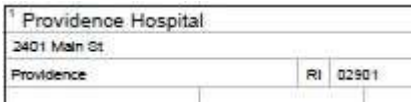
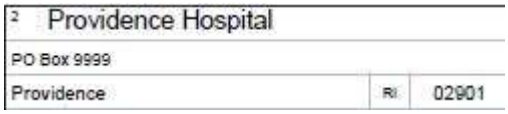
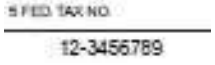
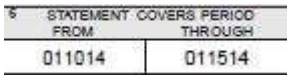
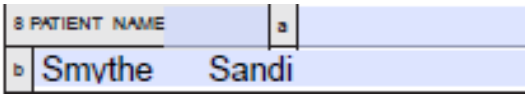
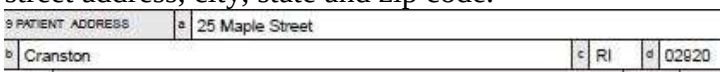
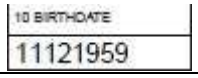
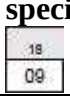
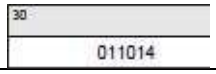
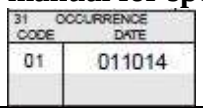
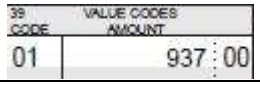
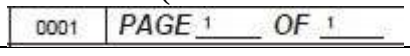
UB-04 CLAIM FORM INSTRUCTIONS

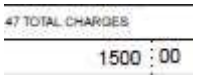
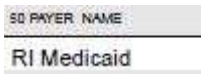
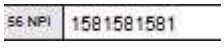
FIELD NUMBER	FIELD NAME	INSTRUCTIONS
1	Billing Provider Name & Address	Enter the name and address of the hospital/facility submitting the claim. 
2	Pay to Address	Pay to address if different than field 1. 
3a	Patient Control Number	Enter your facility's unique account number assigned to the patient, up to 20 alpha/numeric characters. This number will be printed on the RA and will help you identify the patient. 
3b	Medical Record Number	Number assigned to patient's medical record by provider. Up to 30 alpha/numeric characters. *(see above)*
4	Type of Bill	Enter the four digit code that identifies the specific type of bill and frequency of submission. **The first digit is a leading zero.** See **National Uniform Billing Committee for guidelines.** 
5	Federal Tax Number	Enter the facility's tax identification number. 
6	Statement Covers Period	Enter the beginning and ending service dates of for the period covered on the claim in MMDDYY format. 

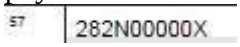
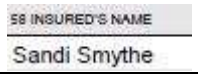
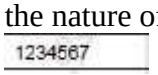
7	Administrative Necessary Days	Not required
8 b	Patient Name	Enter the patient's name exactly as it is spelled on the Medicaid ID card using the Last, First name, MI format. 
9	Patient Address	Enter the patient's mailing address including street address, city, state and zip code. 
10	Birth Date	Enter the patient's date of birth in MMDDCCYY format. 
11	Sex	Enter "M" for Male, "F" for Female or "U" for unknown. 
12	Admission Date	Enter the start date of this episode of care. Use the MMDDCCYY format. 
13	Admission Hour	Enter the hour (using a two-digit code below) that the patient entered the facility. 1:00 a.m. - 01 2:00 a.m. - 02 3:00 a.m. - 03 4:00 a.m. - 04 5:00 a.m. - 05 6:00 a.m. - 06 7:00 a.m. - 07 8:00 a.m. - 08 9:00 a.m. - 09 10:00 a.m. - 10 11:00 a.m. – 11 12:00 noon - 12 1:00 p.m. - 13 2:00 p.m. - 14 3:00 p.m. - 15 4:00 p.m. - 16 5:00 p.m. - 17 6:00 p.m. - 18 7:00 p.m. - 19 8:00 p.m. - 20 9:00 p.m. - 21 10:00 p.m. - 22 11:00 p.m. - 23 12:00 a.m. – 00 
14	Admit Type	Enter one of the following primary reason for admission codes: 1 = Emergency 2 = Urgent 3 = Elective

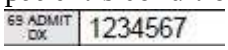
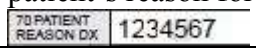
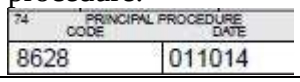
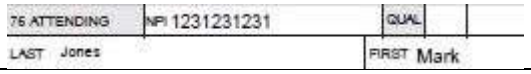
		4 = Newborn 5 = Trauma 9 = Information Not Available 
15	Source of Admission	Enter one of the following source of admission codes: 1 = Physician Referral 2 = Clinic Referral 3 = HMO Referral 4 = Transfer from Hospital 5 = Transfer from SNF 6 = Transfer From Another Health Care Facility 7 = Emergency Room 8 = Court/Law Enforcement 9 = Information Not Available In the Case of Newborn 1 = Normal Delivery 2 = Premature Delivery 3 = Sick Baby 4 = Extramural Birth 
16	Discharge Hour	Enter the hour (using a two-digit code below) that the patient was discharged from the facility. 1:00 a.m. - 01 2:00 a.m. - 02 3:00 a.m. - 03 4:00 a.m. - 04 5:00 a.m. - 05 6:00 a.m. - 06 7:00 a.m. - 07 8:00 a.m. - 08 9:00 a.m. - 09 10:00 a.m. - 10 11:00 a.m. - 11 12:00 noon - 12 1:00 p.m. - 13 2:00 p.m. - 14 3:00 p.m. - 15 4:00 p.m. - 16 5:00 p.m. - 17 6:00 p.m. - 18 7:00 p.m. - 19 8:00 p.m. - 20 9:00 p.m. - 21 10:00 p.m. - 22 11:00 p.m. - 23 12:00 a.m. – 00 
17	Patient Discharge Status	Enter the two-digit code for the patient's status (as of the "through" date). **See NUBC manual for specific codes.** 

18-28	Condition Codes	Enter two digit alpha numeric codes up to eleven occurrences to identify conditions that may affect processing of this claim. **See NUBC manual for specific codes.** 
29	Accident State	Enter two-digit state abbreviation, if applicable. 
30	Accident Date	Date accident occurred, if applicable in MMDDYY 
31-34	Occurrence Codes and Dates	Enter up to four code(s) and associated date(s) for any significant event(s) that may affect processing of this claim in format MMDDYY. **See NUBC manual for specific codes.** 
35-36	Occurrence Span	Enter the span of occurrence dates as indicated in 31 – 35 in MMDDYY format.
37		Not Required
38	Responsible Party Name and Address	Enter the responsible party name and address. Name should be entered in Last name, First name, MI format. 
39 - 41	Value Code and Amount	Enter up to three value codes to identify special circumstances that may affect processing of this claim, if applicable. **See NUBC manual for specific codes.** In the Amount box, enter the number, amount, or UCR value associated with that code. 
42	Revenue Code	Enter a four digit Revenue Code beside each service described in column 43. The first digit is a leading zero. **See NUBC manual for specific codes.**  After the last Revenue Code, enter "0001" corresponding with the Total Charges amount in column 47. (PAPER CLAIMS ONLY) 

43	Description	Enter a brief description that corresponds to the Revenue Code in column 42. 43 DESCRIPTION Emergency Room Visit List applicable NDC if field 44 is a J code which requires an NDC (see current J Code table). Report the N4 qualifier in the first two (2) positions, left justified, followed immediately by the 11 character NDC number. Immediately following the last character of the NDC (no space) the Unit of Measurement Qualifier immediately followed by the quantity with a floating decimal with a limit of 3 characters to the right of the decimal point. Unit of Measurement: F2 - International Unit GR - Gram ML - Milliliter UN - Unit To report more than one NDC per HCPC use the NDC attachment form. 43 DESCRIPTION N449230053010ML10
44	HCPC	Utilized for outpatient bills. 44 HCPCS / RATE / HIPPS CODE 1234567 If billing for an injectable code must display an NDC in field 43, if J code entered requires an NDC (see J code table). 44 HCPCS / RATE / HIPPS CODE J1756
45	Service Date	Enter the date this service was provided in MMDDYY format. 45 SERV. DATE 011014
46	Service Units	Enter the number of hospital accommodation days or units of service (such as pints of blood) which were rendered. 46 SERV. UNITS 1

47	Total Charges	Enter the total amount charged for each line of service. Also, enter the total of all charges after the last amount in this column.  
48	Non-Covered Charges	Enter the amount, if any that is not covered by the primary payer for this service.
50	Payer	Enter the three-digit carrier code and name of the primary payer on line A and other payers on lines B and C. (Medicaid is always the payer of last resort.) **If the patient has Medicaid only, enter "RI Medicaid" on line A.**   If Medicare is the primary payer, indicate Part A or Part B coverage. Carrier codes are found at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/carrier_code.pdf
51	Health Plan ID	The number used by the health plan to identify itself. Carrier codes are found at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/carrier_code.pdf
52	Release of Information	Enter "Y" for yes or "N" for no. 
53	Assignment of Benefits	Enter "Y" for yes. 
54	Prior Payments	Enter the amounts paid by the other insurance payers listed in field 50, if applicable. If payment is made by other insurance, proof of payment (e.g., EOB) must be attached to the claim form.
55	Estimated Amount Due	The amount estimated to be due.
56	National Provider Identifier Billing Provider (NPI)	Unique identifier assigned to the provider. Seven digit RI Medicaid Provider ID if not submitting NPI. 

57	Other Provider Identifier	**Taxonomy must be entered if NPI is entered in field 56**. This ID **must** be entered in line A,B,C that corresponds to the line in which the "RI Medicaid" payer information is entered in field 50. 
58	Insured's Name	If other health insurance is involved, enter the insured's name. 
59	Patient's Relationship to Insured	Enter the code for the patient's relationship to the insured. 01 = Spouse 18 = Self 19= Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship 
60	Insured's Unique Identifier	Enter recipient's Medicaid ID. This ID **must** be entered in line A,B,C that corresponds to the line in which the RI Medicaid payer information is entered in field 50. 
61	Group Name	Enter the name of insured's other group health coverage, if applicable.
62	Insurance Group Number	Enter insured's group number, if applicable.
63	Treatment Authorization Number	Number that designates that treatment has been Authorized, if applicable.
64	Document Control Number	Control number assigned to the original bill.
65	Employer Name	Name of employer providing health coverage.
66	Diagnosis and Procedure Code Qualifier	Enter 9 for ICD 9 coding or 0 for ICD-10 coding depending on date(s) of service. 
67	Principal Diagnosis Code on Admission	Enter the appropriate ICD diagnosis code that describes the nature of the illness or injury. 

67A - Q	Other Diagnosis Codes	Enter up to 16 ICD codes for other diagnoses. 
68		Not Required
69	Admitting Diagnosis Code	Enter the ICD diagnosis code that describes the patient's condition at the time of admission. 
70	Patient's Reason for Visit	Enter the ICD diagnosis code that describes the patient's reason for visit. 
71	PPS Code	Not Required
72	External Cause of Injury Code	Enter the ICD diagnosis code pertaining to external cause of injuries.
74	Principal Procedure Code and Date	Enter the ICD code that identifies the principal procedure performed. Enter the date of that procedure. 
74A-E	Other Procedure Codes	Enter other ICD codes identifying all significant procedures performed. Enter the date of those procedures.
75		Not Required
76	Attending Provider Name and Identifiers	Enter NPI of individual in charge of patient care. If UPIN number is entered, qualifier must be 1G. Enter the last and first name below. 
77	Operating Physician Name and Identifiers	Required when surgical procedure is performed. Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name.
78	Other Provider Name and Identifiers	Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name.
79	Other Provider Identifier	If required for your provider type, enter the NPI for the Ordering, Referring, or Prescribing provider.
80	Remarks Field/**Signature**	**Enter the provider signature or authorized agent's original signature.** Stamps, copies, or initials are not acceptable. Must be an original signature.
81cc	Code-Code Field	Enter B3 in the qualifier if fields 76-79 contain an NPI. **Enter the corresponding provider taxonomy of provider NPI's entered in locations** 76a – 81CCa 77b – 81CCb

		78c – 81CCc 79d – 81CCd