

# Expanded Access to Primary Care Program

## **Medi-Cal Provider Training Module**

**Disclaimer:** The EAPC workbook was produced specifically for use as curriculum in training workshops. Providers should always refer to the Medi-Cal Provider Manual for the most current program, policy and billing information, as it is updated monthly.

## Introduction

### Purpose

The purpose of this module is to provide an overview of the Expanded Access to Primary Care (EAPC) program and to familiarize providers with the billing requirements established for reimbursable EAPC services.

### Module Objectives

- Review program policies and service requirements
- Identify recipient eligibility
- Determine qualifying visits
- Introduce new program billing codes
- Review billing guidelines for the *UB-04* claim form
- Discuss common claim errors (billing tips) and review common denials

### Resource Information

#### REFERENCES

The following reference materials provide EAPC program information and *UB-04* claim submission guidelines.

#### Provider Manual References

Part 1: *Share of Cost (SOC)* (share)

Part 2: *Child Health and Disability Prevention (CHDP) Program* (child)

Part 2: *Expanded Access to Primary Care (EAPC) Program* (expand)

Part 2: *Expanded Access to Primary Care (EAPC) Program Billing codes* (expand cd)

Part 2: *Forms: Legibility and Completion Standards* (forms leg)

Part 2: *UB-04 Completion: Outpatient Services* (ub comp op)

Part 2: *UB-04 Special Billing Instructions for Outpatient Services* (ub spec op)

#### Other References

Medi-Cal Web site, *UB-04 Claim Form Tutorial*  
<http://files.medi-cal.ca.gov/pubsdoco/eo/elearning.asp>

#### ACRONYMS

A list of current acronyms is located in the Appendix section of this workbook.

## Program Policies and Service Requirements

### Background

The Expanded Access to Primary Care program was established to improve the quality of and expand the access to outpatient health care for medically indigent persons residing in under-served areas of California. The EAPC program is funded by the Cigarette and Tobacco Products Surtax Fund, the State General Fund and Title V.

### Program Policies

The EAPC program reimburses community-based primary care clinic corporations that are exempt from federal taxation, including clinics operated by tribes or tribal organizations. Primary care clinics are funded for the delivery of medical services and preventive health care, including smoking prevention and cessation health education.

### Service Requirements

Each eligible primary care clinic applying for EAPC funds must provide comprehensive primary and preventive health care services to a medically under-served area of population.

Corporations must have a valid National Provider Identifier (NPI) and be a Medi-Cal provider. EAPC requires each EAPC corporation to designate an NPI number as the “sole” NPI to identify the EAPC corporation. All funded EAPC clinics must submit claims with the NPI number designated for EAPC. This ensures no interruption in payment of EAPC claims. Corporations participating in the EAPC program assume full financial risk for administering the program. DHCS reimburses the participating clinic up to the amount of its EAPC allocation. However, primary care services must continue to be rendered to EAPC-eligible patients after the allocation is exhausted. Allocations may be augmented, should additional funds be made available.

## Recipient Eligibility

People in families with incomes at or below 200 percent of the federally defined poverty level, who do not have any third party health or dental coverage, are eligible for EAPC for health services. It is the responsibility of the clinic providing the services to ensure that EAPC recipients meet specific income criteria and that all criteria relative to the definition of an outpatient visit are met for every visit billed to the EAPC program. Each clinic must determine how eligibility will be verified and documented for each EAPC patient visit.

EAPC is not available for those who are eligible for Medi-Cal services with the exception of persons with limited Medi-Cal benefits, such as pregnancy, emergency services, or recipients with an unmet Share of Cost for the month that the service was provided. For additional information, refer to the *Share of Cost (SOC)* section in Part 1 of the Medi-Cal Provider Manual.

Federal poverty level incomes are adjusted on an annual basis. The following income levels are effective April 1, 2009.

POVERTY INCOME GUIDELINES  
200 Percent of Poverty Level by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	\$ 1,805	\$ 21,660
2	\$ 2,429	\$ 29,140
3	\$ 3,052	\$ 36,620
4	\$ 3,675	\$ 44,100
5	\$ 4,299	\$ 51,580
6	\$ 4,922	\$ 59,060
7	\$ 5,545	\$ 66,540
8	\$ 6,169	\$ 74,020
9	\$ 6,792	\$ 81,500
10	\$ 7,415	\$ 88,980
For each additional person, add	\$ 624	\$ 7,480

People in families whose gross monthly or gross annual income is less than or equal to the amount specified in the federal *Poverty Income Guidelines* are eligible to participate in the EAPC program. "Gross income" means income before taxes and other deductions.

*Recipient Eligibility (Continued)*

## Recipient Identification

Providers are to request a Medi-Cal Client Identification Number (CIN) from the Benefits Identification Card (BIC) for each EAPC patient and enter it in the *Insured's Unique ID* field (Box 60A) of the *UB-04* claim form or comparable data field in electronic media claims. EAPC claims are checked against the Medi-Cal eligibility history files to ensure that EAPC does not reimburse a clinic for an individual medical or dental encounter that is reimbursable by Medi-Cal. This will maximize the use of EAPC funds and is consistent with the EAPC program's role as "payer of last resort."

If an EAPC recipient is retroactively determined to be Medi-Cal eligible, subsequent to billing EAPC, a *Claims Inquiry Form* (CIF) must be submitted to void the previous EAPC paid claim.

A "pseudo" patient identification number should be used for patients who do not have a Medi-Cal number. This "pseudo" number should consist of the patient's numerical six-digit date of birth (MMDDYY) and the first three letters of the patient's last name. If the patient's last name has less than three letters, then "X" as a placeholder should be used for the second and/or third letter.

**Note:** If Box 60A is not completed, the claim will be denied. In such cases, the *Remittance Advice Details* (RAD) will indicate error code **049** for provider billing error.

## Qualifying Visits

### Outpatient Visits

Each claimed EAPC outpatient visit must conform to the following definition:

*“A face-to-face contact between a patient and a health educator or a licensed, registered, or certified health care provider who exercises independent judgment in the provision of preventive, diagnostic or treatment services. A visit includes medically indicated pharmacy, radiology and laboratory services. For a health service to be defined as a visit, the contact and provision of health services must be recorded in the patient’s record.”*

To meet the criteria of independent judgment, a clinic provider must be acting independently and not assisting another provider.

**Example 1:** A nurse assisting a physician during a physical examination by checking vital signs, taking a history or drawing a blood sample is *not* credited with a separate visit.

**Example 2:** A nurse who sees a patient to monitor physiologic signs or provide medication renewal, without the patient routinely seeing the physician at the same time, *is* credited with a medical visit.

**Note:** A visit provided by a dental hygienist does not need to meet the criteria of independent judgment in order to be reimbursed, but all such visits must be co-signed by a dentist.

#### BASIC SERVICES

An outpatient visit includes pharmacy, radiology and laboratory tests when medically indicated. EAPC-funded clinics need not have these services on site, but must either directly provide the services or refer patients to and reimburse appropriate providers as necessary. Services provided on site or through a secondary provider are considered part of the visit.

Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling or dispensing prescriptions, or performing optician services do *not* constitute a visit unless the provider is also responsible for independently acting upon the results.

*Qualifying Visits (Continued)*

## Type of Visits

A recipient may have more than one visit during one continuous period of service at the clinic. However, the number of visits per site, per day, is limited as follows:

Type of provider	Number and type of visits per site, per day
Physician	1 medical visit
Mid-level Practitioner	1 medical visit
Nurse	1 medical visit
Cardiologist	1 medical specialist visit
Radiologist	1 medical specialist visit
Cardiologist	1 medical specialist visit
Specialist*	1 medical specialist visit
Dentist	1 dental visit
Dental Hygienist	1 dental visit
Health Educator	1 other health visit with one other health provider
Nutritionist	1 other health visit with one other health provider
Other Provider	1 other health visit with one other health provider

\* Level of specialization equivalent to cardiologist and radiologist.

A second visit may be claimed when:

1. Interpretation of the test results requires a return visit to the clinic; or
2. Interpretation of the test results requires the independent judgment of a medical specialist, such as a radiologist or pathologist.

**Note:** When billing for two separate visits on the same day, providers must include documentation in the *Remarks* field (Box 80) of the claim, or on an attachment to the claim, explaining why the service was rendered more than once. When billing electronically, enter the statement in the *Remarks* field. A statement indicating “this service is not a duplicate” is not sufficient to clarify why the service was rendered more than once. Failure to document the second visit will result in RAD denial code **010** for duplicate services billed.

*Qualifying Visits (Continued)*

A clinic provider may be reimbursed for only one visit per day during one continuous period of service to a recipient, regardless of the number or type of services provided.

A visit may take place in the clinic or at any other location in which project-supported activities are carried out (such as mobile vans, hospitals, patient's home and extended care facilities) and by a volunteer, salaried, or contract staff member.

A visit may be billed for a health education or nutrition class session such as smoking cessation group sessions led by a provider. At least one EAPC recipient must be in attendance, and no more than one visit may be billed per class session, even though more than one EAPC recipient may be in attendance.

### Examples of a Qualifying Visit

1. Medical Services Visit: A contact between a physician, non-physician assistant or registered nurse and the patient in which the practitioner acts as an independent provider.
2. Medical Specialist Visit: A visit between a medical specialist and a patient. Psychiatrist visits are considered medical specialists visits.
3. Dental Services Visit: A visit between a dentist or a dental hygienist and a patient for the purpose of prevention, assessment, diagnosis, or treatment of a dental problem, including restoration.
4. Other Health Services Visit: A visit between a health educator, a nutritionist, or another appropriate provider and a patient. Visits must be on a one-to-one basis and include individualized evaluation and instruction or treatment.

*Qualifying Visits (Continued)***Sliding Fee Scale**

Clinics using a sliding fee scale (for example, assessing patient charges based upon patient income) may continue to use the same sliding fee scale for all EAPC-eligible patients.

EAPC providers are not required to reduce the amount of EAPC program reimbursement claimed by the amount of the sliding fee scale assessed to the EAPC-eligible recipient. No additional sliding fee may be assessed for any ancillary services required as a result of the visit for which EAPC reimbursement is claimed, such as pharmacy, laboratory and X-ray services.

EAPC providers may not charge a copay to EAPC-eligible patients. Sliding fee scale assessments are separate and distinct from copayments charged to Medi-Cal recipients. A copayment is not related to the ability to pay, and is charged to all recipients. Sliding fee scale charges are related to patient income and the ability to pay.

The sliding fee should be entered in the *Value Codes* field on the *UB-04* claim form (Boxes 39-41).

**CHDP SERVICES**

Sliding fee scale charges may also be assessed for treatment of conditions identified through the Child Health and Disability Prevention (CHDP) health assessment. Although Medi-Cal-eligible children should not be charged a copayment for treatment of conditions identified by a CHDP assessment, sliding fees may be assessed and charged when EAPC is to be billed for the treatment.

The legislation that authorized the continuation of the EAPC program requires that services under the CHDP program be continued as part of the EAPC mandate. CHDP assessments and treatment may be limited to certain provider types. The EAPC-CHDP Treatment Log will be submitted quarterly to the EAPC program to verify EAPC-CHDP activity.

When billing for CHDP services, a separate claim form must be used for non-CHDP services provided on the same date. Payment will be denied if a clinic claims CHDP and other services for the same date of service on one claim form.

## Program Billing Code Conversion

The following codes have been established for reimbursable EAPC services, including services resulting from a CHDP health assessment. Clinics must use the appropriate code when completing the *UB-04* claim form.

**For dates of service prior to July 1, 2010**, EAPC services must be billed with the following codes:

<u>Procedure Code</u>	<u>EAPC Service</u>
Z9700	Medical encounter
Z9701	Dental encounter
Z9702	Medical encounter as a result of CHDP health assessment
Z9703	Dental encounter as a result of CHDP health assessment

**Effective for dates of service on or after July 1, 2010**, EAPC services must be billed with HCPCS Level II codes and modifiers, in combination with National Uniform Billing Committee (NUBC) revenue codes to comply with provisions of HIPAA.

<u>Revenue Code</u>	<u>HCPCS Code</u>	<u>Modifier</u>	<u>EAPC Service</u>
0529	T1015	SE	Medical encounter
0512	T1015	SE	Dental encounter
0529	T1015	HA	Medical encounter/CHDP Assessment result
0512	T1015	HA	Dental encounter/CHDP Assessment result

These codes are date of service driven. The use of these codes outside of the specified date ranges will result in your claim being denied with RAD code 0145 for not a benefit on the date of service.

Please refer to *Figures 1 – 4* at the end of this module for examples of claims submitted for dates of service prior to or after July 1, 2010.

### Reimbursement

The uniform statewide EAPC reimbursement rate for these services is \$71.50. This rate includes all medically necessary ancillary pharmacy, laboratory and X-ray services.

## Billing Guidelines for the UB-04 Claim Form

The *UB-04* claim form is used to request reimbursement for services rendered by the following institutions:

- Inpatient hospital facilities, such as medical/surgical intensive care, burn care and coronary care.
- Outpatient institutional facilities, such as outpatient departments, rural health clinics, chronic dialysis services and adult day health care.

The *UB-04* is also used to request reimbursement for ancillary charges (for example, labor and delivery, anesthesiology and central services and supplies).

*UB-04* claims must be received by the DHCS Fiscal Intermediary (FI) within six months following the month in which services were rendered in order to process reimbursement. The time frames are very specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been incorrectly filled out or are incomplete will be denied.

EAPC providers must use Computer Media Claims (CMC) or the *UB-04* claim form and follow the normal Medi-Cal process for completing the claims. A tutorial for completing the *UB-04* claim form is located on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) by clicking the “eLearning” link, then “UB-04 Claim Form Tutorial”.

## UB-04 Claim Submission

### Form Submission Method

#### PAPER FORMAT

The following guidelines apply to claim forms submitted by mail.

#### Submission Instructions

- Bill in the Medi-Cal format. Follow claim form completion instructions outlined in the Medi-Cal and Computer Media Claims (CMC) Billing and Technical manuals.
- Send original claims only (printed with red “drop-out ink”).
- Photocopies, carbon copies and computer-generated claim form facsimiles are unacceptable.
- Separate individual claim forms. Do not staple original claims together. Stapling original claims together indicates the additional claims are attachments, not original claims that need to be processed.
- Submit one claim form per set of attachments.
- Tape undersized attachments to 8½ x 11 inch white paper using non-glare tape.
- Do not use colored paper.

UB-04 Claim Completion Guidelines (Continued)

Form Completion Instructions

- Ensure that a valid HCPCS code is used for the date of service, with appropriate modifier if necessary. In addition, make sure that the revenue code is valid and on file.
- Handwritten claims should be printed neatly using black ballpoint pen ONLY.
- Only typed or computer-printed forms can be scanned by Optical Character Recognition (OCR) equipment.
  - Type all information using capital letters on forms.
  - For best possible clarity and accuracy, use 10-pt. pica type, six lines per inch. Do not use script or italic font.
- Data must fall completely within the text space and should be properly aligned.
- Undesignated white space (such as Box 2) and undesignated shaded areas or areas labeled “FOR F.I. USE ONLY” should be left blank.
- Punctuation or symbols (\$, %, &, /, etc.) must not be used except in designated areas.
- Do not use highlighters or correction fluid on the hard copy claim or follow-up forms. Correction tape is acceptable.
- Strike out incorrect information by drawing a line through the entire detail line from the left border of the *Revenue Code* field (Box 42) to the right border (Box 49). Enter the correct billing information on another detail line.

Mailing Instructions

To expedite the sorting and preparation of claims for scanning, do not fold or crease forms to fit into small-sized envelopes. Enclose forms in full-sized, color-coded envelopes supplied by the Fiscal Intermediary.

Notes

---

---

---

---

---

*UB-04 Claim Completion Guidelines (Continued)*

## ELECTRONIC TRANSMISSION

Computer Media Claims (CMC) submission is the most efficient method of Medi-Cal billing. CMC submission offers additional efficiency to providers because these claims are submitted and entered into the claims processing system faster.

The following guidelines apply to claim forms submitted by electronic transmission:

Submission Instructions

- Claims may be submitted electronically via CMC telecommunications (modem) or on the Medi-Cal Web site.
- Claims requiring hard copy attachments may be billed electronically.
- Attachments must be accompanied by a *Medi-Cal Claim Attachment Control Form (ACF)* and mailed or faxed to the FI, HP Enterprise Services. The attachments must be completed as specified or they will not be linked with the electronic claim, resulting in claim denial.

Billing Instructions

Electronic data specifications and billing instructions can be located in the *Medi-Cal CMC Billing and Technical Manual* found on the Medi-Cal Web site. On the home page, click the "References" tab, then the "Technical Publications" link.

Contact Information

For additional information, contact the Telephone Service Center (TSC) at 1-800-541-5555.

## ADDITIONAL FORMS (ATTACHMENTS)

## MEDI-CAL CLAIM ATTACHMENT CONTROL FORM (ACF)

An ACF makes it possible to process paper attachments. Under HIPAA rules, an ASC X22 837v.4010A1 electronic claim cannot be rejected (denied) simply because it requires an attachment. The California Medicaid Management Information Systems (CA-MMIS) has been modified to process paper attachments submitted in conjunction with an 837v.4010A1 electronic claim.

For each electronic claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers are required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the Paperwork (PWK) segment of the 837 transaction.

*UB-04 Claim Form Completion Guidelines (Continued)*

Attachments must be mailed or faxed to the address below:

Fiscal Intermediary  
HP Enterprise Services  
P.O. Box 526022  
Sacramento, CA 95852  
Fax: 1-866-438-9377

The following guidelines apply to attachments submitted with a *UB-04* claim forms.

Attachment Policies

- All attachments must be received within 30 days of the electronic claim submission.
- Paper attachments cannot be matched after 30 calendar days.
- To ensure accurate processing, only one ACN value will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

Denied Claim Reasons

- If an 837 v.4010A1 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If no ACF or a non-original ACF is submitted, the attachments or documentation will be returned with a reject letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- The method of transmission must match the method of transmission indicated in the PWK segment; otherwise, the attachment will not link up with the claim and it will be denied because no attachment was received.

ACF Order/Reorder Instructions

To place an order for ACFs, or to reorder forms, follow the instructions below:

- To order ACF documents, call TSC at 1-800-541-5555.
- To reorder forms, complete and mail the hard copy reorder form.

For more information regarding ACFs, refer to the *Forms Reorder Request: Guidelines* section (forms reo) in the Part 2 provider manual or visit the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

**Note:** ACFs and envelopes are provided FREE of charge to all providers submitting 837 v.4010A1 electronic transactions.

UB-04 Claim Form Completion Guidelines (Continued)

ATTACHMENT CONTROL FORM EXAMPLE



**MEDI-CAL CLAIM ATTACHMENT CONTROL FORM**  
STATE OF CALIFORNIA      DEPARTMENT OF HEALTH SERVICES

**ATTACHMENT CONTROL NUMBER**      99999999999

**PROVIDER NUMBER :**  (REQUIRED)

**PROVIDER NAME :** \_\_\_\_\_

**PROVIDER ADDRESS :** \_\_\_\_\_

VOID

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RETURN THIS FORM WITH ATTACHMENTS TO:

**FISCAL INTERMEDIARY**  
P.O. BOX 526022  
SACRAMENTO, CA 95852

**PROVIDER SIGNATURE**

X \_\_\_\_\_

**DATE**

\_\_\_\_\_

DO NOT WRITE IN THIS SPACE

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM. FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

ACF Example

# UB-04 Claim Completion

## UB-04 Claim Form

The *UB-04* claim form is a national form; therefore, some fields are not required by Medi-Cal. The information presented in this module will focus on the claim form fields that apply to EAPC claims.

### Field Descriptions: 1 — 7

Box #	Field Name	Instructions
1	PROVIDER NAME, ADDRESS, ZIP CODE	Enter the provider name, clinic address without a comma between the city and the state, and the 9-digit ZIP code without a hyphen. A telephone number is optional in this field.
3a	PATIENT CONTROL NUMBER	<i>(Optional Field)</i> Enter the patient's financial record number or account number in this field. A maximum of 20 characters may be used, but only 10 characters will appear on the <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Note: This field helps providers easily identify a recipient on RTDs and RADs.
3b	MEDICAL RECORD NUMBER	<i>Not Required for Medi-Cal</i> Use Box 3a to enter a patient control number.
4	TYPE OF BILL	<i>Required for Medi-Cal</i> Enter the appropriate three-character type of bill code as specified in the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> . Billing Tip: The type of bill code includes a two digit facility type code and a one digit claim frequency code.

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b		b		c		d	
						e	

Sample Partial UB-04 Claim Form: Fields 1 – 7

UB-04 Claim Completion (Continued)

Field Descriptions: 8 – 30

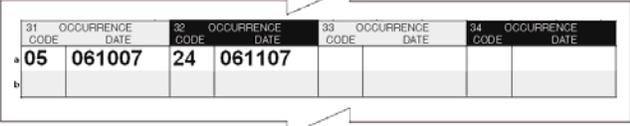
Box #	Field Name	Instructions
8b	PATIENT NAME	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.
10	BIRTH DATE	Enter the patient's date of birth, using an 8-digit MMDDYYYY (month, day, year) format (for example, September 16, 1967 = 09161967).
11	SEX	Enter the capital letter "M" for male or "F" for female.
18 - 24	CONDITION CODES	Condition codes are used to identify conditions related to the patient's bill that may affect payer processing. These codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, "A1" (services related to Family Planning), "80" (Other Health Coverage) and "82" (Outside Laboratory), enter "80" in Box 18, "82" in Box 19, and "A1" in Box 20.
25 – 30	CONDITION CODES	Not required. The Medi-Cal claims processing system recognizes condition codes entered in Boxes 18 – 24 only.

8 PATIENT NAME		a	9 PATIENT ADDRESS										a						
b										c		d	e						
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION			16 DHR	17 STAT	18	19	20	21	CONDITION CODES					29 ACDT STATE	30	
			13 HR	14 TYPE	15 SRC							22	23	24	25	26	27	28	

Sample Partial UB-04 Claim Form: Fields 8 – 30

UB-04 Claim Completion (Continued)

Field Descriptions: 31 – 38

Box #	Field Name	Instructions												
31 – 34 a – b	OCCURRENCE CODES AND DATES	<p>Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha order starting with the lowest value.</p> <p><u>Example:</u> If billing for two occurrence codes “24” (accepted by another payer) and “05” (accident/no medical or liability coverage), enter “05” in Box 31a and “24” in Box 32a.</p>  <p>Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers can include codes and dates billed to other payers in Boxes 31 – 34. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u> Use these codes if the accident or injury was non-employment related:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Accident/medical coverage</td> </tr> <tr> <td>02</td> <td>No fault insurance involved – including auto accident/other</td> </tr> <tr> <td>03</td> <td>Accident/tort liability</td> </tr> <tr> <td>05</td> <td>Accident/no medical or liability coverage</td> </tr> <tr> <td>06</td> <td>Crime victim</td> </tr> </tbody> </table> <p>Enter the accident/injury date in corresponding box (6-digit format MMDDYY).</p> <p><b>Note:</b> Enter code “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter accident/injury date in the corresponding box.</p> <p><b>OUTPATIENT CLAIMS:</b> Discharge date is not applicable.</p>	Code	Description	01	Accident/medical coverage	02	No fault insurance involved – including auto accident/other	03	Accident/tort liability	05	Accident/no medical or liability coverage	06	Crime victim
Code	Description													
01	Accident/medical coverage													
02	No fault insurance involved – including auto accident/other													
03	Accident/tort liability													
05	Accident/no medical or liability coverage													
06	Crime victim													

31	OCCURRENCE CODE	DATE	32	OCCURRENCE CODE	DATE	33	OCCURRENCE CODE	DATE	34	OCCURRENCE CODE	DATE	35	CODE	OCCURRENCE SPAN FROM	THROUGH	36	CODE	OCCURRENCE SPAN FROM	THROUGH	37
a																				
b																				
38											39	VALUE CODES	40	VALUE CODES	41	VALUE CODES				
											CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT				
											a									
											b									
											c									
											d									

Sample Partial UB-04 Claim Form: Fields 31 – 38

UB-04 Claim Completion (Continued)

Field Descriptions: 39 – 41

Box #	Field Name	Instructions
39 – 41	VALUE CODES & AMOUNTS	<p>Enter value codes and amounts from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even.</p> <p>Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 – 41. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u></p> <p><b>EAPC claims will use value code "23" to report the sliding fee scale amount collected from the recipient.</b></p>

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	5000	30	10000		
b						
c						
d						

Sample Partial UB-04 Claim Form: Fields 39 – 41

UB-04 Claim Completion (Continued)

Field Descriptions: 42 — 43

Box #	Field Name	Instructions
42	REVENUE CODE	EAPC CLAIMS PRIOR TO JULY 1, 2010: <i>Not required</i> EAPC CLAIMS ON OR AFTER JULY 1, 2010: Enter the appropriate revenue code. Billing Tip: Enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in Box 47, line 23.
43	DESCRIPTION	OUTPATIENT CLAIMS: ( <i>Optional</i> ) Information entered into this field will help separate and identify the descriptions of each service. Note: If there are multiple pages of the claim, enter page numbers on line 23. Billing Tip: For outpatient claims, the description must identify the particular service code indicated in <i>HCPCS/Rate</i> field (Box 44).

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

Sample Partial UB-04 Claim Form: Fields 42 – 43

UB-04 Claim Completion (Continued)

Field Descriptions: 44 — 45

Box #	Field Name	Instructions
44	HCPCS/RATE	EAPC CLAIMS PRIOR TO JULY 1, 2010: Enter the applicable procedure code.  EAPC CLAIMS ON OR AFTER JULY 1, 2010: Enter the applicable procedure code and modifier. The descriptor for the code must match the procedure performed and the modifier must be billed appropriately.  All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate field (Box 44) with no spaces.
45	SERVICE DATE	OUTPATIENT CLAIMS: Enter the date the service was rendered in 6-digit format.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A							56 NPI
B							57 OTHER
C							PRV. ID

Sample Partial UB-04 Claim Form: Fields 44 – 57

## UB-04 Claim Completion (Continued)

Field Descriptions: 46 — 57

Box #	Field Name	Instructions
46	SERVICE UNITS	<p>OUTPATIENT CLAIMS: Enter the actual number of times a single procedure or item was provided for the date of service</p> <p>Billing Tip: Although <i>Service Units</i> is a 7-digit field, Medi-Cal only allows 2 digits.</p>
47	TOTAL CHARGES	<p>In full dollar amount, dollars and cents. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents, even if the amt. is even (e.g., if billing for \$100, enter "10000" not "100").</p> <p>Enter the total charge for all services on the last line or on line 23. Enter "001" in <i>Revenue Code</i> field (Box 42, line 23) to indicate this is the total charge line.</p> <p>Note: Up to 22 lines of data (fields 42 – 49) can be entered. It is acceptable to skip lines.</p> <p>To delete a line, mark with a thin line through the entire detail line (Boxes 42-49), using a blue or black ballpoint pen.</p>
50 A	PAYER NAME	<p>OUTPATIENT CLAIMS: Enter "O/P MEDI-CAL" to indicate outpatient claim and payer.</p> <p>Billing Tip: When completing Boxes 50 – 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Medi-Cal is the only payer billed, all information in Boxes 50 – 65 (excluding Box 56) should be entered on Line A.</p>
55 A	ESTIMATED AMT. DUE	In full dollar amount. Do not enter a decimal point (.) or dollar sign (\$).
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.
57	OTHER PROVIDER ID	Use only if the NPI is not entered in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.

UB-04 Claim Completion (Continued)

Field Description: 60

60 A	INSURED'S UNIQUE ID	<p>Enter the recipient's 14-digit ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal card.</p> <p>Note: If the patient doesn't have a Medi-Cal ID, use the birth date in 6-digit format (MMDDYY) and the first three letters of the last name. If there are less than three letters in the last name, use the letter "X" in place of the second and/or third letters.</p> <p>Billing Tip: Verify that the recipient is eligible for the services rendered by using the Point of Service (POS) network.</p>
------	---------------------	---

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID
A			
B			
C			

Sample Partial UB-04 Claim Form: Fields 58 – 60

Field Descriptions: 67 — 67A

67	UNLABELED (PRIMARY DIAGNOSIS CODE)	Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including the fourth and fifth digits (if present). Do not include a decimal point.
67A	UNLABELED (SECONDARY DIAGNOSIS CODE)	If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code, including the fourth and fifth digits (if present). Do not include a decimal point.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C
66 DX	67 A B C D E F G H	68
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE
74 PRINCIPAL PROCEDURE CODE	a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE
75	c. OTHER PROCEDURE CODE	76 ATTENDING NPI
		QUAL
		LAST
		FIRST
c. OTHER PROCEDURE CODE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE
		77 OPERATING NPI
		QUAL
		LAST
		FIRST

Sample Partial UB-04 Claim Form: Fields 63 – 77

UB-04 Claim Completion (Continued)

Field Descriptions: 76 — 77

76	ATTENDING	OUTPATIENT CLAIMS: Enter the referring or prescribing physician's NPI in the first box.
77	OPERATING	OUTPATIENT CLAIMS: Enter the rendering physician's NPI in the first box.

76 ATTENDING	NPI	QUAL		
LAST		FIRST		
77 OPERATING	NPI	QUAL		
LAST		FIRST		
78 OTHER	NPI	QUAL		
LAST		FIRST		
79 OTHER	NPI	QUAL		
LAST		FIRST		
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.				

Sample Partial UB-04 Claim Form: Fields 76 – 79

UB-04 Claim Completion (Continued)

Field Description: 80

80	REMARKS	<p>Use this area for procedures that require additional information, justification or an <i>Emergency Certification Statement</i>.</p> <p><b>Billing Tips:</b> If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 8½ x 11 inch white paper.</p>
----	---------	---

80 REMARKS	81CC	
	a	
	b	
	c	
	d	

Sample Partial UB-04 Claim Form: Fields 80 – 81

# UB-04 Claim Form Examples

1 <b>ABC COMMUNITY CLINIC</b> 1000 RURAL ROAD ANY CITY, CA 00000-0000		2		3a PAT CNTL #		4 TYPE OF BILL <b>711</b>	
b <b>DOE JANE</b>		9 PATIENT ADDRESS		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
19 BIRTHDATE <b>02141986</b>		11 SEX <b>F</b>		12 DATE		13 HR	
14 TYPE		15 SRC		16 OHR		17 STAT	
18		19		20		21	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
43 DESCRIPTION <b>MEDICAL ENCOUNTER</b>		44 HCPCS / RATE / HIPPS CODE <b>Z9700</b>		45 SERV DATE <b>063010</b>		46 SERV UNITS <b>1</b>	
47 TOTAL CHARGES <b>7150</b>		48 NON-COVERED CHARGES		49		50	
51 PAYER NAME <b>O/P MEDI-CAL</b>		52 HEALTH PLAN ID		53 REL INFO		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE <b>7150</b>		56 NPI <b>1234567890</b>		57 OTHER PRV ID		58	
59 P PBL		60 INSURED'S UNIQUE ID <b>021486DOE</b>		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66	
67		68		69		70	
71 PRINCIPAL PROCEDURE DATE		72 OTHER PROCEDURE DATE		73 OTHER PROCEDURE DATE		74	
75 OTHER PROCEDURE DATE		76 OTHER PROCEDURE DATE		77 OTHER PROCEDURE DATE		78	
79 OTHER NPI		80 OTHER NPI		81 OTHER NPI		82	
83 OTHER NPI		84 OTHER NPI		85 OTHER NPI		86	
87 OTHER NPI		88 OTHER NPI		89 OTHER NPI		90	

Figure 1. Example of Single-Encounter Visit Prior to July 1, 2010

UB-04 Claim Form Examples (Continued)

1 <b>ABC COMMUNITY CLINIC</b>		2		3a PAT CNTL #		4 TYPE OF BILL	
1000 RURAL ROAD				b. MED. REC. #		711	
ANY CITY, CA 00000-0000				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		a <b>DOE JANE</b>		9 PATIENT ADDRESS		a	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HRS	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
1 <b>0529</b>		2 <b>MEDICAL ENCOUNTER</b>		3 <b>T1015SE</b>		4 <b>070110</b>	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	
101		102		103		104	
105		106		107		108	
109		110		111		112	
113		114		115		116	
117		118		119		120	
121		122		123		124	
125		126		127		128	
129		130		131		132	
133		134		135		136	
137		138		139		140	
141		142		143		144	
145		146		147		148	
149		150		151		152	
153		154		155		156	
157		158		159		160	
161		162		163		164	
165		166		167		168	
169		170		171		172	
173		174		175		176	
177		178		179		180	
181		182		183		184	
185		186		187		188	
189		190		191		192	
193		194		195		196	
197		198		199		200	
201		202		203		204	
205		206		207		208	
209		210		211		212	
213		214		215		216	
217		218		219		220	
221		222		223		224	
225		226		227		228	
229		230		231		232	
233		234		235		236	
237		238		239		240	
241		242		243		244	
245		246		247		248	
249		250		251		252	
253		254		255		256	
257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
277		278		279		280	
281		282		283		284	
285		286		287		288	
289		290		291		292	
293		294		295		296	
297		298		299		300	
301		302		303		304	
305		306		307		308	
309		310		311		312	
313		314		315		316	
317		318		319		320	
321		322		323		324	
325		326		327		328	
329		330		331		332	
333		334		335		336	
337		338		339		340	
341		342		343		344	
345		346		347		348	
349		350		351		352	
353		354		355		356	
357		358		359		360	
361		362		363		364	
365		366		367		368	
369		370		371		372	
373		374		375		376	
377		378		379		380	
381		382		383		384	
385		386		387		388	
389		390		391		392	
393		394		395		396	
397		398		399		400	
401		402		403		404	
405		406		407		408	
409		410		411		412	
413		414		415		416	
417		418		419		420	
421		422		423		424	
425		426		427		428	
429		430		431		432	
433		434		435		436	
437		438		439		440	
441		442		443		444	
445		446		447		448	
449		450		451		452	
453		454		455		456	
457		458		459		460	
461		462		463		464	
465		466		467		468	
469		470		471		472	
473		474		475		476	
477		478		479		480	
481		482		483		484	
485		486		487		488	
489		490		491		492	
493		494		495		496	
497		498		499		500	
501		502		503		504	
505		506		507		508	
509		510		511		512	
513		514		515		516	
517		518		519		520	
521		522		523		524	
525		526		527		528	
529		530		531		532	
533		534		535		536	
537		538		539		540	
541		542		543		544	
545		546		547		548	
549		550		551		552	
553		554		555		556	
557		558		559		560	
561		562		563		564	
565		566		567		568	
569		570		571		572	
573		574		575		576	
577		578		579		580	
581		582		583		584	
585		586		587		588	
589		590		591		592	
593		594		595		596	
597		598		599		600	
601		602		603		604	
605		606		607		608	
609		610		611		612	
613		614		615		616	
617		618		619		620	
621		622		623		624	
625		626		627		628	
629		630		631		632	
633		634		635		636	
637		638		639		640	
641		642		643		644	
645		646		647		648	
649		650		651		652	
653		654		655		656	
657		658		659		660	
661		662		663		664	
665		666		667		668	
669		670		671		672	
673		674		675		676	
677		678		679		680	
681		682		683		684	
685		686		687		688	
689		690		691		692	
693		694		695		696	
697		698		699		700	
701		702		703		704	
705		706		707		708	
709		710		711		712	
713		714		715		716	
717		718		719		720	
721		722		723		724	
725		726		727		728	
729		730		731		732	
733		734		735		736	
737		738		739		740	
741		742		743		744	
745		746		747		748	
749		750		751		752	
753		754		755		756	
757		758		759		760	
761		762		763		764	
765		766		767		768	
769		770		771		772	
773		774		775		776	
777		778		779		780	
781		782		783		784	
785		786		787		788	
789		790		791		792	
793		794		795		796	
797		798		799		800	
801		802		803		804	
805		806		807		808	
809		810		811		812	
813		814		815		816	
817		818		819		820	
821		822		823		824	
825		826		827		828	
829		830		831		832	
833							

UB-04 Claim Form Examples (Continued)

1 <b>ABC COMMUNITY CLINIC</b> 1000 RURAL ROAD ANY CITY, CA 00000-0000		2		3a PAT CNTL #		4 TYPE OF BILL <b>711</b>	
5 FED. TAX NO		6 STATEMENT COVERS PERIOD FROM		7 THROUGH			
8 PATIENT NAME a <b>WU JOHN</b>		9 PATIENT ADDRESS a					
10 BIRTH-DATE <b>05011955</b>		11 SEX <b>M</b>		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC	
16 DHR		17 STAT <b>82</b>		18		19	
20		21		22		23	
24		25		26		27	
28		29 ACCT STATE		30			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT			
a <b>23</b>		b <b>2500</b>		c		d	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		<b>MEDICAL ENCOUNTER</b>		<b>Z9700</b>		<b>063010</b>	
2		<b>MEDICAL ENCOUNTER</b>		<b>Z9700</b>		<b>063010</b>	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		<b>001 PAGE OF</b>		<b>CREATION DATE</b>		<b>TOTALS 14300</b>	
50 PAYER NAME A <b>O/P MEDI-CAL</b>		51 HEALTH PLAN ID		52 REL INFO		53 ASG BDL	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE B <b>14300</b>		56 NPI C <b>1234567890</b>		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID A <b>050155WUX</b>		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX A <b>25002</b>		67		68		69	
70 ADMIT REASON DX		71 PATIENT REASON DX		72 FPS CODE		73	
74 PRINCIPAL PROCEDURE DATE		75 OTHER PROCEDURE DATE		76 OTHER PROCEDURE DATE		77 OTHER PROCEDURE DATE	
78 ATTENDING NPI		79 OPERATING NPI A <b>1087654329</b>		80 OTHER NPI		81	
82		83		84		85	
86		87		88		89	
90 REMARKS A <b>FIRST ENCOUNTER W/PHYSICIAN AT 8 A.M.</b> B <b>SECOND ENCOUNTER W/SPECIALIST AT 1 P.M. FOR TEST</b>		91 CC		92		93	
94		95		96		97	
98		99		00		01	

Figure 3. Example of Dual-Encounter Visit Prior to July 1, 2010

UB-04 Claim Form Examples (Continued)

1 <b>ABC COMMUNITY CLINIC</b> 1000 RURAL ROAD ANY CITY, CA 00000-0000		2		3a PAT CNTL # b. MED REC. #		4 TYPE OF BILL <b>711</b>	
8 PATIENT NAME a <b>WU JOHN</b>				9 PATIENT ADDRESS a			
10 BIRTHDATE <b>05011955</b>		11 SEX <b>M</b>		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
1 <b>0529</b>		<b>MEDICAL ENCOUNTER</b>		<b>T1015SE</b>		<b>070110</b>	
2 <b>0529</b>		<b>MEDICAL ENCOUNTER</b>		<b>T1015SE</b>		<b>070110</b>	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		<b>001</b>		<b>PAGE</b>		<b>OF</b>	
				<b>CREATION DATE</b>		<b>TOTALS</b>	
						<b>14300</b>	
50 PAYER NAME <b>O/P MEDI-CAL</b>		51 HEALTH PLAN ID		52 REL INFO		53 A50 BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE <b>14300</b>		56 NPI <b>1234567890</b>		57 OTHER PRV ID	
58 INSURED'S NAME		59 P REL		60 INSURED'S UNIQUE ID <b>050155WUX</b>		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX <b>25002</b>		67		68		69	
70 PATIENT REASON DX		71 ICD CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE		75		76 ATTENDING NPI		77 OPERATING NPI <b>1087654329</b>	
78 OTHER NPI		79 OTHER NPI		80 REMARKS <b>FIRST ENCOUNTER W/PHYSICIAN AT 8 A.M. SECOND ENCOUNTER W/SPECIALIST AT 1 P.M. FOR TEST</b>		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44			