UB-04 Claim Form

Introduction

Purpose

The purpose of this module is to provide participants with detailed information about the completion of the *UB-04* claim form for Medi-Cal services. Claim completion requirements, claim information and detailed examples will be discussed for the *UB-04* claim form required by the Medi-Cal program.

Module Objectives

- Identify the section in the provider manual related to *UB-04* claim form completion
- Outline Diagnosis-Related Groups (DRG) reimbursement requirements
- Introduce general completion and submission billing guidelines for the *UB-04* claim form
- Understand the differences between inpatient and outpatient services claim completion on a *UB-04* claim form
- Discuss common claim completion errors (billing tips)
- Participate in an interactive claim completion learning activity.

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Diagnosis-Related Groups Reimbursement

Payments for inpatient general acute care for many hospitals are calculated using an All Patient Refined Diagnosis-Related Groups (APR-DRG) reimbursement methodology. For the purposes of this module, APR-DRG is referred to as the DRG reimbursement method or the DRG model.

It is important for inpatient providers to know their reimbursement method because it affects payment and claim completion standards. For example, claims submitted by hospitals reimbursed according to the DRG model should take extra care to enter all ICD-10-CM diagnosis codes and ICD-10 PCS codes on a claim to ensure payment at the appropriate level. For help understanding the DRG model, refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section (diagnosis ip) of the Part 2 Inpatient Services manual.

Non-DRG Hospitals

Non-DRG reimbursed hospitals are hospitals that are not paid according to the DRG reimbursement methodology. Refer to the *Hospital Directory* section (hospital dir) of the Part 2 Inpatient Services manual for a listing of non-DRG hospitals. Reimbursement for those hospitals may pertain to certified public expenditure (CPE). Listings in the section are subject to change and may be incomplete.

NOTE

For DRG-related questions, comments and concerns, or to subscribe to the DRG listserv, please send an email to DRG@dhcs.ca.gov.

UB-04 Claim Form Description

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, coronary care and ancillary charges (such as labor and delivery, anesthesiology and central services and supplies)
- Outpatient institutional facilities, such as outpatient departments, rural health clinics, chronic dialysis services and Community-Based adult Services (CBAS).

After a *UB-04* claim has been submitted, it must be received by the California Medicaid Management Information System (CA-MMIS) Fiscal Intermediary (FI) within a specified time frame in order to qualify for reimbursement. The time frames are very specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been improperly completed will be denied.

UB-04 Claim Form Completion Guidelines

Form Submission Methods

Paper Format

Providers are required to purchase *UB-04* claim forms from a vendor. The claim forms ordered through vendors must include red "drop-out" ink to meet Centers for Medicare & Medicaid Services (CMS) standards.

The following guidelines apply to claim forms submitted by mail:

Claim Submission Instructions
- Bill in the Medi-Cal format. Follow claim form completion instructions outlined in the *UB-04 Completion: Inpatient Services* section (ub comp ip) or *UB-04 Completion: Outpatient Services* section (ub comp op).
- Send original claims only (printed with red "drop-out" ink).
- Photocopies, carbon copies and computer-generated claim form facsimiles are unacceptable.
- Submit separate claim forms for inpatient services. Do not combine inpatient and outpatient services on the same claim form.
- 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 by 11-inch white paper using non-glare tape.
- Do not use colored paper.
- Appropriate modifiers must be used when billing for surgical, pathology, radiology and some medicine codes.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.

Full Reimbursement Policy

If the Date of Service (DOS) falls within this month:	Then claims must be received by the last day of this month:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Partial Reimbursement Policy

Claims submitted after the six-month billing limit and received by the California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

0 MO.	2 MO.	3 MO.	4 MO.	5 MO.	6 MO.	7 MO.	8 MO.	9 MO.	10 MO.	11 MO.	12 MO.

←————————— 100% —————————→   ←———— 75% ————→   ←———— 50% ————→
Reimbursement   Reimbursement   Reimbursement

Delay Reason Codes

Claims can be billed beyond the six-month billing limit if a delay reason code is used. The delay reason code indicates that the claim form is being submitted after the six month billing limit.

Although a delay reason code designates approved reason for late claim submission, these exceptions also have time limits. Refer to the *UB-04 Submission and Timeliness Instructions* section (ub sub) of the Part 2 provider manual.

Delay Reason Code	Description
1	Proof of Eligibility (POE) unknown or unavailable
3	TAR approval delays
4	Delay by DHCS in certifying providers
5	Delay in supplying billing forms
6	Delay in delivery of custom made eye appliances
7	Third party processing delay
10	Administrative delay in prior approval process
11	Other (eg. theft); attach documentation justifying delay reason
15	Natural disaster

NOTE
To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with a delay reason code without the required attachments will be denied or reimbursed at a reduced rate.

BILLING NOTICE
Most providers may no longer bill Medi-Cal or CCS using a recipient's Social Security Number (SSN). Claims submitted with a recipient's SSN will be denied.

UB-04 Delay Reason Code Claim Example

Place the delay reason code in the unlabeled Box 37.

Claims Over One Year

Occasionally, a claim may be delayed more than one year past the date of service (DOS). The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

- Third party decision or appeals
- Determination of Medi-Cal eligibility
- Treatment Authorization Request (TAR) approval delay

Providers may still be eligible to receive 100 percent reimbursement of the Medi-Cal maximum allowable rate. Claims submitted more than 12 months after the month of service must use delay reason code 10. These claims must be billed hard copy and with appropriate attachments. Providers can send late claims to the California MMIS Fiscal Intermediary at the following address:

Attn: Over One Year Claims Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

NOTE
- Claims and attachments more than a year old may not be submitted electronically
- Claims more than a year old will not receive an acknowledgement or response letter.
- Providers will receive a RAD message indicating the status of their claim.

Refer to the appropriate Part 2 provider manual section: *UB-04 Submission and Timeliness Instructions* (ub sub).

Form Completion Instructions

- Handwritten claims should be printed neatly using <u>black</u> ballpoint pen ONLY. Do not use red pencils or red ink ballpoint pens.
- Only typed, handwritten 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 FI USE ONLY" should be left blank. These areas are reserved for FI use only.
- Punctuation or symbols ($, %, &, /, etc.) must not be used except in designated areas.
- Ensure that a valid CPT/HCPCS code is used for the date of service. In addition, make sure the revenue code is valid and on file.
- Do not use highlighters or correction tape/fluid on the hard copy claim or follow-up form.
- 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 of 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 at no charge by the FI.

Electronic Format

Most claims for inpatient services can also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the CMC sections (cmc and cmc enroll) of the Part 1 provider manual.

The following guidelines apply to claim forms submitted by electronically.

The method of submitting claims electronically is referred to as CMC submission, and is the most efficient method of Medi-Cal billing. CMC submission offers additional efficiency to providers because these claims are submitted faster and entered into the claims processing system faster.

Submission Instructions

- Claims may be submitted electronically via CMC telecommunications (modem) or Medi-Cal website (*www.medi-cal.ca.gov*).
- Claims requiring hard copy attachments may be billed electronically.
- CMC claims requiring attachments must be accompanied by a *Medi-Cal Claim Attachment Control Form* (ACF) and mailed or faxed to the FI. The attachments must be completed as specified or the attachments will not be linked with the electronic claim, resulting in claim denial. Each ACF has a unique number that must be entered on the CMC in the appropriate field in order for the CMC to match the ACF.

Billing Instructions

Electronic data specifications and billing instructions are located in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*.

Contact Information

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

Medi-Cal Claim Attachment Control Form (ACF)

An ACF makes it possible to process paper attachments. Under HIPAA rules, an 837 v.5010 electronic claim cannot be rejected (denied) because it requires an attachment. The California Medicaid Management Information System (CA-MMIS) has been modified to process paper attachments submitted in conjunction with an (837 v.5010) electronic claim.

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

Attachments must be mailed or faxed to the address below:

California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852
Fax: 1-866-438-9377

The following guidelines apply to attachments submitted with *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.5010 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 reorder forms, follow the instructions below:

- To order ACF documents, call the 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) of the Part 2 provider manual or visit the Medi-Cal website (*www.medi-cal.ca.gov*).

NOTE
ACFs and envelopes are provided <u>free</u> of charge to all providers submitting 837 v.5010 electronic transactions.

DO NOT STAPLE
IN BAR AREA

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

DO NOT
WRITE IN
THIS SPACE

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
1   2   3   4

RETURN THIS FORM WITH ATTACHMENTS TO:
FISCAL INTERMEDIARY
P.O. BOX 526022
SACRAMENTO, CA 95852

PROVIDER SIGNATURE   DATE

X_____ _____

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

Sample Medi-Cal Claim Attachment Control Form

California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

Date:

ATTACHMENT CONTROL FORM REJECT LETTER

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

_____   **Invalid ACF**
            (Only original ACFs provided by California Department of Health Care Services (DHCS) will be accepted)

_____   **Missing ACF**
            (Paper attachments submitted without ACF)

_____   **Supporting documentation missing**
            (ACF received without paper attachments)

_____   **Invalid Attachment Control Number (ACN) on ACF**
            (Pre-imprinted CANNOT be altered or unreadable)

_____   **Other:** _____

Please resubmit your electronic claim if:

    The resubmitted ACF has an Attachment Control Number (ACN) that differs from your
    original electronic claim form or;

    More than 30 days have passed since you originally submitted your electronic claim.

Mail attachments to: California MMIS Fiscal Intermediary
            P.O. Box 526022
            Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center (TSC) at 1-800-541-5555.

Sincerely,

California Medicaid Management Information System Fiscal Intermediary

Sample ACF Rejection Letter

UB-04 Claim Form Completion

UB-04 Claim Form

The *UB-04* claim form is a national form; <u>however</u>, many fields are not required by Medi-Cal. Items described as "Not required by Medi-Cal" may be completed for other payers, but are not recognized by Medi-Cal claims processing system.

The information presented in this module focuses on the claim form fields that apply to Medi-Cal claims.

Sample Partial *UB-04* Claim Form

Field Descriptions: 1 – 6

Box #	Field Name	Instructions
1	Provider Name, Address, ZIP Code	Enter the provider name, hospital and clinic address, without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field. **NOTE** The nine-digit ZIP code entered in this box must match the billing provider's ZIP code on file for claims to be reimbursed correctly.
3a	Patient Control Number	*(Optional Field)* 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 *Remittance Advice Detail* (RAD).
3b	Medical Record Number	*Not Required (for Medi-Cal)* Use Box 3a to enter a patient control number.
4	Type Of Bill	*Required (for Medi-Cal)* Enter the appropriate three-character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual*. **NOTE** For subacute services, specify the appropriate Place of Service and use modifier U2 (Outpatient Services). **Billing Tip:** The type of bill code includes a two-digit facility type code and a one-digit claim frequency code.

Box #	Field Name	Instructions
6	Statement Covers Period (From-Through)	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **NOTE** For "From-Through" billing instructions, refer to the *UB-04 Special Billing Instructions for Inpatient Services* section (ub spec ip) in the Part 2 provider manual.

8 PATIENT NAME	a		9 PATIENT ADDRESS	a					
b			b			c	d		e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30

Sample Partial *UB-04* Claim Form

Field Descriptions: 8B – 10

Box #	Field Name	Instructions
8b	Patient Name	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn Infant:** When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 8b. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, JONES BABY GIRL). **Billing Tip:** If billing for newborn infants from a multiple birth, each newborn must also be designated by a number or a letter (for example, JONES BABY GIRL TWIN A) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. Enter the mother's name in the *Insured's Name* field (Box 58) and enter "03" (Child) in the *Patient's Relationship to Insured* field (Box 59). **Organ Donors:** When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in the *Insured's Name* field (Box 58) and enter "11" (Donor) in the *Patient's Relationship to Insured* field (Box 59).

Box #	Field Name	Instructions
10	Birth Date	Enter the patient's date of birth, using an eight-digit MMDDYYYY (month, day, year) format (for example, September 16, 1967 = 09161967).

NOTE
If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8B). |

Field Descriptions: 11 – 15

Box #	Field Name	Instructions
11	Sex	Enter the capital letter "M" for male or "F" for female.

Billing Tip: When submitting a claim for a newborn infant using the mother's ID number, enter the infant's gender in Field 11. |
| 12 – 13 | Admission Date and Hour | **Outpatient Claims:** *Not required*

Inpatient Claims: Enter the date of hospital admission, in six-digit format. Convert the hour of admission to the 24-hour (00-23) format. Do not include the minutes.

Billing Tip: The admit time of 1:45 p.m. will be entered on the claim as 13. |
| 14 | Admission Type | **Outpatient Claims:** Enter an admit type code of "1" when billing for emergency room-related services (in conjunction with facility type "14" in Box 4). This field is not required by Medi-Cal for any other use.

Inpatient Claims: Enter the numeric code indicating the necessity for admission to the hospital. |

Patient Admission Status	Code
Emergency	1
Elective	3
Newborn	4

NOTE
If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission and admission source code "4" (extramural birth) in the Source of Admission field (Box 15).

15	Admission Source	**Outpatient Claims:** *Not required*
		Inpatient Claims: If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code "1" or "3" in Box 14 to indicate whether the transfer was an emergency or elective.

Transfer Source	Code
Transfer from a hospital	4
Transfer from a Skilled Nursing Facility (SNF)	5
Transfer from another health care facility	6

When the type of admission code in Box 14 is "4" (newborn [used by Medi-Cal only; baby born outside hospital], submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42.

Field Descriptions: 16 – 24

Box #	Field Name	Instructions
16	Discharge Hour	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the discharge hour as follows: • Do not include the minutes • Convert discharge hour to 24-hour (00-23) format, e.g. 3:00 p.m. = 15. **NOTE** If the patient has not been discharged, leave this field blank.
17	Status	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the numeric code explaining patient status as of the "THROUGH" date indicated in (Box 6) under *Statement Covers Period. (*The listed codes below are only a few examples of the codes utilized to describe patient status). Refer to billing instructions in the *UB-04 Completion: Inpatient Services* section (ub comp ip) of the Part 2 provider manual for status codes and explanations.

Patient Status	Code
Discharged to home	01
Expired	20
Still a patient	30

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.
		Billing Tip: Enter code "81" when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the *Remarks* field (Box 80).
		NOTE Providers may include codes accepted by other payers. The claims processing system recognizes condition codes entered in Boxes 18 – 24 only.

Sample Partial *UB-04* Claim Form

NOTES

Field Descriptions: 31 – 34A – B

Box #	Field Name	Instructions
31 – 34 a – b	Occurrence Codes and Dates	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. **Example**: 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. 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: <table><tr><th>Code</th><th>Description</th></tr><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></table> Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **NOTE** Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. **Outpatient Claims:** Discharge date is not applicable. **Inpatient Claims:** Discharge Date: Enter occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of discharge is different from the "THROUGH" date in Box 6.

Field Descriptions: 37A

Box #	Field Name	Instructions
37a	Unlabeled *(use for delay reason codes)*	If there is an exception to the six-month billing limit, enter one of the delay reason codes in Box 37a and include the required documentation.

Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None *
11	Other (theft, sabotage)	Attachment *
15	Natural disaster	Attachment

NOTE
Documentation justifying the delay reason must be attached to the claim to receive full payment.

Billing Tip: Providers billing with delay reason "11" without an attachment will either receive reimbursement at a reduced rate or a claim denial.

For hospitals that are not reimbursed according to the diagnosis-related groups (DRG) model: Providers must use claim frequency code "5" in the *Type of Bill* field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.

	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

Field Descriptions: 39 – 41A – D

Box #	Field Name	Instructions
39 – 41 a – d	Value Codes and Amounts (Patient's Share of Cost)	Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. If billing for two value codes "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in Box 39a and "30" in Box 40a. If the SOC collect/obligated is $50, enter 5000, not 50.
		Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 – 41. The claims processing system ignores all codes not applicable to Medi-Cal.
		Example: Enter code "23" and amount of the patient's SOC for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even. (For example, if billing for $100, enter 10000, not 100). For more information about Share of Cost, see the *Share of Cost: UB-04 for Inpatient Services* or *UB-04 Outpatient Services* section of the Part 2 provider manual. If the SOC collected/obligated is $50, enter 5000 not 50.
		Billing Tip: Value code information is required for Medicare/Medi-Cal crossover claims.

NOTES

Sample Partial *UB-04* Claim Form

Field Descriptions: 42 – 43

Box #	Field Name	Instructions
42	Revenue Code	**Outpatient Claims:** Revenue codes are required (for instance, for organ procurement) doe select OP billing. Specific instructions are included in select provider manual sections.
		Inpatient Claims: Enter the appropriate revenue or ancillary code. Refer to the *Revenue Codes for Inpatient Services* section (rev cd ip) in the appropriate Part 2 provider manual. Ancillary codes are listed in the *Ancillary Codes* section (ancil cod) of the Part 2 provider manual.
		Billing Tip: For both outpatient and inpatient claims (single-page claims), 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:** Information entered into this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the *HCPCS/Rate/HIPPS Code* field (Box 44). This field is **optional**, except when billing for physician-administered drugs. Refer to the *Physician-Administered Drugs – NDC UB-04 Billing Instructions* section (physician ndc ub) of the Part 2 provider manual for more information.
		Inpatient Claims: Enter the description of the revenue or ancillary code listed in the *Revenue Code* field (Box 42).
		NOTE If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

Sample Partial *UB-04* Claim Form

Field Descriptions: 44 – 57 A-C

Box #	Field Name	Instructions
44	HCPCS/Rate	**Outpatient Claims:** Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claim for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the *TAR & Non-Benefit List: Codes (10000 – 99999)* sections in the appropriate Part 2 manual. All modifiers must be billed immediately following the HCPCS code in the *HCPCS/Rate* field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient *UB-04* claim form. **Inpatient Claims:** *Not required*
45	Service Date	**Outpatient Claims:** Enter the date the service was rendered in six-digit format. **Inpatient Claims:** *Not required by Medi-Cal* **Billing Tip:** For "From-Through" billing instructions, see the *UB-04 Special Billing Instructions for Outpatient Services* section (ub spec op).

Field Descriptions: 46 – 50A – C

Box #	Field Name	Instructions
46	Service Units	**Outpatient Claims:** Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines.
		Billing Tip: Although *Service Units* is a seven-digit field, Medi-Cal only allows two digits.
		Inpatient Claims: Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines.
47	Total Charges	In full dollar amount, enter the usual and customary fee for the service billed. 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").
		Enter the total charge for all services on the last line or on line 23. Enter "001" in *Revenue Code* field (Box 42, line 23) to indicate this is the total charge line.
		NOTE Up to 22 lines of data (fields 42 – 49) can be entered. It is acceptable to skip lines.
		Outpatient Claims: If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Boxes 42-49), using a black ballpoint pen.
50a – c	Payer Name	**Outpatient Claims:** Enter "O/P MEDI-CAL" to indicate outpatient claim and payer.
		Inpatient Claims: Enter "I/P MEDI-CAL" to indicate inpatient claim and payer.
		NOTE If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.
		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.

Field Descriptions: 54A – 57A – C

Box #	Field Name	Instructions
54a – c	Prior Payments (Other Coverage)	Leave blank if not applicable. Enter the full dollar amount of payment received from OHC, on line A or B that corresponds with OHC in the *Payer* field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. **NOTE** For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the *Medicare/Medi-Cal Crossover Claims: UB-04* section (medi cr ub) in the provider manual.
55a – c	Estimated Amount Due (Net amount billed)	In full dollar amount, enter the difference between "Total Charges" (Box 47, line 23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). Example: Patient's SOC *Value Codes Amount* and/or OHC *Prior Payments*.
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.
57a – c	Other Provider ID	Not required by Medi-Cal for inpatient providers. Outpatient: Enter the Medi-Cal provider number, corresponding to the information on lines A, B or C. **NOTE** Required when the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.

NOTES

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

Sample Partial *UB-04* Claim Form

Field Descriptions: 58A – 60A – C

Box #	Field Name	Instructions
58a – c	Insured's Name	If billing for an infant using the mother's ID or for an organ donor, enter the Medi-Cal recipient's name and the patient's relationship to the Medi-Cal recipient in the *Patient's Relationship to Insured* field (Box 59). **NOTE** This field is not required by Medi-Cal except under these circumstances.
59a – c	Patient's Relationship to Insured	If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [CHILD] or "11" [DONOR]). **NOTE** This field is not required by Medi-Cal except under these circumstances.
60a – c	Insured's Unique ID	Enter the recipient's 14-digit ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal card. When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 8B). **NOTE** Medi-Cal does not accept Health Insurance Claim (HIC) numbers.

Sample Partial *UB-04* Claim Form

Field Descriptions: 63A – 67A

Box #	Field Name	Instructions
63a – c	Treatment Authorization Codes	For services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the TAR. Recipient information on the claim must the match TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TCN can cover services billed on any one claim. **Inpatient Claims:** Inpatient claims must be submitted with a TCN, even if an Extension TAR was issued for the same stay. (Enter the Extension TCN in the *Remarks* field [Box 80].) **Billing Tip:** TAR and Non-TAR procedures should not be combined on the same claim.
66	Diagnosis Code Header	Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015.
67	Unlabeled (Primary Diagnosis Code)	Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include a decimal point. The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A. Present on Admission (POA) indicator. Each diagnosis code may require a POA indicator. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67A, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the hospital.
67a	Unlabeled (Secondary Diagnosis Code)	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point. **NOTE** Paper claims accommodate up to 18 diagnosis codes.

Field Descriptions: 74 – 74A – E

Box #	Field Name	Instructions
74	Principle Procedure Code and Date	**Outpatient Claims:** *Not required by Medi-Cal* **Inpatient Claims:** Enter the appropriate ICD-10-PCS code identifying the primary medical or surgical procedure. Enter the ICD-10-PCS code, without periods or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed. **Billing Tip:** Inpatient providers must enter ICD-10-PCS code in this field (not CPT-4/HCPCS surgical procedure code).
74a – e	Other Procedure Codes and Dates	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **NOTE** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in either Box 74 or 74a – e.

Sample Partial *UB-04* Claim Form

Field Description: 76 – 78

Box #	Field Name	Instructions
76	Attending	**Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. Referring or prescribing physician's first and last names are not required by Medi-Cal. **Billing Tip:** For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the *Qual ID* box and enter the Medi-Cal provider number next to it. **Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required. **Billing Tip:** For inpatient claims, do not enter the operating or admitting physician NPI in this field.

77	Operating	**Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering provider number may be entered per claim. Do not use a group number or state license number.
		Billing Tip: For atypical rendering physicians, enter the Medicaid Identifier "1D" in the *Qual ID* box and the Medi-Cal Provider number next to it. Do not use a group provider number.
		Inpatient Claims: Enter the operating physician's NPI in the first box. Do not enter a group provider number. The operating physician's first and last name is not required by Medi-Cal.
78	Other	**Outpatient Claims:** *Not required*
		Inpatient Claims: Enter the admitting physician's NPI in the first box. Do not enter a group provider number. The admitting physician's first and last name is not required by Medi-Cal.

NOTES

80 REMARKS	81CC a
	b
	c
	d

Sample Partial *UB-04* Claim Form

Field Description: 80

Box #	Field Name	Instructions
80	Remarks	Use this area for procedures that require additional information, justification or an *Emergency Certification Statement*. This statement must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the *Emergency Certification Statement* will not fit in this area, attach the statement to the claim.
		Billing Tips: If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 8½ by 11-inch white paper.
		• "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the *Remarks* field (Box 80) of the claim may be sufficient.
		• Eligibility Verification Confirmation (EVC) numbers, are not required as attachments unless the claim is over 1 year old.

Learning Activity

What is wrong with this claim?

Identify 10 claim completion errors.

Incorrect Claim Example

1 UPTOWN MEDICAL CENTER	2		3a PAT. CNTL #		4 TYPE OF BILL
140 SECOND STREET			b. MED. REC. #		721
ANYTOWN CA 958235555		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	

8 PATIENT NAME	a OTT, MARY	9 PATIENT ADDRESS	a				
b				c	d		e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
08241980	F				YO				

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37	
a							a
b							b

38			39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
		a			
		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		Maintenance Dialysis With		060117					1
2		Lab 06/1,4,8,12,15,19,22,26,29		062917	9	1104 00			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	001	PAGE ___ OF ___	CREATION DATE	TOTALS ➡	110400			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	987654321	
A O/P MEDI-CAL					1104 00	57		A
B						OTHER		B
C						PRV ID		C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A		09876543210987			A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	D1D1D1D	A	B	C	D	E	F	G	H	68
0		I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 2345678901 QUAL
				LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI 0123456789 QUAL
				LAST FIRST

80 REMARKS	81CC a	78 OTHER NPI QUAL
	b	LAST FIRST
	c	79 OTHER NPI QUAL
	d	LAST FIRST

UB-04 CMS-1450
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OMB APPROVAL PENDING

NUBC™ National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Correct Claim Example

Learning Activity: Answer Key

Box #	Incorrect Data Entries	Correct Data Entries
1	95823	The nine-digit ZIP code is required.
4	72	The three-digit type of bill code is required.
8	Ott, Mary	The name must be in all capital letters.
44 (Line 2)	9	Field should be blank.
46 (Line 2)	(blank)	Nine. The number of items must equal the number of "from-through" dates listed. The claim indicates nine in the incorrect field (Box 44, Line 2).
47 (Line 2)	$1104.00	Do not enter a decimal point (.) or dollar sign ($).
55 (Line A)	(blank)	An estimated amount due must be listed.
56	(blank)	Billing provider's NPI must be listed.
60 (Line A)	90000000A	A 14-digit ID number must be listed.
66	9	An ICD indicator of "0" must be listed for claims received after October 1, 2015, for the new ICD-10 classification system.

NOTES

Resource Information

References

The following reference materials provide Medi-Cal claim submission information.

Provider Manual References

Part 1
CMC (cmc)

Part 2
Forms: Legibility and Completion Standards (forms leg)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (ub comp op)
UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)
UB-04 Tips for Billing: Inpatient Services (ub tips ip)
UB-04 Tips for Billing: Outpatient Services (ub tips op)

Other References

- Medi-Cal website (*www.medi-cal.ca.gov*)

- *UB-04* Claim Form Tutorial (*https://learn.medi-cal.ca.gov/training.aspx*)

- Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual