PEAK TPA
Third Party Administration

# Institutional UB-04 Billing Guidance

The National Uniform Billing Committee* (NUBC) was developed to maintain a single billing form and standard data sets to be used nationwide by institutional, private and public providers and payers for handling health care claims. The below table details all required elements for submitting standardized and non-standardized claims.

| **Claim Form Field Location** *(on the Standardized Claim Form)* | **Description** | **Inpatient** *(applies when using the Standardized Claim Form OR Non-Standardized Claim Form)* | **Outpatient** *(applies when using the Standardized Claim Form OR Non-Standardized Claim Form)* |
|---|---|---|---|
| 1 | Provider Name and Address | Required<br>▪ Address cannot be a PO Box or Lock Box<br>▪ Zip code must be 9 digits | Required<br>▪ Address cannot be a PO Box or Lock Box<br>▪ Zip code must be 9 digits |
| 2 | Pay-to-Name and Address | Situational<br>Address can be a PO Box or Lock Box | Situational<br>Address can be a PO Box or Lock Box |
| 3a | Patient Control Number | Required | Required |
| 3b | Medical Record Number | Situational | Situational |
| 4 | Type of Bill | Required | Required |
| 5 | Federal Tax Number | Required | Required |
| 6 | Statement Covers Period (from – through dates, beginning and end dates of service) | Required | Required |
| 7 | Untitled, data entered will be ignored | Not Required | Not Required |
| 8a | Patient ID | Situational | Situational |
| 8b | Patient Name | Required | Required |
| 9 | Patient Address | Required | Required |
| 10 | Patient Birthdate | Required | Required |
| 11 | Patient Sex | Required | Required |
| 12 | Admission Date | Required | Required for home health care and hospice |
| 13 | Admission Hour | Required, except for Type of Bill 021x | Not Required |
| 14 | Type of Admission/Visit | Required | Situational |
| 15 | Source of Admission | Required, except for Type of Bill 014x | Required, except for Type of Bill 014x |

| **Claim Form Field Location** *(on the Standardized Claim Form)* | **Description** | **Inpatient** *(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)* | **Outpatient** *(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)* |
|---|---|---|---|
| 16 | Discharge Hour | Required on all **final** inpatient bill, except for Type of Bill 021x | Not Required |
| 17 | Patient Discharge Status | Required | Required |
| 18 – 28 | Condition Codes | Situational<br>Required when there is a Condition Code that applies to the claim | Situational<br>Required when there is a Condition Code that applies to the claim |
| 29 | Accident State | Situational<br>Two-digit state abbreviation where accident occurred | Situational<br>Two-digit state abbreviation where accident occurred |
| 30 | Untitled, data entered will be ignored | Not Required | Not Required |
| 31 - 34 | Occurrence Codes and Dates | Situational<br>Required when there is an Occurrence Code that applies to the claim | Situational<br>Required when there is an Occurrence Code that applies to the claim |
| 35 - 36 | Occurrence Span Codes and Dates | Situational<br>Include when an Occurrence Span Code is used | Situational<br>Include when an Occurrence Span Code is used |
| 37 | Untitled, data entered will be ignored | Not Required | Not Required |
| 38 | Responsible Party Name and Address | Not Required | Not Required |
| 39 - 41 | Value Codes and Amounts | Situational<br><u>Paper Claims</u><br>Required when there is a Value Code that applies to the claim<br><br><u>Electronic Claims</u><br>N/A | Situational<br><u>Paper Claims</u><br>Required when there is a Value Code that applies to the claim<br><br><u>Electronic Claims</u><br>N/A |
| 42 | Revenue Code | Required | Required |

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|---|---|---|---|
| 43 | Revenue Description | <u>Paper Claims</u><br>Required if –<br>▪ Billing using an NDC number. NDC number must be preceded by N4.<br>▪ If billing for revenue codes 096x, 097x, & 098x <u>and</u> the rendering provider is different from fields 78-79, include individual provider NPI.<br><br><u>Electronic Claims</u><br>Required if –<br>▪ Billing using an NDC number. NDC number must be preceded by N4.<br>▪ If billing for revenue codes 096x, 097x, & 098x <u>and</u> the rendering provider is different from fields 78-79, include individual provider NPI.<br>**Refer to X12 Companion Guide for specific segments used** | <u>Paper Claims</u><br>Required if –<br>▪ Billing using an NDC number. NDC number must be preceded by N4.<br>▪ If billing for revenue codes 096x, 097x, & 098x <u>and</u> the rendering provider is different from fields 78-79, include individual provider NPI.<br><br><u>Electronic Claims</u><br>Required if –<br>▪ Billing using an NDC number. NDC number must be preceded by N4.<br>▪ If billing for revenue codes 096x, 097x, & 098x <u>and</u> the rendering provider is different from fields 78-79, include individual provider NPI.<br>**Refer to X12 Companion Guide for specific segments used** |

| **Claim Form Field Location** *(on the Standardized Claim Form)* | **Description** | **Inpatient** *(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)* | **Outpatient** *(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)* |
|---|---|---|---|
| 44 | HCPCS/Rate/HIPPS Code | See below | See below |
| | HCPCS / HIPPS | ▪ Required when an appropriate HCPCS or HIPPS code exists for the service line.<br><br>▪ HIPPS** codes must always be present when Revenue Code 0022, 0023, or 0024 is billed. | ▪ Required when an appropriate HCPCS or HIPPS code exists for the service line.<br><br>▪ HIPPS** codes must always be present when Revenue Code 0023 is billed. |
| | Accommodation Rate | Not Required | Not Required |
| | HCPCS Modifiers | Required when a modifier clarifies or improves the reporting accuracy of the associated procedure codes | Required when a modifier clarifies or improves the reporting accuracy of the associated procedure codes |
| 45 | Service Date | Required | Required |
| 46 | Units of Service | Required | Required |
| 47 | Total Charges | Required | Required |
| 48 | Non-Covered Charges | Situational | Situational |
| 49 | Untitled, data entered will be ignored | Not Required | Not Required |
| 50 A-C | Payer Identification | A = Required<br>B-C = Situational | A = Required<br>B-C = Situational |
| 51 A-C | Health Plan ID | A = Required<br>B-C = Situational | A = Required<br>B-C = Situational |
| 52 | Release of Info Certification | Not Required | Not Required |
| 53 | Assignment of Benefit Certification | Not Required | Not Required |
| 54 | Prior Payments | Situational | Situational |
| 55 | Estimated Amount Due from Patient | Not Required | Not Required |
| 56 | National Provider ID | Required<br>Atypical providers must submit 1234567893 | Required<br>Atypical providers must submit 1234567893 |
| 57 | Other Provider ID | Not Required | Not Required |
| 58 | Insured's Name | Required | Required |

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|---|---|---|---|
| 59 | Patient's Relationship to Insured | Required<br>Should be Self<br>(code 18) | Required<br>Should be Self<br>(code 18) |
| 60 | Insured's Unique ID | Required<br>Should be PeakTPA member ID number | Required<br>Should be PeakTPA member ID number |
| 61 | Insured's Group Name | Not Required | Not Required |
| 62 | Insured's Group Number | Not Required | Not Required |
| 63 | Treatment Authorization Code | Required if -<br>An authorization number is issued for the services | Required if –<br>An authorization number is issued for the services |
| 64 | Document Control Number | Required if –<br>Type of Bill (FL 04) indicates claim is a replacement or void to a previously adjudicated claim (type of bill 0xx7 or 0xx8) | Required if –<br>Type of Bill (FL 04) indicates claim is a replacement or void to a previously adjudicated claim (type of bill 0xx7 or 0xx8) |
| 65 | Employer Name | Not Required | Not Required |
| 66 | Diagnosis and Procedure Code Qualifier | Not Required | Not Required |
| 67 A-Q | Principal Diagnosis Code and Present on Admission (POA) Indicator (shaded area) | Principal Diagnosis = Required<br>POA = Situational<br>▪ Each diagnosis code should only be listed once<br>▪ List all diagnosis codes applicable to the services rendered | Principal Diagnosis = Required<br>POA = Situational<br>▪ Each diagnosis code should only be listed once<br>▪ List all diagnosis codes applicable to the services rendered |
| 68 | Untitled, data entered will be ignored | Not Required | Not Required |
| 69 | Admitting Diagnosis | Required<br>▪ Except Type of Bill 028x, 065x, 066x & 086x<br>▪ External Cause Diagnosis codes cannot be used in this field | Not Required |

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|---|---|---|---|
| 70 A-C | Patient's Reason for Visit | Not Required | Situational<br>Refer to the Medicare Transmittal 3435*** or subsequently published documentation |
| 71 | PPS Code (DRG) | Situational | Not Required |
| 72 A-C | External Cause of Injury Code and Present on Admission (POA) Indicator (shaded area) | Situational<br>▪ ECI Code: Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment<br>▪ POA: Follow Field 67 instructions | Situational<br>▪ ECI Code: Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment<br>▪ POA: Not Required |
| 73 | Untitled, data entered will be ignored | Not Required | Not Required |
| 74 A-E | Principal Procedure Code and Date | Required if -<br>▪ If a procedure was performed or<br>▪ Revenue Code 036x is present | Not Required |
| 75 | Untitled, data entered will be ignored | Not Required | Not Required |
| 76 | Attending Provider Name and Identifiers (including NPI) | Required<br><br>Name: Required<br><br>NPI: Required | Required<br><br>Name: Required when claim contains services other than non-scheduled transportation<br><br>NPI: Required |
| 77 | Operating Provider Name and Identifiers (including NPI) | Situational<br><br>Name: Required only when a surgical procedure is listed<br><br>NPI: Required | Situational<br><br>Name: Required only when a surgical procedure is listed<br><br>NPI: Required |

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|---|---|---|---|
| 78 – 79 | Other Provider Name and Identifiers (including NPI) | Situational<br><br>Used to report Referring, Other Operating Physician (Assistant Surgeon), Rendering Provider, or Ordering Provider<br><br>Use the following Qualifiers, if applicable:<br>DN – Referring Provider<br>ZZ – Other Operating Physician<br>82 – Rendering Provider<br>DK – Ordering Provider | Situational<br><br>Used to report Referring, Other Operating Physician (Assistant Surgeon), Rendering Provider, or Ordering Provider<br><br>Use the following Qualifiers, if applicable:<br>DN – Referring Provider<br>ZZ – Other Operating Physician<br>82 – Rendering Provider<br>DK – Ordering Provider |
| 80 | Remarks | Situational | Situational |
| 81 | Code – Code Fields | See below | See below |
| | 0 – A0 | Not Required | Not Required |
| | A1 – A4 | Not Required | Not Required |
| | A5 – AB | Not Required | Not Required |
| | AC – Attachment Control Number | Not Required | Not Required |
| | AD – B0 | Not Required | Not Required |
| | B1 – B2 | Not Required | Not Required |
| | B3 – provider taxonomy code | Required<br>use the appropriate taxonomy for the service rendered | Required<br>use the appropriate taxonomy for the service rendered |

Additional Information

*NUBC resources may be purchased by visiting https://www.nubc.org/subscription-information

**FL 44 HIPPS Codes - Refer to guidance found at: HIPPS Codes | CMS

***FL 70 A-C – Patient's Reason for visit, refer to Medicare Transmittal 3435 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3435CP.pdf

Please to refer to standard billing practices using the appropriate Medicare Claims Processing Manuals for guidance at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

For PACE plans, please also refer to your State guidelines for billing instructions.

Additional Instructions for Paper Billers:

- Do not make copies of claim forms as they are copywrited
- Do not alter the size of the claim form in any way
- When additional service lines are required, a multiple page claim may be used
- Typed claims are preferred over handwritten if handwritten claims are submitted, data elements MUST fit within the required spaces and are not be overlap into other fields or outside the lines
- Font used must be clear so that scanning equipment can read all letters/numbers, Arial, Calibri, or Times New Roman are the preferred fonts.
- All fields have a limited space/character count

**Audit History**

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