H0 = Delayed Filing, Statement Of Intent Submitted</p>
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<b>Required for automobile accidents</b>	29	<b>Accident State</b> Two-digit state abbreviation of the state where the accident occurred.
	30	Untitled Not used.
<b>Recommended Required for all accidents</b>	31 – 41:	<b>Occurrence Codes and Dates</b> Required when there is a condition code that applies to this claim. Form locators 31, 32, 33, and 34 – allow both an occurrence codes and a date. Dates must be in MMDDYY format. The Occurrence Span Code can contain an occurrence code where the “Through” date would not contain an entry. <p><b>Valid Occurrence Codes</b></p> <p><b>Accident Related Codes</b></p> 01 = Accident/Medical Coverage 02 = No-Fault Insurance Involved 03 = Accident/Tort Liability 04 = Accident/Employment Related 05 = Accident/No Medical or Liability Coverage 06 = Crime Victim <p><b>Medical Condition Codes</b></p> 09 = Start of Infertility Treatment Cycle 10 = Last Menstrual Period 11 = Onset of Symptoms/Illness (Outpatient claims only.) 12 = Date of Onset for a Chronically Dependent Individual (CDI) (HHA Claims Only) <p><b>Insurance Related Codes</b></p> 16 = Date of Last Therapy 17 = Date Outpatient Occupational Therapy Plan Established or Reviewed 18 = Date of Retirement Patient/Beneficiary. 19 = Date of Retirement Spouse 20 = Guarantee of Payment Began (Part A hospital claims only) 21 = UR Notice Received (Part A SNF claims only.) 22 = Date Active Care Ended 23 = Date of Cancellation of Hospice Election Period 24 = Date Insurance Denied 25 = Date Benefits Terminated by Primary Payer 26 = Date SNF Bed Available 27 = Date of Hospice Certification or Re-Certification 28 = Date CORF Plan Established or Last 29 = Date OPT Plan Established or Last Reviewed <p>30 = Date Outpatient Speech Pathology Plan Established or Last Reviewed</p>

		<p>31 = Date Beneficiary Notified of Intent to Bill (Accommodations)</p> <p>32 = Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)</p> <p>33 = First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP</p> <p>34 = Date of Election of Extended Care Services</p> <p>35 = Date Treatment Started for Physical Therapy</p> <p>36 = Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)</p> <p>37 = Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant</p> <p>38 = Date treatment started for Home IV Therapy</p> <p>39 = Date discharged on a continuous course of IV</p> <p>40 = Scheduled Date of Admission</p> <p>41 = Date of First Test for Pre-admission Testing</p> <p>42 = Date of Discharge (Hospice claims only)</p> <p>43 = Scheduled Date of Cancelled Surgery</p> <p>45 = Date Treatment Started for Speech Therapy</p> <p>46 = Date Treatment Started for Cardiac</p> <p>47 = Date Cost Outlier Status Begins</p> <p><b>Service Related Codes</b></p> <p>A1 = Birth Date-Insured A The birth-date of the insured in whose name the insurance is carried.</p> <p>A2 = Effective Date-Insured A Policy</p> <p>A3 = Benefits Exhausted</p> <p>A4 = Split Bill Date</p> <p>B1 = Birth Date-Insured B</p> <p>B2 = Effective Date-Insured B Policy</p> <p>B3 = Benefits Exhausted</p> <p>C1 = Birth Date-Insured C</p> <p>C2 = Effective Date-Insured C Policy</p> <p>C3 = Benefits Exhausted</p> <p>70 = Qualifying Stay Dates (Part A claims for SNF level of care only)</p> <p>71 = Hospital Prior Stay Dates (Part A claims only)</p> <p>72 = First/Last Visit</p> <p>74 = Non-covered Level of Care</p> <p><b>Codes 76 and 77 apply to most non-covered care</b></p> <p>76 = Patient Liability The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary.</p> <p>77 = Provider Liability- Utilization Charged The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care)</p>
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		<p>M2 = Dates of Inpatient Respite From/Through dates of a period of inpatient  M3 = ICF Level of Care  M4 = Residential Level of Care</p>
	37:	<p>Untitled  Not used.</p>
	38:	<p>Responsible Party Name and Address</p>
<b>Required</b>	<b>39 – 41 a - d:</b>	<p><b>Value Codes and Amounts</b>  Enter value code. Amount is required when a value code is entered. If value code 45 is entered then amount needs to reflect an admission hour (see Form Locator 13).</p> <p><b>Valid Value Codes</b>  01 = Most common semi-private rate  02 = Hospital has no semi-private rooms  03 = Inpatient professional component charges which are combined billed  04 = Inpatient professional component charges which are combined billed  05 = Professional component included in charges and also billed separate to carrier  06 = Medicare blood deductible  08 = Medicare life time reserve amount in the first calendar year  09 = Medicare coinsurance amount in the first calendar year  10 = Lifetime reserve amount in the second calendar year  11 = Coinsurance amount in the second calendar year  12 = Working aged beneficiary/spouse with employer group health plan.  13 = ESRD beneficiary in a Medicare coordination period with an employer group health plan  14 = No fault, including auto/other  15 = Worker’s compensation  16 = PHS or other federal agency</p>

		<p><b>Medicaid Specific Codes</b>  21 = Catastrophic  22 = Surplus  23 = Recurring monthly income  24 = Medicaid rate code</p> <p><b>Reserved Codes</b>  31 = Patient liability amount  32 = Multiple Patient Ambulance Transport  37 = Pints of blood furnished  38 = Blood deductible pints  39 = Pints of blood replaced  40 = New coverage not implemented by HMO (for inpatient service only)  41 = Black Lung  42 = VA  43 = Disabled beneficiary under age 65 with LGHP  44 = Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received, then a Medicare secondary payment is due  45 = Accident Hour  46 = Number of grace days  47 = Any liability insurance  48 = Hemoglobin reading  49 = Hematocrit reading  50 = Number of physical therapy visits from onset (at the billing provider through this billing period)  51 = Number of occupational therapy visits from onset of symptoms ( at the billing provider through this billing period)  52 = Number of speech therapy visits from onset of symptoms (at the billing provider)  53 = Number of cardiac rehabilitation visits (at the billing provider through this billing period)  54 = Newborn birth weight in grams</p>
		<p><b>Home Health Specific Codes</b>  56 = Skilled nursing - home visit hours (HHA only)  57 = Home health aide - home visit hours (HHA only)  58 = Arterial blood gas value  59 = Oxygen saturation value  60 = HHA branch MSA  61 = Place of residence where service is furnished (HHA and Hospice)  67 = Peritoneal dialysis  68 = Number of units of EPO drug administered and/or</p>

		<p>supplied</p> <p>71 = Funding of ESRD Networks  72 = Flat Rate Surgery Charge  73 = Drug deductible  74 = Drug coinsurance  76 = Provider's Interim Rate  80 = Covered days  81 = Non-covered days  82 = Co-insurance days  83 = Lifetime Reserve days</p> <p><b>Deductible Coinsurance Codes</b>  A1 = Deductible amount Payer A  B1 = Deductible amount Payer B  C1 = Deductible amount Payer C  A2 = Coinsurance amount Payer A  B2 = Coinsurance amount Payer B  C2 = Coinsurance amount Payer C  A3 = Estimated responsibility Payer A  B3 = Estimated responsibility Payer B  C3 = Estimated responsibility Payer C  D3 = Estimated responsibility patient</p> <p>A4 = Covered self-administrable drugs – emergency  A5 = Covered self-administrable drugs – not self-administrable in form and situation furnished to patient  A6 = Covered Self-Administrable Drugs – Diagnostic Study and Other (For use with Revenue Code 0637)  A7 = Co-payment Payer A  B7 = Copayment Payer B  C7 = Copayment Payer C  A8 = Patient Weight  A9 = Patient Height  G8 = Facility where inpatient hospice service is delivered</p>
<b>Required for each charge entered</b>	<b>42:</b>	<b>Revenue Code</b> See Revenue Code table listed after <i>UB-04</i> instructions for a complete listing of available revenue codes. An accommodation revenue code (0100-0219) is required for all inpatient type of bill (TOB).
Optional	43:	<b>Revenue Description</b> A narrative description of the related revenue categories included on the claim. Abbreviations may be used.
<b>Recommended</b>	<b>43:</b>	<b>Revenue Description for National Drug Code (NDC) information</b> Enter the two-digit Product ID Qualifier "N4" in the first two positions, immediately followed by the NDC code with no

		<p>hyphens. Directly following the last digit of the NDC (no delimiter), enter the two-digit Unit of Measurement Qualifier. Immediately following the Unit of Measurement Qualifier, enter the nine-digit quantity. The nine digits consist of six digits for the whole number, followed by the three-digit decimal portion of the number.</p> <p><b>Valid Unit of Measurement Qualifiers are:</b>  F2 – International unit  GR – Gram  ML – Milliliter  UN – Unit</p> <p>The HCPCS code should be entered in Form Locator 44 and the Units in Form Locator 46.</p>
<b>Required</b>	<b>44:</b>	<p><b>HCPCS/Rates/HIPPS Rate Codes</b>  A CPT or HCPCS code is required for outpatient services or supplies.</p>
<b>Required</b>	<b>45:</b>	<p><b>Service Date</b>  Enter the date that the services were provided. Must be in MMDDCCYY format.</p>
<b>Required</b>	<b>46:</b>	<p><b>Units of Service</b>  Enter the number of units rendered for each service. Units can be hours, days/sessions, tests/services or items. See Revenue Code table listed after UB-04 instructions for additional requirements.</p>
<b>Required for each revenue code entered</b>	<b>47:</b>	<p><b>Total Charges</b>  Enter total charges Enter total charges pertaining to the related revenue code for the current billing period. Zeros are valid.</p>
Optional	<b>48:</b>	<p><b>Non-Covered Charges</b>  Enter non-covered charges.</p>
	<b>49:</b>	<p><b>Untitled</b>  Not used.</p>
	<b>51</b> a- c:	<p><b>Health Plan ID</b>  See Form locators 56 and 57 for NPI and Regence Identifier fields.</p>
<b>Required</b>	<b>52</b> a – c:	<p><b>Release of Information Certification Indicator</b>  A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. This is required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.</p>
Optional	<b>53</b>	<p><b>Assignment of Benefits Certification Indicator</b></p>

	a – c:	
<b>Optional</b>	<b>54</b> a – c:	<b>Prior Payments-Payers and Patient</b> Enter the amount of the prior payments from other insurance.
Optional	55 a – c:	Estimated Amount Due from patient
<b>Required for electronic claim submissions</b>	<b>56:</b>	<b>Billing Provider National Provider ID (NPI)</b> The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
<b>Required for paper claim submissions if NPI is not submitted in form locator 56</b>	<b>57:</b>	<b>Other Provider ID (primary, secondary, and/or tertiary)</b> Use this field to report your Regence provider identification number if submitting a paper claim without an NPI.  Until further notice a billing provider can electronically submit both an NPI and a Regence provider identification number.
<b>Required</b>	<b>58</b> a – c:	<b>Insured's Name</b> Enter the insured's last name, first name and middle initial as it appears on the member card.
<b>Required</b>	<b>59</b> a – c:	<b>Patient's Relationship to Insured</b> Enter patient's relationship to insured code. 01 = Spouse 18 = Self 19 = Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship
<b>Required</b>	<b>60</b> a – c:	<b>Insured's Unique Identification (ID)</b> Enter insured's identification number as shown on member card.
Optional	61 a – c:	Insured's Group Name
<b>Required</b>	<b>62</b> a – c:	<b>Insurance Group Number</b> Enter the insured's group number as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Optional	63:	Treatment Authorization Code
Optional	64:	Document Control Number (DCN)

Optional	65:	Employer Name
Optional	66:	<p>Diagnosis and Procedure Code Qualifier (ICD Version Indicator)</p> <p>The qualifier denotes the version of <i>International Classification of Diseases</i> (ICD) reported. The following qualifier code reflects the edition portion of the ICD 9 – Ninth Revision</p>
Required	67:	<p><b>Principal Diagnosis Code and Present on Admission Indicator</b></p> <p>Enter the ICD-9 diagnosis code for the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for this hospital admission. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. Do not include the decimal between the third and fourth digits. "V" codes are acceptable as principal diagnoses.</p> <p>This field is eight positions long. The principal diagnosis is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p>
Required	67A – 67Q:	<p><b>Other Diagnoses Codes</b></p> <p>Enter up to seventeen ICD-9 diagnosis codes for the other diagnoses. The codes must be the full ICD-9 diagnosis codes, including all five digits where applicable. Do not include the decimal between the third and fourth digits. Both "V" and "E" codes may be entered as other diagnoses, though E codes are preferably billed in form locator 72.</p> <p>There are 17 Other Diagnosis fields. Each Other Diagnosis field is eight positions long. The diagnosis code is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p> <p>Diagnosis codes must be carried to their highest degree of detail. Do not duplicate the principal diagnosis in this field.</p>
	68:	<p>Untitled</p> <p>Not used.</p>
Required for inpatient type of bills	69:	<p><b>Admitting Diagnosis</b></p> <p>Must be a valid ICD diagnosis code. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.</p>
Required for outpatient	70 a – c:	<p><b>Patient's Reason for Visit</b></p> <p>Required for all unscheduled outpatient visits for outpatient</p>

<b>if applicable</b>		bills.
Optional	71:	Prospective Payment System (PPS) Code
<b>Required if applicable</b>	<b>72:</b>	<b>External Cause of Injury Code (E-Code)</b> Enter up to three E-Codes if an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. The codes must be the full ICD-9 E-code, including all five digits where applicable. Do not include the decimal between the fourth and fifth positions.  There are 3 E-Code fields. Each E-Code field is eight positions long. The E-Code is entered in positions 1 - 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
	73:	Untitled Not used.
<b>Required for inpatient type of bills if applicable</b>	<b>74:</b>	<b>Principal Procedure Code and Date</b> Enter the principal procedure code and date. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
<b>Required for inpatient type of bills well if applicable</b>	<b>74A – 74E:</b>	<b>Other Procedure Codes and Dates</b> Enter up to five other procedure codes and dates. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
	75:	Untitled Not used.
<b>Required</b>	<b>76:</b>	<b>Attending Provider Name and Identifiers (including NPI)</b> Enter the unique provider's NPI and the name of the attending physician for inpatient bills or the physician that requested the outpatient services.  Definition of attending provider: The provider who is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.
Optional	77:	Operating Provider Name and Identifiers (including NPI)
Optional	78 and 79:	Other Provider Name and Identifiers (including NPI)
<b>Required under circumstances listed</b>	<b>80:</b>	<b>Remarks</b> 1. If revenue code 0450, 0456 or 0459 are entered in Form Locator 42, remarks should clarify circumstances for emergency room visit, i.e. who, what, when, where, why, how and time of day. Use of E-Code and Occurrence codes are valid.

		<p>2. If CPT codes are used in place of HCPCS codes with any of the following revenue codes entered in Form Locator 44, remarks should specify the type of drug, implant, or device:  0254 = Drugs incident to other diagnostic service  0255 = Drugs incident to radiology  0256 = Experimental drugs  0259 = Other pharmacy  0274 = Prosthetic device  0278 = Other implants  0279 = Other supplies/devices  0623 = Surgical dressings  0624 = Investigational device  <b>0636 = Drugs requiring detailed coding</b>  <b>0637 = Self-administrable drugs</b></p> <p>3. <b>If CPT codes are used in place of HCPCS</b> codes with any of the following revenue codes entered in Form Locator 44, remarks should specify the type of equipment and for rental equipment, the period of rental:  0290 = General Classification  0291 = Rental  0292 = Purchase of new equipment   0293 = Purchase of used equipment  0294 = Supplies/drugs for DME effectiveness  0299 = Other equipment</p> <p>4. If occurrence codes 01-05 are entered in Form Locators 31-41 and/or diagnosis codes 800-959.9, E800-849, E880-E929, E969-E999 are entered in Form Locators 67A -67Q or E999 is entered in Form Locator 72, remarks should clarify accident information, i.e. who, what, when, where, why, how and time of day.</p>
<b>Recommended</b>	<b>81:</b>	<p><b>Code-Code Field</b>  Enter for the following:  A1 = NUBC Condition Codes (FL 18-28)  A2 = NUBC Occurrence Codes/Dates  A3 = NUBC Occurrence Span  A4 = NUBC Value Codes (FL 39-41)</p>

# Sample UB-04 claim form

1		2		3a. ICD-9-CM 3b. ICD-9-PCS		4. TYPE OF BILL	
8. PATIENT NAME		9. PATIENT ADDRESS		5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM THROUGH	
10. BIRTHDATE		11. SEX		12. DATE		13. ADMISSION 13 HR 14 TYPE 15 SRC	
16. ICD-9-CM		17. ICD-9-PCS		18. ICD-9-CM		19. ACDT STATE	
20. OCCURRENCE DATE		21. OCCURRENCE DATE		22. OCCURRENCE DATE		23. OCCURRENCE DATE	
24. OCCURRENCE DATE		25. OCCURRENCE DATE		26. OCCURRENCE DATE		27. OCCURRENCE DATE	
28. VALUE CODES AMOUNT		29. VALUE CODES AMOUNT		30. VALUE CODES AMOUNT		31. VALUE CODES AMOUNT	
32. REV. CD.		33. DESCRIPTION		34. HCPCS / RATE / NAPS CODE		35. SERV. DATE	
36. SERV. UNITS		37. TOTAL CHARGES		38. NON-COVERED CHARGES		39.	
PAGE OF		CREATION DATE		TOTALS			
40. PAYER NAME		41. HEALTH PLAN ID		42. PRIOR PAYMENTS		43. EST. AMOUNT DUE	
44. INSURED'S NAME		45. INSURED'S UNIQUE ID		46. GROUP NAME		47. INSURANCE GROUP NO.	
48. TREATMENT AUTHORIZATION CODES		49. DOCUMENT CONTROL NUMBER		50. EMPLOYER NAME			
51. ADMIT CX		52. PATIENT REASON CODE		53. PPS CODE		54. OTHER PRV ID	
55. PRINCIPAL PROCEDURE CODE		56. OTHER PROCEDURE CODE		57. OTHER PROCEDURE CODE		58. OTHER PROCEDURE CODE	
59. REMARKS		60. ATTENDING		61. OPERATING		62. OTHER	
63. REMARKS		64. OTHER		65. OTHER		66. OTHER	

# Revenue Codes for UB-04 Claims

The following revenue code table describes our specific requirements for submission of a UB-04 claim either electronically or through paper submission. Please note the asterisk in the revenue code column require the 4<sup>th</sup> digit always be used and asterisk in the procedure code column require specific remarks as identified in form locator 80 found in the UB-04 instructions.

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>0001</b>	<b>Total Charge - Required for each claim, must be last revenue code on claim</b>					
<b>001X</b>	<b>Reserved for Internal Payer Use</b>					
<b>002X</b>	<b>New Revenue category- (HIPPS ) Health Insurance Prospective Payment System for Skilled Nursing Fee Prospective Payment System</b>					
<b>0</b>	Reserved					
<b>1</b>	Reserved					
<b>2</b>	Skilled Nursing Facility		X			
<b>3</b>	Home Health		X			
<b>4</b>	Inpatient Rehabilitation Facility		X			
<b>5</b>	Reserved					
<b>6</b>	Reserved					
<b>7</b>	Reserved					
<b>8</b>	Reserved					
<b>9</b>	Reserved					
<b>0023</b>	<b>Home Health</b>					
<b>0024</b>	<b>Inpatient Rehabilitation Facility- Prospective Payment System</b>					
<b>003X to 006X</b>	<b>Reserved for National Assignment</b>					
<b>007X to 009X</b>	<b>Reserved for State Use</b>					
<b>010X</b>	<b>All Inclusive Rate</b>					
<b>0</b>	All inclusive room & board plus ancillary		X			
<b>1</b>	All inclusive room and board		X			
<b>011X</b>	<b>Room &amp; Board - Private</b>					
<b>*0</b>	General Classification		X			
<b>1</b>	Medical/Surgical/GYN		X			
<b>2</b>	OB		X			
<b>3</b>	Pediatric		X			
<b>*4</b>	Psychiatric		X			
<b>5</b>	Hospice		X			
<b>6</b>	Detoxification		X			
<b>7</b>	Oncology		X			
<b>*8</b>	Rehabilitation		X			
<b>9</b>	Other		X			

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>012X</b>	<b>Room &amp; Board - Semi-Private Two Bed</b>					
0	General Classification		X			
1	Medical/Surgical/GYN		X			
2	OB		X			
3	Pediatric		X			
4	Psychiatric		X			
5	Hospice		X			
6	Detoxification		X			
7	Oncology		X			
8	Rehabilitation		X			
9	Other		X			
<b>013X</b>	<b>Semi-Private - Three &amp; Four Beds</b>					
0	General Classification		X			
1	Medical/Surgical/GYN		X			
2	OB		X			
3	Pediatric		X			
4	Psychiatric		X			
5	Hospice		X			
6	Detoxification		X			
7	Oncology		X			
8	Rehabilitation		X			
9	Other		X			
<b>014X</b>	<b>Private (Deluxe)</b>					
0	General Classification		X			
1	Medical/Surgical/GYN		X			
2	OB		X			
3	Pediatric		X			
*4	Psychiatric		X			
5	Hospice		X			
6	Detoxification		X			
7	Oncology		X			
*8	Rehabilitation		X			
9	Other		X			
<b>015X</b>	<b>Room &amp; Board - Ward</b>					
0	General Classification		X			
1	Medical/Surgical/GYN		X			
2	OB		X			
3	Pediatric		X			
*4	Psychiatric		X			
5	Hospice		X			
6	Detoxification		X			
7	Oncology		X			
*8	Rehabilitation		X			
9	Other		X			

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>016X</b>	<b>Other Room &amp; Board</b>					
0	General Classification		X			
4	Sterile environment		X			
7	Self care		X			
9	Other		X			
<b>017X</b>	<b>Nursery</b>					
0	General Classification		X			
1	Newborn Level I		X			
2	Newborn Level II		X			
3	Newborn Level III		X			
4	Newborn Level IV		X			
9	Other		X			
<b>018X</b>	<b>Leave of Absence</b>					
0	General Classification		X			
2	Patient convenience charges		X			
3	Therapeutic leave		X			
5	Hospitalization		X			
9	Other leave of absence		X			
<b>019X</b>	<b>Subacute Care</b>					
0	General Classification		X			
1	Subacute Care - Level I		X			
2	Subacute Care - Level II		X			
3	Subacute Care - Level III		X			
4	Subacute Care - Level IV		X			
9	Other Subacute Care		X			
<b>020X</b>	<b>Intensive Care</b>					
0	General Classification		X			
1	Surgical		X			
2	Medical		X			
3	Pediatric		X			
*4	Psychiatric		X			
6	Intermediate ICU		X			
7	Burn care		X			
8	Trauma		X			
9	Other intensive care		X			
<b>021X</b>	<b>Coronary Care</b>					
0	General Classification		X			
1	Myocardial infarction		X			
2	Pulmonary care		X			
3	Heart transplant		X			
4	Intermediate CCU		X			
9	Other coronary care		X			
<b>022X</b>	<b>Special Charges</b>					
*0	General Classification		X			
*1	Admission charge		X			
*2	Technical support charge		X			

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
*3	UR service charge		X			
*4	Late discharge, medically necessary		X			
*9	Other special charges	X				
<b>023X</b>	<b>Incremental Nursing Charges</b>					
0	General Classification		X			
1	Nursery		X			
2	OB		X			
3	ICU (includes transitional care)		X			
4	CCU (includes transitional care)		X			
5	Hospice		X			
9	Other		X			
<b>024X</b>	<b>All Inclusive Ancillary</b>					
0	General Classification		X			
1	Basic		X			
2	Comprehensive		X			
3	Specialty		X			
9	Other inclusive ancillary		X			
<b>025X</b>	<b>Pharmacy</b>					
0	General Classification	X				
1	Generic drugs	X				
2	Non-generic drugs	X				
*3	Take home drugs			**CPT/ HCPCS Remarks required if CPT used		
*4	Drugs incident to other diagnostic service			**CPT/ HCPCS Remarks required if CPT used		
5	Drugs incident to radiology			**CPT/ HCPCS Remarks required if CPT used		
*6	Experimental drugs			**CPT/ HCPCS Remarks required if CPT used		
*7	Non-prescription	X				
*8	IV solutions	X				
*9	Other drugs/other			**CPT/ HCPCS Remarks required if CPT used		
<b>026X</b>	<b>IV Therapy</b>					
*0	General Classification			CPT/ HCPCS		
*1	Infusion pump			CPT/ HCPCS		
*2	IV therapy/pharmacy services			CPT/ HCPCS		
*3	IV therapy/ drug/supply/delivery			CPT/ HCPCS		
*4	IV therapy/supplies	X				
*9	Other IV therapy			CPT/ HCPCS		
<b>027X</b>	<b>Medical/Surgical Supplies</b>					

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
0	General Classification	X				
1	Nonsterile supply	X				
2	Sterile supply	X				
*3	Take home supplies	X				
*4	Prosthetic/orthotic devices			**CPT/ HCPCS Remarks required if CPT used		
*5	Pacemaker	X				
6	Intraocular lenses	X				
7	Oxygen-take home			CPT/ HCPCS		
*8	Other implants			**CPT/ HCPCS Remarks required if CPT used		
*9	Other supplies/devices			**CPT/ HCPCS Remarks required if CPT used		
<b>028X</b>	<b>Oncology</b>					
0	General Classification	X				
9	Other oncology	X				
<b>029X</b>	<b>Durable Medical Equipment (other than rental)</b>					
*0	General Classification			**CPT/ HCPCS Remarks required if CPT used		
*1	Rental			**CPT/ HCPCS Remarks required if CPT used		
*2	Purchase of new DME			**CPT/ HCPCS Remarks required if CPT used		
*3	Purchase of used DME			**CPT/ HCPCS Remarks required if CPT used		
*4	Supplies/drugs for DME (HHA only)			**CPT/ HCPCS Remarks required if CPT used		
*9	Other equipment			**CPT/ HCPCS Remarks required if CPT used		
<b>030X</b>	<b>Laboratory</b>					
*0	General Classification			CPT/ HCPCS		Tests/Services
1	Chemistry			CPT/ HCPCS		Tests/Services
2	Immunology			CPT/ HCPCS		Tests/Services
3	Renal patient (home)			CPT/ HCPCS		Tests/Services
*4	Non-routine dialysis			CPT/ HCPCS		Tests/Services
5	Hematology			CPT/ HCPCS		Tests/Services
6	Bacteriology and Microbiology			CPT/ HCPCS		Tests/Services
7	Urology			CPT/ HCPCS		Tests/Services
9	Other laboratory			CPT/ HCPCS		Tests/Services

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>031X</b>	<b>Laboratory Pathological</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Cytology			CPT/ HCPCS		Tests/Services
2	Histology			CPT/ HCPCS		Tests/Services
4	Biopsy			CPT/ HCPCS		Tests/Services
9	Other			CPT/ HCPCS		Tests/Services
<b>032X</b>	<b>Radiology - Diagnostic</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Angiocardiology			CPT/ HCPCS		Tests/Services
2	Arthrography			CPT/ HCPCS		Tests/Services
3	Arteriography			CPT/ HCPCS		Tests/Services
4	Chest x-ray			CPT/ HCPCS		Tests/Services
9	Other			CPT/ HCPCS		Tests/Services
<b>033X</b>	<b>Radiology - Therapeutic</b>					
*0	General Classification			CPT/ HCPCS		Tests/Services
*1	Chemotherapy injected			CPT/ HCPCS		Tests/Services
*2	Chemotherapy - oral			CPT/ HCPCS		Tests/Services
*3	Radiation therapy			CPT/ HCPCS		Tests/Services
*5	Chemotherapy - IV			CPT/ HCPCS		Tests/Services
*9	Other			CPT/ HCPCS		Tests/Services
<b>034X</b>	<b>Nuclear Medicine</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Diagnostic procedures			CPT/ HCPCS		Tests/Services
2	Therapeutic procedures			CPT/ HCPCS		Tests/Services
3	Diagnostic radiopharmaceuticals			CPT/HCPCS		Tests/Services
4	Therapeutic radiopharmaceuticals			CPT/HCPCS		Tests/Services
9	Other			CPT/ HCPCS		Tests/Services
<b>035X</b>	<b>Computed Tomographic (CT) Scan</b>					
*0	General Classification			CPT/ HCPCS		Tests/Services
*1	Head scan			CPT/ HCPCS		Tests/Services
*2	Body scan			CPT/ HCPCS		Tests/Services
*9	Other CT scans			CPT/ HCPCS		Tests/Services
<b>036X</b>	<b>Operating Room Services</b>					
0	General Classification			CPT/ HCPCS		
1	Minor surgery			CPT/ HCPCS		
*2	Organ transplant/ except kidney		X			
*7	Kidney transplant		X	CPT/ HCPCS		
9	Other operating room		X	CPT/ HCPCS		
<b>037X</b>	<b>Anesthesia</b>					
0	General Classification	X				
1	Anesthesia incident to radiology	X				
2	Anesthesia incident to other diagnostic services	X				
4	Acupuncture	X				
9	Other anesthesia	X				

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>038X</b>	<b>Blood</b>					
0	General Classification	X				
1	Packed red cells	X				
2	Whole blood	X				
3	Plasma	X				
4	Platelets	X				
5	Leucocytes	X				
6	Other components	X				
7	Other derivatives (cryoprecipitates)	X				
9	Other blood	X				
<b>039X</b>	<b>Blood Storage and Processing</b>					
0	General Classification	X				
1	Blood administration	X				
9	Other blood storage and processing	X				
<b>040X</b>	<b>Other Imaging Services</b>					
*0	General Classification			CPT/ HCPCS		Tests/Services
*1	Diagnostic mammography			CPT/ HCPCS		Tests/Services
*2	Ultrasound			CPT/ HCPCS		Tests/Services
*3	Screening mammography			CPT/ HCPCS		Tests/Services
*4	Positron emission tomography					Tests/Services
*9	Other imaging services			CPT/ HCPCS		Tests/Services
<b>041X</b>	<b>Respiratory Services</b>					
0	General Classification			CPT/ HCPCS	X	Visits/Sessions
2	Inhalation services			CPT/ HCPCS	X	Visits/Sessions
*3	Hyperbaric oxygen therapy			CPT/ HCPCS	X	Visits/Sessions
9	Other respiratory services			CPT/ HCPCS	X	Visits/Sessions
<b>042X</b>	<b>Physical Therapy</b>					
*0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Visit charge			CPT/ HCPCS	X	Visits/Sessions
*2	Hourly charge			CPT/ HCPCS	X	Visits/Sessions
*3	Group rate			CPT/ HCPCS	X	Visits/Sessions
*4	Evaluation or re-evaluation			CPT/ HCPCS	X	Visits/Sessions
*9	Other physical therapy			CPT/ HCPCS	X	Visits/Sessions
<b>043X</b>	<b>Occupational Therapy</b>					
*0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Visit charge			CPT/ HCPCS	X	Visits/Sessions
*2	Hourly charge			CPT/ HCPCS	X	Visits/Sessions
*3	Group rate			CPT/ HCPCS	X	Visits/Sessions
*4	Evaluation or re-evaluation			CPT/ HCPCS	X	Visits/Sessions
*9	Other occupational therapy			CPT/ HCPCS	X	Visits/Sessions
<b>044X</b>	<b>Speech - Language Pathology</b>					
*0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Visit charge			CPT/ HCPCS	X	Visits/Sessions
*2	Hourly charge			CPT/ HCPCS	X	Visits/Sessions

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
*3	Group rate			CPT/ HCPCS	X	Visits/Sessions
*4	Evaluation or re-evaluation			CPT/ HCPCS	X	Visits/Sessions
*9	Other speech-language pathology			CPT/ HCPCS	X	Visits/Sessions
<b>045X</b>	<b>Emergency Room</b>					
0	General Classification			**CPT/ HCPCS Remarks required		
1	EMTALA emergency medical screening services			CPT/ HCPCS		
2	ER beyond EMTALA screening			CPT/ HCPCS		
6	Urgent Care			**CPT/ HCPCS Remarks required		
9	Other emergency room			**CPT/ HCPCS Remarks required		
<b>046X</b>	<b>Pulmonary Function</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
9	Other pulmonary function			CPT/ HCPCS		Tests/Services
<b>047X</b>	<b>Audiology</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Diagnostic			CPT/ HCPCS		Tests/Services
2	Treatment			CPT/ HCPCS		Tests/Services
9	Other audiology			CPT/ HCPCS		Tests/Services
<b>048X</b>	<b>Cardiology</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Cardiac cath lab			CPT/ HCPCS		Tests/Services
2	Stress test			CPT/ HCPCS		Tests/Services
3	Echocardiography			CPT/ HCPCS		Tests/Services
9	Other cardiology			CPT/ HCPCS		Tests/Services
<b>049X</b>	<b>Ambulatory Surgical Care</b>					
0	General Classification			CPT/ HCPCS		
9	Other ambulatory surgical care			CPT/ HCPCS		
<b>050X</b>	<b>Outpatient Services</b>					
0	General Classification	X				
9	Other outpatient services	X				
<b>051X</b>	<b>Clinic</b>					
0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Chronic pain center			CPT/ HCPCS	X	Visits/Sessions
*2	Dental clinic			CPT/ HCPCS	X	Visits/Sessions
*3	Psychiatric clinic			CPT/ HCPCS	X	Visits/Sessions
4	OB-GYN clinic			CPT/ HCPCS	X	Visits/Sessions
5	Pediatric Clinic			CPT/ HCPCS	X	Visits/Sessions
6	Urgent Care Clinic			CPT/ HCPCS	X	Visits/Sessions
7	Family Practice Clinic			CPT/ HCPCS	X	Visits/Sessions
*9	Other clinic			CPT/ HCPCS	X	Visits/Sessions
<b>052X</b>	<b>Freestanding Clinic</b>					
*0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Rural health - clinic			CPT/ HCPCS	X	Visits/Sessions

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
*2	Rural health - home			CPT/ HCPCS	X	Visits/Sessions
*3	Family practice			CPT/ HCPCS	X	Visits/Sessions
*6	Urgent care clinic			CPT/ HCPCS	X	Visits/Sessions
*7	Visiting Nurse Services - home health shortage area			CPT/HCPCS	X	Visits/Sessions
*8	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)			CPT/HCPCS	X	Visits/Sessions
*9	Other freestanding clinic			CPT/ HCPCS	X	Visits/Sessions
<b>053X</b>	<b>Osteopathic Services</b>					
0	General Classification			CPT/ HCPCS		Visits/Sessions
1	Osteopathic therapy			CPT/ HCPCS		Visits/Sessions
9	Other osteopathic services			CPT/ HCPCS		Visits/Sessions
<b>054X</b>	<b>Ambulance</b>					
0	General Classification			CPT/ HCPCS		
1	Supplies			CPT/ HCPCS		
2	Medical transport			CPT/ HCPCS		
3	Heart mobile			CPT/ HCPCS		
4	Oxygen			CPT/ HCPCS		
5	Air ambulance			CPT/ HCPCS		
6	Neonatal ambulance			CPT/ HCPCS		
7	Pharmacy			CPT/ HCPCS		
8	Telephone transmission EKG			CPT/ HCPCS		
9	Other ambulance			CPT/ HCPCS		
<b>055X</b>	<b>Skilled Nursing</b>					
*0	General Classification				X	
*1	Visit charge				X	
*2	Hourly charge				X	
*9	Other skilled nursing				X	
<b>056X</b>	<b>Medical Social Services</b>					
0	General Classification				X	
1	Visit charge				X	
2	Hourly charge				X	
9	Other medical social services				X	
<b>057X</b>	<b>Home Health Aide (Home Health)</b>					
0	General Classification				X	
1	Visit charge				X	
2	Hourly charge				X	
9	Other home health aide				X	
<b>058X</b>	<b>Other Visits (Home Health)</b>					
0	General Classification				X	
1	Visit charge				X	
2	Hourly charge				X	
3	Assessment				X	
9	Other home health visits				X	
<b>059X</b>	<b>Units of Service (Home Health)</b>					

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
0	General Classification				X	
9	Home health other units				X	
<b>060X</b>	<b>Oxygen (Home Health)</b>					
0	General Classification				X	
1	Oxygen-State equip/supp/or cont				X	
2	Oxygen-State equip/supp/under 1 LPM				X	
3	Oxygen-State equip/over 4 LPM				X	
4	Oxygen - Portable add-on				X	
<b>061X</b>	<b>Magnetic Resonance Imaging (MRI)</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Brain (including brain stem)			CPT/ HCPCS		Tests/Services
2	Spinal cord (including spine)			CPT/ HCPCS		Tests/Services
4	MRI Other			CPT/HCPCS		Tests/Services
5	MRA - Head and Neck			CPT/HCPCS		Tests/Services
6	MRA - Lower Extremities			CPT/HCPCS		Tests/Services
8	MRA - Other			CPT/HCPCS		Tests/Services
9	MRT- Other			CPT/ HCPCS		Tests/Services
<b>062X</b>	<b>Medical/Surgical Supplies (extension of 27X)</b>					
1	Supplies incident to radiology	X				
2	Supplies incident to other diagnostic services	X				
3	Surgical Dressings			**CPT/ HCPCS Remarks required if CPT used	X	Items
4	Investigational Device			**CPT/ HCPCS Remarks required if CPT used	X	Items
<b>063X</b>	<b>Pharmacy (extension of 025X)</b>					
0	Reserved					
1	Single source drug			CPT/ HCPCS		
2	Multiple source drug			CPT/ HCPCS		
3	Restrictive prescription			CPT/ HCPCS		
4	Erythropoietin (EPO), less than 10,000 units			CPT/ HCPCS		
5	Erythropoietin (EPO), 10,000 or more units			CPT/ HCPCS		
*6	Drugs requiring detailed coding/ hemophilia blood clotting factor			CPT/ HCPCS		
7	Self-administrable Drugs			**CPT/ HCPCS Remarks required if CPT used		
<b>064X</b>	<b>Home IV Therapy Services</b>					
0	General Classification				X	
1	Non-routine nursing, central line				X	
2	IV site care, central line				X	

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
3	IV start/change, peripheral line				X	
4	Non-routine nursing, peripheral line				X	
5	Training patient/caregiver, central line				X	
6	Training disabled patient, central line				X	
7	Training patient/caregiver, peripheral line				X	
8	Training disabled patient peripheral line				X	
9	Other IV therapy services				X	
<b>065X</b>	<b>Hospice Services</b>					
0	General Classification				X	
1	Routine home care				X	
2	Continuous home care				X	
5	Inpatient respite care		X			
6	General inpatient care (non-respite)		X			
7	Physicians services				X	
8	Hospice Room & Board Nursing Facility		X			
9	Other hospice				X	
<b>066X</b>	<b>Respite Care (HHA only)</b>					
0	General Classification				X	
1	Hourly charge/skilled nursing				X	
2	Hourly charge/aide/ homemaker/ companion				X	
3	Daily respite charge				X	
9	Other respite care				X	
<b>067X</b>	<b>Outpatient Special Residence Charges</b>					
0	General Classification				X	
1	Hospital based				X	
2	Contracted				X	
9	Other special residence charges				X	
<b>068X</b>	<b>Trauma Response/ charges for a trauma team activation</b>					
0	Not used				X	
1	Level I				X	
2	Level II				X	
3	Level III				X	
4	Level IV				X	
9	Other trauma response				X	
<b>070X</b>	<b>Cast Room</b>					
0	General Classification			CPT/ HCPCS		
9	Other cast room			CPT/ HCPCS		
<b>071X</b>	<b>Recovery Room</b>					
0	General Classification	X				

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
9	Other recovery room	X				
<b>072X</b>	<b>Labor Room/Delivery</b>					
0	General Classification	X				
1	Labor	X				
2	Delivery	X				
3	Circumcision	X				
4	Birth center	X				
9	Other labor room/delivery	X				
<b>073X</b>	<b>Electrocardiogram (EKG/ECG)</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
1	Holter monitor			CPT/ HCPCS		Tests/Services
2	Telemetry			CPT/ HCPCS		Tests/Services
9	Other EKG/ECG			CPT/ HCPCS		Tests/Services
<b>074X</b>	<b>Electroencephalogram (EEG)</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
9	Other EEG			CPT/ HCPCS		Tests/Services
<b>075X</b>	<b>Gastrointestinal Services (Use for endoscopic procedures not performed in an operating room)</b>					
0	General Classification			CPT/ HCPCS		Tests/Services
9	Other gastrointestinal room			CPT/ HCPCS		Tests/Services
<b>076X</b>	<b>Treatment or Observation Room</b>					
0	General Classification					Hours
1	Treatment room					Hours
2	Observation room					Hours
9	Other treatment room					Hours
<b>077X</b>	<b>Preventive Care Services</b>					
0	General Classification			CPT/ HCPCS		Items
1	Vaccine Administration			CPT/ HCPCS		Items
9	Other			CPT/ HCPCS		Items
<b>079X</b>	<b>Extra-Corporeal Shock Wave Therapy or ESWT (formerly Lithotripsy)</b>					
0	General Classification			CPT/ HCPCS		
9	Other ESWT			CPT/ HCPCS		
<b>080X</b>	<b>Inpatient Renal Dialysis</b>					
*0	General Classification		X			
*1	Inpatient hemodialysis		X			
*2	Inpatient peritoneal (non-CAPD)		X			
*3	Inpatient continuous ambulatory peritoneal dialysis (CAPD)		X			
*4	Inpatient continuous cycling peritoneal dialysis (CCPD)		X			
*9	Other inpatient dialysis		X			
<b>081X</b>	<b>Organ Acquisition</b>					
*0	General Classification		X			
*1	Living donor		X			
*2	Cadaver donor		X			
*3	Unknown donor		X			

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
*4	Unsuccessful organ search donor bank charge		X			
*9	Other organ donor		X			
<b>082X</b>	<b>Hemodialysis - Outpatient or Home</b>					
*0	General Classification	X				
*1	Hemodialysis/composite-other rate	X				
*2	Home supplies	X				
*3	Home equipment	X				
*4	Maintenance 100%	X				
*5	Support services	X				
*9	Other hemodialysis outpt.	X				
<b>083X</b>	<b>Peritoneal Dialysis - Outpatient or Home</b>					
*0	General Classification	X				
*1	Peritoneal/composite or other rate	X				
*2	Home supplies	X				
*3	Home equipment	X				
*4	Maintenance 100%	X				
*9	Other peritoneal dialysis	X				
<b>084X</b>	<b>Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home</b>					
*0	General Classification	X				
*1	CAPD/composite or other rate	X				
*2	Home supplies	X				
*3	Home equipment	X				
*4	Maintenance 100%	X				
*5	Support services	X				
*9	Other CAPD dialysis	X				
<b>085X</b>	<b>Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient</b>					
*0	General Classification	X				
*1	CCPD/composite or other rate	X				
*2	Home supplies	X				
*3	Home equipment	X				
*4	Maintenance 100%	X				
*5	Support services	X				
*9	Other CCPD dialysis	X				
<b>088X</b>	<b>Miscellaneous Dialysis</b>					
*0	General Classification	X				
*1	Ultrafiltration	X				
*2	Home dialysis aid visit	X				
*9	Other miscellaneous dialysis	X				
<b>090X</b>	<b>Behavior Health Treatment /Services (also see 091X, an extension of 090X)</b>					
0	General Classification			CPT/ HCPCS	X	Visits/Sessions
1	Electroshock treatment			CPT/ HCPCS	X	Visits/Sessions
2	Milieu therapy			CPT/ HCPCS	X	Visits/Sessions
3	Play therapy			CPT/ HCPCS	X	Visits/Sessions

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
4	Activity Therapy			CPT/ HCPCS	X	Visits/Sessions
5	Intensive Outpatient Services/Psychiatric			CPT/HCPCS	X	Visits/Sessions
6	Intensive Outpatient Services – Chemical Dependency			CPT/HCPCS	X	Visits/Sessions
7	Community Behavioral Health Program (Day Treatment)			CPT/HCPCS	X	Visits/Sessions
<b>091X</b>	<b>Behavioral Health Treatment/Services (extension of 090X)</b>					
1	Rehabilitation			CPT/ HCPCS	X	Visits/Sessions
2	Partial hospitalization - less intensive			CPT/ HCPCS	X	Visits/Sessions
3	Partial hospitalization - intensive			CPT/ HCPCS	X	Visits/Sessions
4	Individual therapy			CPT/ HCPCS	X	Visits/Sessions
5	Group therapy			CPT/ HCPCS	X	Visits/Sessions
6	Family therapy			CPT/ HCPCS	X	Visits/Sessions
7	Biofeedback			CPT/ HCPCS	X	Visits/Sessions
8	Testing			CPT/ HCPCS	X	Visits/Sessions
9	Other Behavior Health Treatments/Services			CPT/ HCPCS	X	Visits/Sessions
<b>092X</b>	<b>Other Diagnostic Services</b>					
0	General Classification			CPT/ HCPCS		Visits/Sessions
1	Peripheral vascular lab			CPT/ HCPCS		Visits/Sessions
2	Electromyogram			CPT/ HCPCS		Visits/Sessions
3	Pap smear			CPT/ HCPCS		Visits/Sessions
4	Allergy test			CPT/ HCPCS		Visits/Sessions
5	Pregnancy test			CPT/ HCPCS		Visits/Sessions
9	Other diagnostic services			CPT/ HCPCS		Visits/Sessions
<b>093X</b>	<b>Medical Rehabilitation Day Program</b>					
1	Half-Day			CPT/HCPCS	X	Visits/Sessions
2	Full-Day			CPT/HCPCS	X	Visits/Sessions
<b>094X</b>	<b>Other Therapeutic Services (also see 095X, an extension of 094X)</b>					
*0	General Classification			CPT/ HCPCS	X	Visits/Sessions
*1	Recreational therapy			CPT/ HCPCS	X	Visits/Sessions
*2	Education/Training includes diabetes related dietary therapy			CPT/ HCPCS	X	Visits/Sessions
*3	Cardiac rehabilitation			CPT/ HCPCS	X	Visits/Sessions
*4	Drug rehabilitation			CPT/ HCPCS	X	Visits/Sessions
*5	Alcohol rehabilitation			CPT/ HCPCS	X	Visits/Sessions
*6	Complex medical equipment,routine			CPT/ HCPCS	X	Visits/Sessions
*7	Complex medical equipment, ancillary			CPT/ HCPCS	X	Visits/Sessions
*9	Other therapeutic services			CPT/ HCPCS	X	Visits/Sessions
<b>095X</b>	<b>Other Therapeutic Services (Extension of 094X)</b>					
*1	Athletic training			CPT/HCPCS	X	Visits/Sessions
*2	Kinesiotherapy			CPT/HCPCS	X	Visits/Sessions
<b>096X</b>	<b>Professional Fees</b>					

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
0	General Classification			CPT/ HCPCS	X	Visits/Sessions
1	Psychiatric			CPT/ HCPCS	X	Visits/Sessions
2	Ophthalmology			CPT/ HCPCS	X	Visits/Sessions
3	Anesthesiologist (MD)			CPT/ HCPCS	X	Visits/Sessions
4	Anesthetist (CRNA) (RN)			CPT/ HCPCS	X	Visits/Sessions
9	Other professional fees			CPT/ HCPCS	X	Visits/Sessions
<b>097X</b>	<b>Professional Fees (Extension of 096X)</b>					
1	Laboratory			CPT/ HCPCS	X	Visits/Sessions
2	Radiology - diagnostic			CPT/ HCPCS	X	Visits/Sessions
3	Radiology - therapeutic			CPT/ HCPCS	X	Visits/Sessions
4	Radiology - nuclear medicine			CPT/ HCPCS	X	Visits/Sessions
5	Operating room			CPT/ HCPCS	X	Visits/Sessions
6	Respiratory therapy			CPT/ HCPCS	X	Visits/Sessions
7	Physical therapy			CPT/ HCPCS	X	Visits/Sessions
8	Occupational therapy			CPT/ HCPCS	X	Visits/Sessions
9	Speech pathology			CPT/ HCPCS	X	Visits/Sessions
<b>098X</b>	<b>Professional Fees (Extension of 96X &amp; 97X)</b>					
1	Emergency room			CPT/ HCPCS	X	
2	Outpatient services			CPT/ HCPCS	X	
3	Clinic			CPT/ HCPCS	X	
4	Medical social services			CPT/ HCPCS	X	
5	EKG			CPT/ HCPCS	X	
6	EEG			CPT/ HCPCS	X	
7	Hospital visit		X			
8	Consultation			CPT/ HCPCS	X	
9	Private duty nurse			CPT/ HCPCS	X	
<b>099X</b>	<b>Patient Convenience Items</b>					
0	General Classification	X				
1	Cafeteria/guest tray	X				
2	Private linen service	X				
3	Telephone/telegraph	X				
4	TV/radio	X				
5	Non-patient room rentals	X				
6	Late discharge charge		X			
7	Admission kits	X				
8	Beauty shop/barber	X				
9	Other patient convenience items	X				
<b>100X</b>	<b>Behavioral Health Accommodations</b>					
0	General Classification			CPT	X	Visits/Sessions
1	Residential Treatment – Psychiatric			CPT	X	Visits/Sessions
2	Residential Treatment – Chemical Dependency			CPT	X	Visits/Sessions
3	Supervised Living			CPT	X	Visits/Sessions
4	Halfway House			CPT	X	Visits/Sessions
5	Group Home			CPT	X	Visits/Sessions

Revenue Code * Specific 4 <sup>th</sup> digit required	Description	No Special Coding	Only for Inpatient	Outpatient Services		
				Procedure Code **See form locator 80 for further remark requirements	Service Date	Units Required
<b>210X</b>	<b>Alternative Therapy Services</b>					
<b>0</b>	General Classification			CPT/ HCPCS	X	Visits/Sessions
<b>1</b>	Acupuncture			CPT/ HCPCS	X	Visits/Sessions
<b>2</b>	Acupressure			CPT/ HCPCS	X	Visits/Sessions
<b>3</b>	Massage			CPT/ HCPCS	X	Visits/Sessions
<b>4</b>	Reflexology			CPT/ HCPCS	X	Visits/Sessions
<b>5</b>	Biofeedback			CPT/ HCPCS	X	Visits/Sessions
<b>6</b>	Hypnosis			CPT/ HCPCS	X	Visits/Sessions
<b>9</b>	Other Alternative Therapy Service			CPT/ HCPCS	X	Visits/Sessions
<b>211X to 300X</b>	<b>Reserved for National assignment</b>					
<b>310X</b>	<b>Adult Care</b>					
<b>1</b>	Adult Daycare, Medical and Social/Hourly				X	Hours
<b>2</b>	Adult Day Care, Social - Hourly				X	Hours
<b>3</b>	Adult Day Care, Medical & Social - Daily				X	Visits/Sessions
<b>4</b>	Adult Day Care, Social - Daily				X	Visits/Sessions
<b>5</b>	Adult foster Care - Daily				X	Visits/Sessions
<b>9</b>	Other Adult Care				X	
<b>311X to 899X</b>	<b>Reserved for National assignment</b>					
<b>9000 to 9044</b>	<b>Reserved for Medicare Skilled Nursing Facility Demonstration Project</b>					
<b>9045 to 9099</b>	<b>Reserved for National assignment</b>					