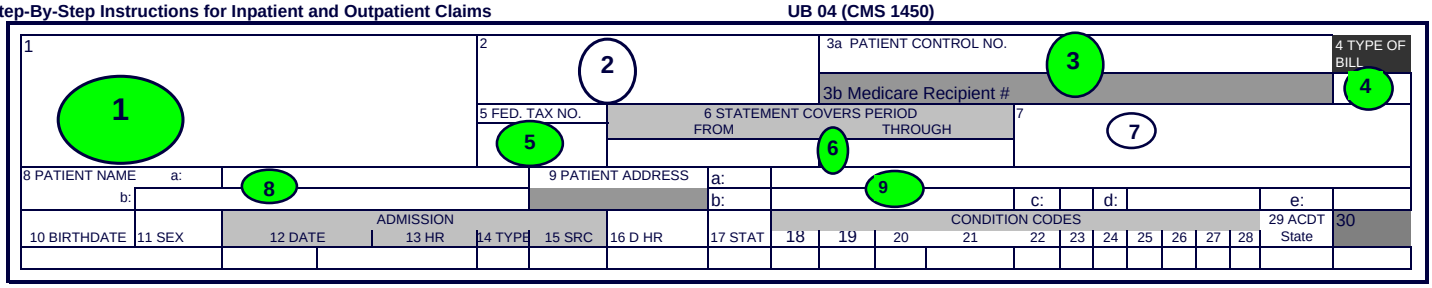
Step-By-Step Instructions for Inpatient and Outpatient Claims **UB 04 (CMS 1450)**



CLAIM ITEM	TITLE	ACTION
1 Required	**Provider Name, Address, and Telephone Number**	The minimum entry is the provider's name, city, state, and zip code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine digit zip codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or fax numbers are desirable.
2	**Unititled**	
3 Required	**Patient Control Number**	The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.
4 Required	**Type of Bill**	This **four**-digit alphanumeric code gives three specific pieces of information after the leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.
5 Not Required	**Federal Tax Number**	**Entry not required, but desirable.**
6 Required	**Statement Covers Period (From-Through)**	The beginning and ending dates of the period included on this bill are shown in numeric fields (MM-DD-YYYY). Days before the patients' entitlement are not shown. Use the "From" date to determine timely filing. For all services received on a single day, enter both the "From" and "Through" dates using the same date for both items. **Inpatient:** Inpatient claims for dates of services which span the end of the month of September into the month of July **MUST** be split billed as follows: 1. For the first bill, enter the discharge date as 10/1/YYYY. Be sure to bill only for those services supplied through this date. 2. For the second bill, enter the actual admission in Item 17, but list 10/1/YYYY as the "From" date in Item 6. Bill only for those services supplied after 10/1/YY.
7	**Untitled**	
8 Required	**Patient's Name**	Enter Patient's first and last name
9 Required	**Patient's Address**	Enter Patient's full address. "a, c, d," = living address "b,c,d" = Mailing address if different than living address

The first Digit is a Zero

2nd Digit - Type of Facility	3rd Digit - Classification	4th Digit - Frequency
1 - Hospital	1 - Inpatient	1 - Admit through Discharge Claim
2 - Skilled Nursing	2 - Hospital Based or Inpatient	2 - Interim - First Claim
3 - Home Health	3 - Outpatient	3 - Interim-Continuing Claims
4 - Religious Non-Medical (Hospital)	4 - Other	4 - Interim - Last Claim
5 - Reserved for National Assignment (discontinued 10/	5 - Intermedicate Care - Level I	5 - Late Charge Only
6 - Intermediate Care	6 - Intermedicate Care - Level II	7 - Replacement of Prior Claim
7 - Clinic or Hospital Based Renal Dialysis Facility	7 - Reserved for National Assignment (discontinued 10/1/05)	
8 - Special Facility or Hospital ACS Surgery	8 - Swing Bed	8 - Void/Cancel of a Prior Claim
9 - Reserved for National Assignment	9 - Reserved for National Assignment	9 - Final Claim for a Home Health PPS

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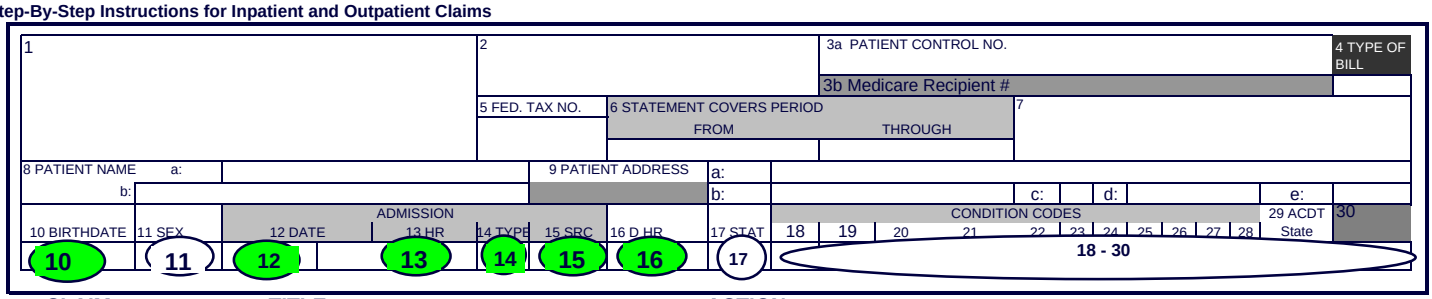

CLAIM	TITLE	ACTION
10 Required	**Birthdate**	Enter the Patient's date of Birth Use the month, day and year of birth - MMDDYYYY - if unknown use zeros for all eight digits
11 Not Required	**Sex**	No entry required for HCRA.
12 Required	**Admission Date**	**Inpatient:** The month, day, and year of admission is shown numberically as MM/DD/YYYY. for January 11, 1999. **Outpatient:** No entry required
13 Required	**Admission Hour**	For Inpatient enter the hour patient was admitted
14 Required	**Type of Admission**	**Inpatient:** Enter the code number indicating the type of admission from the code structure below: **1. - Emergency:** The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room. **2. - Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodations. **3. - Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. **5 - Trauma Center:** Visits to a trauma center/hospital as licensed by or authorized by the State to be a trauma center. **9. - Information Not Available:** The hospital cannot classify the type of admission. This code is rarely used. **Outpatient:** No entry is required.
15 Required	**Source of Admission**	This is the code indicating the source of this admission or outpatient registration. **Code Structure:** For Emergency, Elective or Other Type of Admission. **1. - Physician Referral: Inpatient:** The patient was admitted upon the recommendation of a physician. **Outpatient:** Referred for outpatient or diagnostic services by physician or self-referral. **2. - Clinic Referral:** The patient is admitted upon the recommendation of the facility's clinic physician. **3. - Managed Care Plan Referral:** The patient is admitted upon the recommendation of a managed care organization. **4. - Transfer from a Hospital:** The patient is admitted as a transfer from an acute care facility where he/she was an inpatient. **5. - Transfer from a SNF:** The patient was admitted as a transfer from a SNF where he/she was an inpatient. **6. - Transfer from Another Facility:** The patient was admitted to the facility as a transfer from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a nonskilled level of care. **7. - Emergency Room:** The patient was admitted upon the recommendation of the facility's emergency room physician. **8. - Court/Law Enforcement:** The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's representative. **9. - Information Not Available:** The means by which the patient was admitted is not known.
16 Required	**Discharge Hour**	Enter the time of discharge using the following format: hh:mm a.m. or hh:mm p.m.
17 Required	**Patient Status**	**Inpatient:** Enter the code indicating patient status as of the discharge date (or last date billed in the case of interim billing). **PATIENT STATUS CODES:** **01 -** Discharged to home or self care (routine discharge). **02 -** Discharged/transferred to another short-term general hospital. **03 -** Discharged/transferred to a skilled nursing facility (SNF). **04 -** Discharged/transferred to an intermediate care facility (ICF). **05 -** Discharged/transferred to another type of institution or referred for outpatient services to another institution. **06 -** Discharged/transferred to home under care of organized home health service organization. **07 -** Left against medical advice or discontinued care. **08 -** Reserved for National Assignment **10-19** Reserved for National Assignment **20 -** Expired (or did not recover - Religious Non Medical Health Care Patient) **30 -** Still a patient or expected to return for outpatient services **Outpatient:** **09 -** Admitted as an inpatient to this facility. Otherwise, no entry is required.
18 - 28 Not Required	**Condition Codes**	No Entry is required for HCRA
29 Not Required	**Accident State**	No entry required for HCRA.
30 Untitled		

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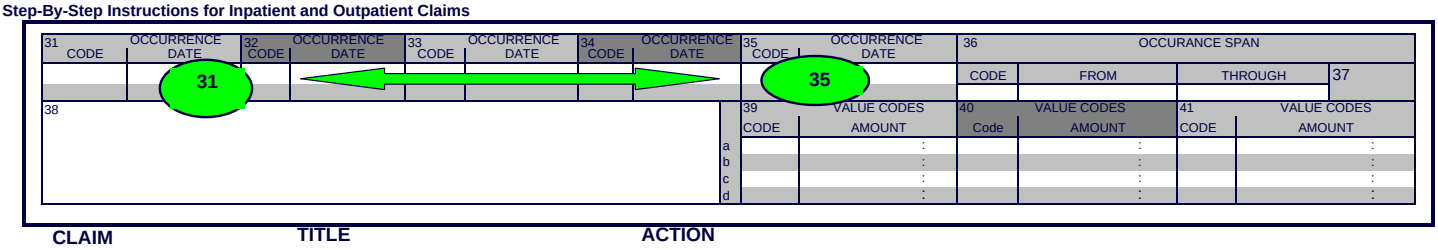

CLAIM ITEM	TITLE	ACTION
31 - 35 Required	**Occurrence Code and Dates**	**Inpatient and Outpatient:** Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Item 32A. If more than one code and date are used, they must be entered in Items 32A through . 35B in chronological order. Enter the date in month, day, year format: MM/DD/YYYY

Code	Title	Definition
01	Accident/Medical Cover	Used to report an auto accident that involves liability insurance.
02	No-Fault Insurance Involved - Including Auto Accident/Other	Accident-related injury for which there is medical payment coverage. Provide date of accident/injury. Sate of an accident where the State has applicable no-fault or liabilty laws.
03	Accident/Tort Liability	Accident resulting from a third party's action(s) that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability. Provide date of accident
04	Accident/ Employment Related	Date of an cccident relating to the patient's employment.
05	Accident/No Mecical or Liability Coverage	Accident not described by the above codes. Used to report that the provider has developed for other casualty related payers and has determined there are none. Provide date of accident.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
11	Onset of Symptoms or Illness	Code indicates date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	The patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit.
16	Date of Last Therapy	Code indicates the last day of therapy services, physical, occupational or speech.
17	Date Occupational Therapy Plan Established or Reviewed	The date a plan was established or last reviewed for occupational therapy
18 - 21		Medicare Related - Not HCRA usable
22	Date Active Care Ended	Date on which a covered level of care ended in a SNF. Code is not required if code 21 is used.
24	Date Insurance Denied	The date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage is no longer available to the patient.
26	Date SNF Bed Available	Date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27 - 30		Medicare Related - Not HCRA usable
31	Date of Beneficiary Notified of Intent to Bill (Accommodations)	Date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Medicare Only - Treatment or procedures not considered reasonable or necessary by Medicare.
33 - 34		Medicare Related - Not HCRA usable
35 - 46		Used for Medicare related services, i.e., physical, occupational or speech therapy, hospice, cardiac rehab., etc.
47 - 49	Payer Codes	Reserved for internal use only by third party payers. HCFA assigns as needed, providers do not report them.
50 - 69		Reserved for State Assignment.
A1	Birthdate-Insured A	The birthdate of the insured in whose name the insurance is carried.
A2	Effective Date - Insured A Policy	Indicates the first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer A.
B1	Birthdate -Insured B	The birthdate of the insured in whose name the insurance is carried.
B2	Effective Date - Insured B Policy	Indicates the first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate -Insured C	The birthdate of the insured in whose name the insurance is carried.
C2	Effective Date - Insured C Policy	Indicates the first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer C.

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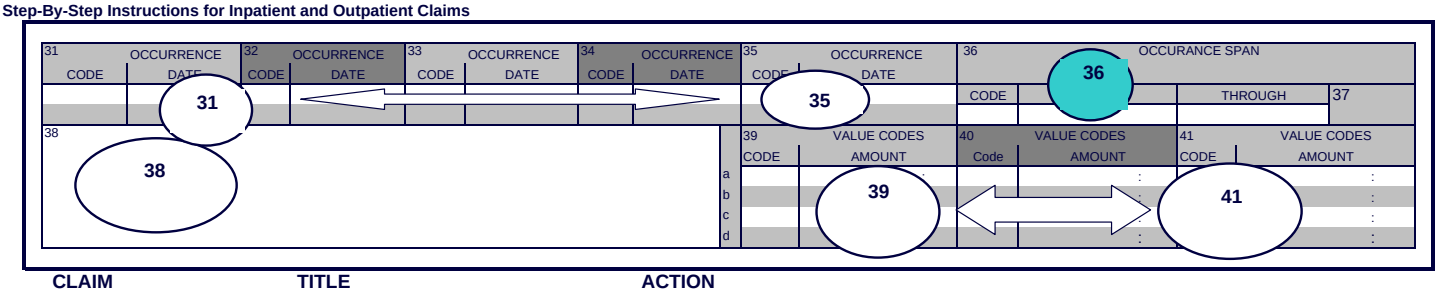

CLAIM ITEM	TITLE	ACTION
36 Required IF:	**Occurrence Span Code and Dates**	Enter codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYYYY.
37	**Untitled**	
38 Not Required	**Responsible Party Name and Address**	Entry not required
39 - 41 A, B, C, D Not Required	**Value Codes and Amounts**	Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. Negative amounts are not allowed except in Item 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Required only for Medicare/Medicaid crossovers.

Code	Title	Definition
04	Inpatient Professional Component Charges Which are Combined Billed	The amount shown is the sum of the inpatient professional component charges which are combined billed. Used only by all-inclusive rate hospitals.
05	Professional Component Included in Charges and Also Billed Separately to Carrier	The charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the carrier.
06 - 13		Medicare exclusive codes.
14	No-Fault, Including Auto/Other Insurance	Amount shown is that portion of a higher priority no-fault, including auto/other, insurance payment made on behalf of a patient that the provider is applying to the covered HCRA charges on the bill.
15 - 19		Other government programs, not including HCRA.
31	Patient Liability Amount	The amount shown is that which was approved by the PRO to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
37 - 46, 48 & 49		Medicare exclusive codes.
47	Any Liability Insurance	Amount is that portion from a higher priority liability insurance made on behalf of the patient that the provider is applying to covered HCRA services on the bill
50 - 57 and 60		These codes are not money amounts but represent the number of home care visits.
58 - 79		Medicare exclusive codes - not usable with HCRA
A1	Deductible Payer A	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
B1	Deductible Payer B	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
C1	Deductible Payer C	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
A2	Coinsurance Payer A	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	Amount estimated by the provider to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	Amount estimated by the provider to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	Amount estimated by the provider to be paid by the indicated payer.
D3	Estimated Responsibility - Patient	Amount estimated by the provider to be paid by the indicated patient.
A4	Covered Self-Administrable Drugs Emergency	Amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (Insulin is the only covered charges for an ordinarily non-covered, self-administered drug administered to a patient in a diabetic coma.)

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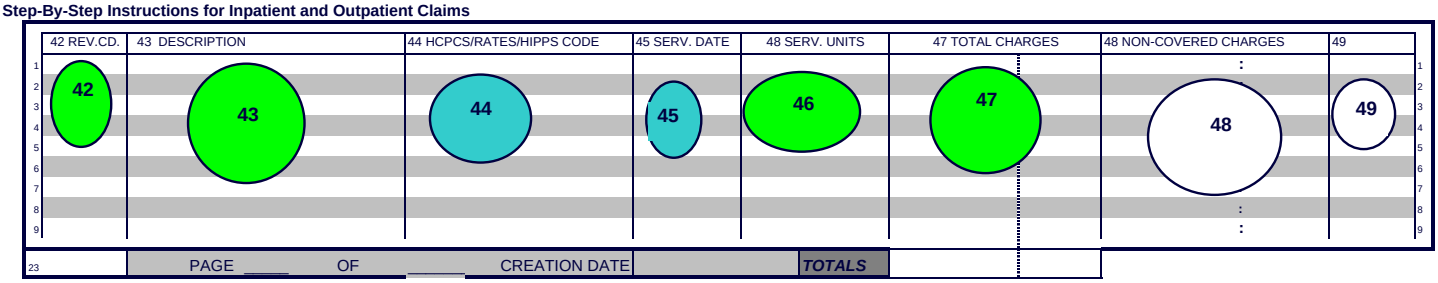

CLAIM ITEM	TITLE	ACTION
42 Required	Revenue Code	**Inpatient and Outpatient:** Enter the appropriate three-digit revenue code itemizing all accommodations and ancillary charges. "General Classification" revenue codes are acceptable. Indicate the total amount of all revenue codes billed in Item 47 accompanied by revenue code "001" in Item 42. Appendix P lists the revenue center codes for inpatient and Appendix Q lists the revenue codes for outpatient hospital services. (Appendix P and Q referrs to the HCRA Handbook) Each applicable revenue code should be used only once per UB-04 invoice, EXCEPT for revenue codes in the 300 - 319 range with different LCPCS codes used on outpatient claims. Each revenue code in the 300 -319 range billed on outpatient claims MUST have an accompanying LCPCS code in Item 44. (See list in HCRA Handbook, Appendix Q for Lab Codes.) Outpatient professional component charges (revenue code range 960 - 989) are not billable on the UB-04. Bill these services on the HCFA-1500 according to guidelines in the Physician Handbook.
43 Required	Revenue Description	**Inpatient and Outpatient:** Enter a written description of the related revenue categories included on this bill. This information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.
44 Required IF	HCPCS / Rates HIPPS CODE	Entry required for Revenue Codes 300 - 319 for HCRA
45 Required IF Outpatient	Service Date	For outpatient claim providers, report a separate date for each day of service.
46 Required	Service Units	The entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. Providers have been instructed to provide the number of covered days, visits, treatments, and tests applicable for the following: Accommodations - 100s-150s, 200s, 210s (days) Blood - 380 (pints) DME - 290s (rental months) Emergency room visits - 450, 0452 and 0459 (HCPCS code for visit or procedure) Clinic visits - 510s and 520s (visits) Dialysis treatments - 800s (sessions or days) Orthotic/prosthetic devices - 0274 (items) Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (visits) Outpatient clinical diagnostic laboratory tests - 30s-31s (tests) Radiology - 32X, 34X, 35X, 40X, 61X, and 333 (tests or services) Oxygen - 600s (rental months, feet or pounds) Hemophilia blood clotting factors - 636 Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.
47 Required	Total Charges	The total charges for the billing period are summed by revenue code (Item 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and entered on the adjacent line in Item 47. The last revenue code entered in Item 42 is "0001" which represents the grand total of all covered and non-covered charges billed. Item 47 totals on the adjacent line. Each line allows up to nine numeric digits. **For outpatient billing**, only charges believed to be covered are submitted in Item 47. Non-covered charges are omitted from the bill.
48 Not Required	Non-Covered Charges	**Inpatient:** No entry required. **Outpatient:** Enter the total payment received or expected to be received from a primary insurance payer identified in Item 50A. Enter each portion of the payment applicable to each code in Item 48. If there is more than one other private payer, lump all amounts together in Item 48 and attach each company's Explanation of Benefits or remittance.
49	Untitled	
Line 23 Required On All Pages	Page ____ of ____ Creation Date Totals	Enter the page numbers, example: Page 1 of 1, Page 1 of 2, etc. Enter the date UB 04 was completed Enter the total amount of Item 47

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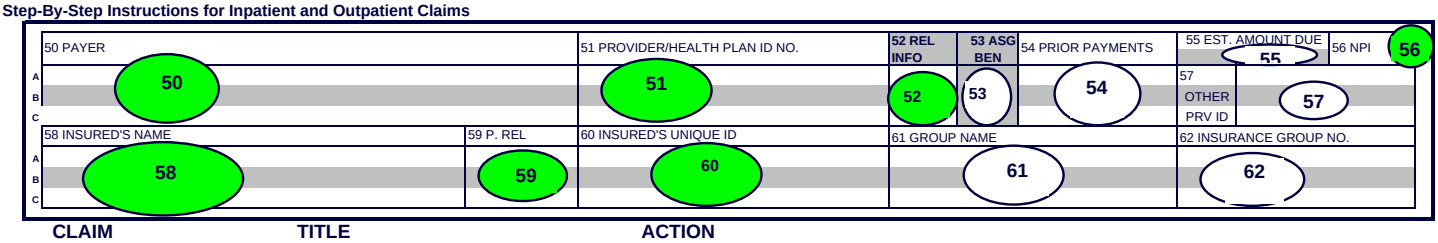

CLAIM ITEM	TITLE	ACTION
50 A, B, C Required	**Payer Identification**	**Inpatient and Outpatient** Enter the name and, if required, number identifying each payer organization from which the provider might expect some payment for the bill.
51 A, B, C Required	**Provider or Heatlh Plan ID Number**	Report the national health plan identifier when one is established otherwise report the "number" FL Medicaid has assigned
52 A, B, C Required	**Release of Information**	A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file. **NOTE:** The back of the UB-04 CMS-1450 contains a certification that all necessary release statements are on file.
53 A, B, C Not Required	**Assignment of Benefits Certification Indicator**	No entry required.
54 A, B, C Not Required	**Prior Payments**	For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.
55 A, B, C Not Required	**Estimated Amount Due**	No entry required.
56 Required	**National Provider ID - NPI**	Required as of May 23, 2007
57 Not Required	**Other Provider ID**	No entry required.
58 A, B, C Required	**Insured's Name**	**Inpatient and Outpatient: Enter if another payer paid some of the charges.** Enter the insured's last name, first name, and middle initial. If the recipient is covered by insurance enter the name of the individual in whose name the insurance is covered.
59 A, B, C Required if Item 58 is completed.	**Patient's Relationship to Insured**	If the provider is claiming a payment under Item 58, it may enter the code indicating the relationship of the patient to the identified insured if this information is readily available.
60 A, B, C Required	**Insured's Unique ID**	**Inpatient and Outpatient:** Enter all of the insured's unique identification numbers assigned by any payer organizations.
61 A, B, C Not Required	**Group Name**	No entry required Where the provider is claiming a payment under Item 58, enter the name of the insurance group or plan.
62 A, B, C Not Required	**Insurance Group Number**	No entry required. Where the provider is claiming a payment under Item 58, enter the identification number, control number, or code assigned by such health insurance carrier.

Code	Title	Definition
01	Spouse	Self-explanatory
18	Self	Self-explanatory
19	Natural Child/Insured has Financial Responsibility	Self-explanatory
20	Employee	Self-explanatory
21	Unkown	Self-explanatory
39	Organ Donor	Code is used in cases where a bill is submitted for care given to an organ donor where it is paid by the receiving patient's insurance coverage.
40	Cadaver Donor	Code is used where a bill is submitted for procedures performed on a cadaver donor where they are paid ge. by the receiving patient's insurance covera
53	Life Partner	Patient is claiming insurance as a result of injury covered by insured.
G8	Other Relationship	

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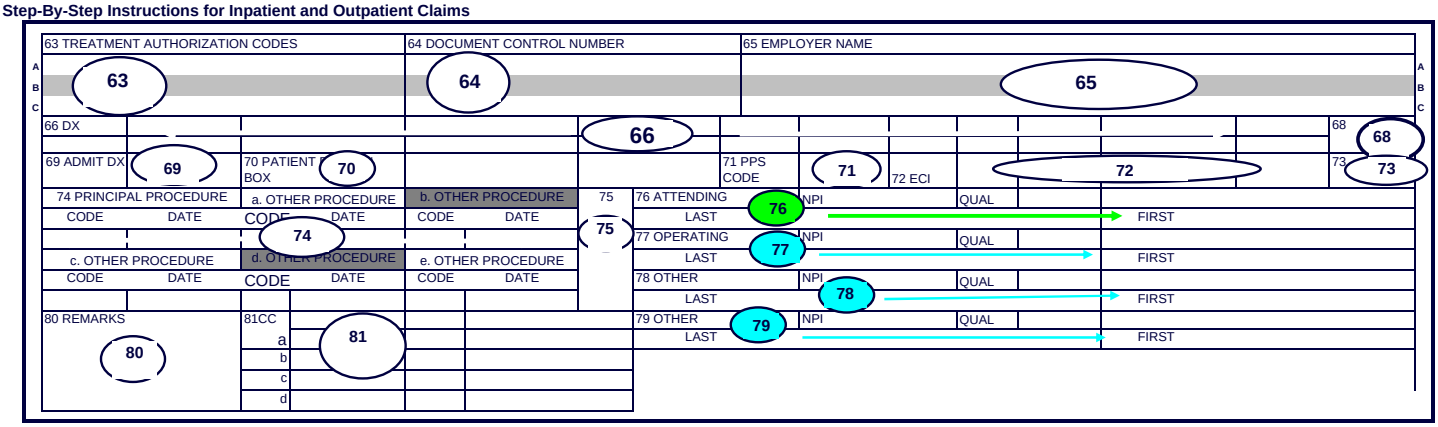

CLAIM ITEM	TITLE	ACTION
63 **A, B, C** **Not Required**	**Treatment Authorization Code**	Whenever PRO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, the authorization number is required for all approved admissions or services. **If you get a pre-approval for HCRA - you can indicate that here**
64 **Not Required**	**Document Control Number**	Entry not required for HCRA
65 **Not Required if not employed**	**Employer Name**	**Inpatient and Outpatient:** Enter the name of the employer that might or does provide health care coverage for the patient in relation to Item 58.
66 **Not Required**	**Diagnosis and Procedure Code Qualifier**	Not required for HCRA
67 **Missing from form**		
68	**Untitled**	
69 **Not Required**	**Admitting Diagnosis**	No entry required for HCRA
70 **Not Required**	**Patient Reason for Visit**	No entry required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. Patient's Reason for Visit may be used by providers for non scheduled visits for outpatient bills
71 **Not Required**	**Prospective Payment System (PPS) Code**	No entry is required. Not used
72 **Not Required**	**External Cause of Injury (ECI) Codes**	No entry is required. Not used
73	**Untitled**	
# **74** **Not Required**	**Principal Procedure Code**	**Inpatient:** The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (Item 67). The procedure code shown must be the full ICD-9-CM procedure code including all four digit codes where applicable. The date applicable to the principal procedure is shown numerically as MM/DD/YYYY.
a, b, c, d, e,	**Other Procedure Code**	**Inpatient:** The full ICD-9-CM procedure codes including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure, Item 80. The date of each procedure is shown in the date portion of Item 81, if applicable, as MM/DD/YYYY.
75	**Untitled**	
76 **Required**	**Attending** **NPI Qual**	**Inpatient and Outpatient:** Enter the Last and First Name of the Attending Physician. Enter the National Provider Identifier Number of the attending physician who preformed the principal procedure.
77 **Not Required** **Required if principal reason for admission is an operation**	**Operating** **NPI Qual**	**Inpatient and Outpatient:** Enter the Last and First Name of the Operating Physician, if applicable. Enter the National Provider Identifier Number of the Operating Physician who preformed the any operation.
78 - 79 **Not Required**	**Other**	**Inpatient and Outpatient:** Enter the Last and First Name of other Physician if different than attending physician. Enter the National Provider Identifier Number of the physician who preformed the principal procedure if different than attending physician.
80 - 81 **Not Required**	**Remarks CC**	No entry required under HCRA