
CLAIMS PAYMENT

Policies Regarding Network Provider Payment

- Providers will be reimbursed by ValueOptions® of California at the contracted or negotiated rate for covered services.
- Providers will not be reimbursed for ValueOptions® of California benefit plan exclusions.
- A member can only be charged for the applicable account-specific co-payment, coinsurance or deductible portion of such rate for covered services.
- Members may not be charged for any fees above the contracted rates when claims are submitted by In-Network providers. The member must not be billed for the difference between the contracted provider's charge amount and the fee schedule. Providers must not bill members for services that would have been paid by ValueOptions® of California when the provider failed to follow the requirements of their agreement.
- Providers are not allowed to "balance-bill" members. This includes any balance billing because a claim was denied for failure to obtain a required authorization for care, or for timely filing.
- The signature in Block 31 of the CMS-1500 Form certifies that services were actually rendered by the provider signing the claim form.

New Transaction and Code Requirements

Under the Health Insurance Portability and Accountability Act (HIPAA), all covered entities must switch to the new transaction and code standards effective October 16, 2003. Technical instructions, Implementation and Companion Guides for these electronic transactions can be found on the ValueOptions® web site at www.valueoptions.com. In using this system, ValueOptions® of California and providers must:

- i. Not change any definition, data condition or use of a data element or segment as proscribed in the Health and Human Services (HHS) Transaction Standard Regulation. (45 CFR 162.915(a)).
- ii. Not add any data elements or segments to the maximum defined data set as defined in the HHS Transaction Standard Regulation. (45 CFR 162.915 (b)).
- iii. Not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (C)).
- iv. Not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (d)).

Providers understand that there exists the possibility that ValueOptions[®] of California or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, providers will participate in such test modification. Providers understand that from time-to-time, HHS may modify and set compliance dates for HHS Transaction Standards. Providers will comply with any such modifications or changes. ValueOptions[®] of California and its providers all agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer.

Prohibition of “Balance Billing”

ValueOptions[®] of California defines balance billing under the *Participating Provider Responsibilities* section of this same Handbook.

Non-Certified Services

In the event that a provider fails to secure the required authorization/certification from ValueOptions[®] of California for services that are included in the member’s plan, the member shall not be held liable for the cost of the services. Providers may bill the member for services that are included in the member’s plan but that are not certified as medically necessary *only* if the provider has followed the procedures set forth in the provider’s contract. In the event that ValueOptions[®] of California notifies the provider that the proposed treatment or services for a member will not be certified, or treatment or services for a member which had been will no longer continue to be certified, the provider may initiate an appeal of such non-certification by following the appeal procedures of ValueOptions[®] of California. The provider must inform the member of the grievance/appeal process at ValueOptions[®] of California. At the time of the first denial, the provider may inform the member of the denial and seek written consent from the member to be financially responsible for the non-certified treatment. However, the provider must continue and complete the appeals process before directly billing the member.

Billing for Missed Appointments

ValueOptions[®] of California does not authorize payment to providers for missed appointments, nor may a member be billed unless he or she has agreed, in writing, to pay out-of-pocket for any missed appointments at the start of treatment.

Maximum Visits per Day

Plans administered by ValueOptions[®] of California provide benefits for only *one* professional service per day except for the following:

- Outpatient psychotherapy with a non-psychiatrist provider and medication management with a provider psychiatrist on the same day
- Outpatient psychotherapy and psychological testing on the same day

- Emergency Room charges on the same day, same or different facility can be paid as long as they both have different admit times.
- EAP and Outpatient Services can be paid on the same day if services are rendered by different providers.
- Lab and Outpatient services on the same day+

Diagnostic Evaluation

A 90-minute diagnostic evaluation will be reimbursed when it is performed in the first session with a new patient.

Changes to your Provider Record

ValueOptions® of California provides information on how to update your demographic information under the *Participating Provider Responsibilities* section of this same Handbook.

Claim Submission Guidelines

Timely and accurate processing of claims is important to ValueOptions® of California. Following the instructions below will facilitate efficient processing of your claim within acceptable timeframes.

- Clean claims must be submitted electronically or on one of the two national industry standard billing forms, both of which have been updated this year and include new fields for the National Provider Identifier and Taxonomy codes.
 - **Definitions:**
 - **NPI – National Provider Identifier** – is the single provider identifier, replacing the different provider identifiers currently used for each health plan with which you do business. This identifier, which implements a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by most HIPAA covered entities, which are health plans, health care clearinghouses, and health care providers that conduct electronic business for which the Secretary had adopted a standard (i.e. standard transactions).
 - **Taxonomy Code** – The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct “levels” including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. A list of the valid Taxonomy codes begins on Page 34 of this document.

⇒ Center for Medicare and Medicaid Services/CMS-1500 All CMS-1500 claims received on or after April 2, 2007 must be submitted on the new version of the CMS-1500 claim form or Uniform Billing Form/UB04 ;or

⇒ HCFA-1450; As of May 23, 2007, all Uniform Billing claims must be received on the new UB04 (CMS-1450) claim form.

- Completed claim forms may be mailed to the following address:

ValueOptions®, Inc.
P.O. Box 1290
Latham, NY 12110

Claims Submission Tips

- A separate claim form must be submitted for each member for whom the provider bills and it must contain all of the required data elements.
- Please limit each billing line to one date of service and one procedure code.

Coordination of Benefits (COB): COB claims can *only* be submitted on a paper claim. Explanation of Benefits (EOB) from the primary carrier must be submitted along with the claim. If the EOB is not received with the claim, the claim will be denied.

- **Duplicate Claim:** ValueOptions® of California strives to have 100% of all claims processed within 30 calendar days of receipt. If notification is not received within 30 calendar days, please take the following steps prior to submitting a duplicate claim:
 - ⇒ If the original claim was submitted on paper (rather than electronically), wait 30 calendar days from the date you submitted the claim before contacting ValueOptions® of California Customer Service to verify receipt and determine next steps. The Customer Service number can be located on the back of the member's insurance card.
 - ⇒ If the original claim was submitted electronically, access the claim status inquiry through our online services at www.valueoptions.com to verify that the claim was accepted.
 - ⇒ When resubmitting a previously denied claim, please indicate on the claim that this is a resubmission. Please **do not add new services** that were not included on the original claim, these should be submitted separately.
- **Itemized bill is needed:** All pertinent information is necessary to process a claim promptly and accurately. Please make sure to include the following elements when submitting a claim:

- ⇒ Dates of service should be listed individually on CMS-1500 claim forms (NO DATE SPANS).
- ⇒ Valid ICD-9 diagnosis codes (NOTE: ICD-9 diagnosis codes are required for Electronically submitted claims.)
- ⇒ Rendering provider and provider billing information, including tax identification number entered in appropriate areas of UB04 and CMS1500 forms.
- ⇒ Appropriate and valid place of service codes with correlating appropriate and valid CPT codes (and Revenue codes, when billing on a UB04 (CMS-1450).
- ⇒ Accurate member/patient information including member identification number, member name and Date of Birth. Please do not use nicknames.
- **Authorization and claim must match:** The services billed must correspond to the care that was authorized. In order for payment to occur, the procedure/revenue code and dates of service must match those authorized.

Claims Payment

The use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. This technology enables ValueOptions® of California to shorten turnaround time and improve quality. The following elements are required to take advantage of this automated process. If you do not follow the guidelines, your claim will still be processed, however, it will require manual intervention and may take longer to process.

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use white out or correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212009)
- Use a fixed width font (Courier, for example)

Clean Claims

Providers must file claims for covered services in the form and manner required by ValueOptions® of California as specified below (herein referred to as a “clean claim”). Clean claims must be *received* by ValueOptions® of California within 90 calendar days from the date of service. A clean claim is a UB-04 or CMS-1500, submitted by a provider for medical care or

health care services rendered to a covered member which accurately contains information including, but not limited to:

- Patient's name and date of birth
- Covered Member's identification number
- Date(s) and place of service or purchase
- Services and supplies provided
- ICD-9 code
- CPT-4 code (and Revenue Code for UB-04 (CMS1450) billing)
- Provider's name, address and tax identification number
- Provider's National Provider Identifier (NPI)
- Taxonomy Code (on claims submitted electronically)
- Provider's license number
- Provider's charges
- Other information or attachments that may be mutually agreed upon by the parties in writing

In addition, the claims must be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the provider agrees to cooperate by providing any information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage and health status. All billings by the provider will be considered final unless a provider dispute request is received by ValueOptions® of California within 60 calendar days from the date indicated on the Explanation of Benefits form sent by ValueOptions® of California.

Reimbursement is based upon certification for services covered under the member's benefit plan and the member's eligibility at the time of service.

Note: In California there are extensive rules and regulations that pertain to the processing of claims by health care service plans, which apply to ValueOptions® of California and providers. These additional claims processing requirements and Provider Dispute guidelines are described in ValueOptions® of California's policies and procedures. You can obtain a copy of these policies by contacting the Provider Relations Department or under the *Provider Dispute and Member Grievances* section of this same Handbook.

Electronic Submission

Providers may elect to file claims electronically, and are in fact encouraged to do so. Online Provider Services at ValueOptions® of California are designed to give providers easy access to eligibility inquiry, claims status inquiry, authorization inquiry, and electronic claims. These services are provided at no cost. Submitting claims electronically improves accuracy, increases the speed of claim payment and reduces your administrative office costs.

- **Note:** If you submit electronic claims to ValueOptions® of California, please note that as of October 16, 2003 ValueOptions® of California will only accept claims transactions in standard HIPAA 837 format, as delineated by the Health Insurance Portability and Accountability Act (HIPAA). To obtain further information regarding claims transactions access www.valueoptions.com, select “For Providers”, and click on “Compliance” proceed to review the HIPAA section. ProviderConnect is our 24 hours a day, seven days a week tool which can be used by providers to check on the status of claims and payments made. You may also use ProviderConnect to review your authorizations; you may identify the number of units paid against the authorization as well as the number of open units remaining on the authorization. It is the online tool providers use to submit electronic claims. Also located at this site is the ValueOptions® Provider Guide to using Single Claim Submission; this is a valuable resource to assist providers with claims submission and can be located at www.valueoptions.com.
- **Note:** Claims received on or after May 23, 2007 must be submitted with the provider’s National Provider Identifier (NPI), regardless of the method of submission. Failure to submit claims with the NPI may result in rejection of a claim file to the system and may result in the denial of claims. Please note, this date is regardless of the date of service on the claim form. Electronic claims must also be received with the provider’s Taxonomy Code. Failure to submit an electronic claim with this required information will be rejected and will not be uploaded to the claims processing system.

Filing Requirements for Claims

Timeliness

ValueOptions® of California must receive clean claims for all services rendered within 90 calendar days from the date of service or date of discharge. ValueOptions® of California will not be responsible for payment of claims for covered services not received within 90 calendar days of the rendering of such services unless the provider can demonstrate good cause for such delay, as determined in accordance with the ValueOptions® of California provider dispute resolution mechanism. Providers are prohibited from billing members for such services.

Incomplete Claims Are Not Clean Claims

Claims with invalid or incomplete information will be **denied** with an Explanation of Benefit advising the provider of the incorrect or invalid information. The provider should send a “corrected” claim to ValueOptions® of California providing the updated information for reconsideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher will not be considered for payment. If ValueOptions® of California is unable to locate a member’s ID number (e.g. social security number or in some instances a member-specific identification number assigned by the member’s employer) provided on the claim form, the claim will be denied, with an Explanation of Benefit indicating the member is unknown. If possible, ValueOptions® of California will indicate the member’s name in the patient account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim sent for consideration. Please be sure to send all requested information within the ValueOptions® of California specific timely filing guidelines.

Coordination of Benefits Payment Methodologies

One of the primary reasons for delays in claims processing is the lack of information necessary to coordinate benefits across multiple payers. The following tips are designed to assist you in reducing payment delays attributed to coordination of benefits related issues.

- Ask each member if they have coverage through multiple payers.
- If the member does not have other coverage and the services are being submitted on a CMS-1500, please make sure that field 11 (d) indicates “NO.” If other coverage is available, the other insured information in box 9 (a-d) needs to be completed.
- Determine the primary and secondary payers.
- Attach the Explanation of Benefits from the primary payer (or payers) when submitting the claim as secondary or tertiary.

Coordination of Benefits

COB claims can *only* be submitted on a paper claim. Explanation of Benefits (EOB) from the primary carrier must be submitted along with the claim. If the EOB is not received with the claim, the claim will be denied.

Third Party Liability/Coordination of Benefits

As part of their contract with ValueOptions® of California, providers agree to cooperate with ValueOptions® of California to provide any information reasonably requested in connection with claims and to obtain necessary information related to the coordination of benefits. Providers also agree to make reasonable efforts to determine whether members have insurance or other health care coverage other than ValueOptions® of California and will promptly report any duplicate coverage to ValueOptions® of California. Providers understand and agree that the coordination of benefit rules of ValueOptions® of California will determine payment made to the provider and that, in no event, shall ValueOptions® of California be obligated to pay the provider any portion of a secondary payment whereby the sum of the primary payment plus the secondary payment exceeds the compensation specified in the reimbursement schedule. Other requirements include:

- The provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered services.
- When the primary insurance carrier has made a decision regarding reimbursement, a copy of the disposition (EOB) must accompany the CMS-1500 or UB04 claim submission to ValueOptions of California® to ensure accurate coordination of benefits payment.
- All timely filing rules are applied and enforced from the date of the primary insurance carrier’s disposition.
- Coordination of Benefits Payment methodologies vary by contract.

Nursing Home Services

Services rendered in a nursing home setting may be considered as outpatient rather than inpatient. It is important to ensure the billed service code represents an outpatient service. For further assistance, contact the Customer Service team at the toll-free number found on the member's insurance card.

SMI/SED Plan Services

ValueOptions® of California may contract directly with a Client group to provide covered services for certain behavioral health conditions on the same terms and conditions ("parity") as with the Client's medical plan. The "parity" plan includes Covered Services provided for Mental Disorders which include Severe Mental Illnesses (SMI) of a person of any age and Serious Emotional Disturbances (SED) of a minor child under the age of eighteen (18) years. Providers agree to render covered services, including those services for treatment of SMI and SED, in accordance with all applicable terms and conditions set forth in the Behavioral Services Agreement entered into by and between ValueOptions® of California and a client. Co-payments, out-of-pocket maximums, benefit and lifetime maximums for SMI/SED services are subject to the same requirements and provisions as in effect for a member's medical and hospital plan.

Provider Disputes – Claim Appeals and Grievances

A provider has the right to dispute ValueOptions® of California claims determination. Provider disputes for an individual claim, billing dispute, or other contractual dispute, or disputes related to demonstrable and unfair plan payment patterns must be submitted in writing and received by ValueOptions® of California within 365 calendar days from the date of the plan action (or the most recent plan action if there are multiple actions) that led to the dispute. (Example: A disputed claim decision must be submitted within 365 calendar days from the date on the ValueOptions® of California Explanation of Benefits.)

The Provider Dispute guidelines are described in ValueOptions® of California's policies and procedures. You can obtain a copy of these policies by contacting the Provider Relations Department or under the *Provider Dispute and Member Grievances* section of this same Handbook.

ERISA Claims Rules and Procedures

On July 1, 2002, federal regulations for claims and appeals for employer-sponsored health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) went into effect. For more information regarding how these rules affect the filing of claims and appeal of denied claims, please contact our National Provider Line at **(800) 397-1630**, Monday through Friday, between 8:30 AM and 5:00 PM EST.

BILLING INSTRUCTIONS

Tips for Completing the CMS-1500 Claim Form

Field Number	Field Description	Data Type	Instructions
Member Information (Fields 1-13)			
1	Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box (e.g., if a Medicare claim is being filed, check the Medicare box).
1a	Insured's ID Number	Required	List the Insured's identification number here. Verify that the identification number corresponds to the insured listed in item 4. The patient and the insured are not always the same person. Some payers assign unique identification numbers to each enrollee or dependent and require the number of the enrollee or dependent receiving services (the patient) instead of the insured's number in this item.
2	Patient's Name	Required	Enter the patient's last name, first name, and middle initial, if any. NOTE: If the patient has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not use any punctuation in this field.
3	Patient's birth date and gender	Required	Enter the patient's birth date and sex. Use the eight digit format (MM DD CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the patient. Only one box can be marked. If the gender is unknown, leave blank.
4	Insured's name	Required	Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name.

Field Number	Field Description	Data Type	Instructions
5	Patient's address, city, state, zip code, and telephone number	Required	<p>Enter the patient's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
6	Patient's relationship to the insured	Required	<p>Check the appropriate box for the patient's relationship to the insured when item 4 is completed. Remember that the patient's relationship to the insured is not always "self".</p>
7	Insured's address, city, state, zip code, and telephone number	Required	<p>Enter the insured's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). When the address is the same as the patient's enter the word "same". Complete this item only when items 4 and 11 are completed.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
8	Patient's status	Required	<p>Check the appropriate box for the patient's marital status and whether employed or a student.</p>
9	Other insured's name	Conditional	<p>Conditional Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.</p>

Field Number	Field Description	Data Type	Instructions
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.
9b	Other insured's date of birth	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.
9c	Other insured's employer's name or school name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.
10a-c	Is the patient's condition related to: <ul style="list-style-type: none"> • Employment? • Auto accident? • Other accident? 	Required	Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.
10d	Reserved for local use	Not Required	Please leave blank.

Field Number	Field Description	Data Type	Instructions
11	Insured's policy group or FECA number	Optional	Enter the Insured's policy or group number as it appears on the insured's health care identification card.
11a	Insured's date of birth and sex	Conditional	Required if the patient is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3.
11b	Employer name or school name	Conditional	Enter the insured's employer's name, if applicable. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.
11c	Insurance plan name or program name	Conditional	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Required Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.
12	Patient's or authorized person's signature (Medicaid/other information release)	Conditional	<p>The patient <i>must</i> sign and date the claim <i>if</i> authorizing the release of medical information. If "signature on file" is indicated, the provider <i>must</i> maintain a signed release form or CMS-1500 (formally HCFA 1500).</p> <p>The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.</p>
13	Insured's or authorized person's signature	Conditional	The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature are acceptable. If there is no signature on file leave this item blank or enter "no signature on file".
Provider of Service or Supplier Information (Fields 14-33)			
14	Date of current illness, injury, or pregnancy	Not required	Not applicable.
15	If patient has had same or similar illness, give first date	Not required	Not applicable.

Field Number	Field Description	Data Type	Instructions
16	Dates patient unable to work in current occupation	Conditional	Required if the patient is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the patient was unable to work in MMDDYY or MMDDCCYY format.
17	Name of referring physician or other source	Conditional	Enter the name of the referring physician or other source if applicable.
17a	ID number of referring physician	Conditional	<p>The CMS-assigned UPIN of the referring or ordering physician listed in Field 17. Enter only the seven-digit base number and the one-digit check digit.</p> <p>NOTE: The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.</p> <p>The other ID number of the referring provider, ordering provider, or other source should be reported in 17a in the shaded area. The qualifier indicating what the number represents should be reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:</p> <ul style="list-style-type: none"> • 0B – State license number • 1B – Blue Shield provider number • 1C – Medicare provider number • 1D – Medicaid provider number • 1G – Provider UPIN number • 1H – CHAMPUS identification number • EI – Employer's identification number • G2 – Provider commercial number • LU – Location number • N5 – Provider plan network identification number • SY – Social Security number (The Social Security number may not be used for Medicare) • X5 – State industrial accident provider number • ZZ – Provider taxonomy – A list of the valid Taxonomy codes begins on Page 38.

Field Number	Field Description	Data Type	Instructions
17b	NPI	Required	Enter the NPI of the referring or ordering physician listed in item 17 as soon as it is available. The NPI may be reported as of October 1, 2006. NOTE: Field 17a and / or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.
18	Hospitalization dates related to current services	Conditional	Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.
19	Reserved for local use	Conditional	If billing for intensive outpatient programs, please write "IOP" in this space.
20	Outside lab/charges	Conditional	Enter if lab tests performed and billed on this claim were processed by a lab outside the provider's premises.
21.1-4	Diagnosis or nature of illness injury	Required	Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.)
22	Medicaid resubmission code/original reference number	Conditional	List the original reference (claim) number for resubmitted claims.
23	Prior authorization number	Not Required	Not applicable.
24a	Dates of Service	Required	Enter "From" and "To" dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C.
24b	Place of Service	Required	Enter the appropriate place of service code from the list provided beginning on Page 19.
24c	EMG	Not Required	Not applicable.
24d	Procedures, services, or supplies CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.

Field Number	Field Description	Data Type	Instructions
24d	Modifier	Conditional	<p>Enter a valid CPT or HCPCS code modifier for each service entered.**</p> <p>HIPAA: Billing Code Modifiers ** When submitting a CPT or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below:</p> <p>Modifier ONE: This field is dedicated for modifiers that affect or define the service (e.g., TG modifier to identify a ‘complex high level of care’)</p> <p>Modifier TWO: This field is dedicated for modifiers that identify pricing (e.g., HA modifier to identify ‘child/adolescent’ or HN modifier to identify ‘bachelors level’)</p> <p>Modifier THREE & FOUR: These fields are dedicated for modifiers that identify statistics (e.g., HV ‘funded by State Addictions Agency’)</p> <p>If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.</p>
24e	Diagnosis pointer	Conditional	<p>Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, either a 1, 2, 3 or 4, is shown. <i>Do not</i> enter the ICD-9 diagnosis code.</p>
24f	Charges	Required	<p>Enter the provider’s billed charges for each service.</p>
24g	Days or units	Required	<p>Enter the appropriate number of units or days that correspond to the “From” and “To” dates indicated in Field 24a.</p>
24h	EPSDT family plan	Conditional	<p>If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.</p>

Field Number	Field Description	Data Type	Instructions
24i	ID Qual.	Conditional	If the provider does not have an NPI, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	Rendering Provider ID#	Required	Enter the NPI number in the un-shaded area of the field.
25	Federal Tax ID number and type: • Social Security Number or • Employer Identification Number	Required	Required Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Patient's account number	Optional	Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher.
27	Accept Assignment?	Required	Enter an "X" in the appropriate box.
28	Total Charge	Required	Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f.
29	Amount Paid	Conditional	Enter the total amount paid by the patient for services billed on this claim.
30	Balance Due	Conditional	Enter the total balance due for the services less any amount entered in Field 29.
31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care <i>must</i> sign and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter name and address where services are rendered.
32a	a.	Required	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
32b	b.	Not Required	Not applicable
33	Physician's/supplier's billing: name, address, zip code and phone	Required	Enter the appropriate billing information

Field Number	Field Description	Data Type	Instructions
33a	PIN number	Required	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.
33b	Group number	Not Required	Not Applicable after May 23, 2007

Place of Service Codes (Field 24B)

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients
02	Unassigned	N/A
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Place of Service Code(s)	Place of Service Name	Place of Service Description
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention
21	Inpatient Hospital	A facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

Place of Service Code(s)	Place of Service Name	Place of Service Description
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

Place of Service Code(s)	Place of Service Name	Place of Service Description
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, or orthotic and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Tips for Completing the UB04 (CMS-1450) Claim Form

Field	Field description	Field type	Instructions
1	Provider name, Address, Telephone Number, and Country Code	Required	This field contains the name, complete mailing address, telephone number, fax number, and country code of the provider submitting the bill.
2	Pay-to Name and Address	Required	This field contains the address to which payment should be sent if different from the information in Field 1.
3a	Patient Control Number	Optional	Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.
3b	Medical / Health Record Number	Optional	In this field, report the patient's medical record number as assigned by the provider.
4	Type of Bill	Required	This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The fourth digit defines the frequency of the bill for professional claims. The leading zero should not be reported on electronic claims. Refer to Attachment B for valid codes.
5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified using federal tax sub-IDs.
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.
7	Reserved for Assignment by the NUBC	Not Required	N/A
8a	Patient Identifier	Required	This field is for the patient's identification number.
8b	Patient Name	Required	This field is for the patient's last, middle initial, and first name.
9a	Patient Address	Required	This field is for entering the patient's street address.
9b	(unlabeled field)	Required	This field is for entering the patient's city.

Field	Field description	Field type	Instructions
9c	(unlabeled field)	Required	This field is for entering the patient's state code.
9d	(unlabeled field)	Required	This field is for entering the patient's ZIP code.
9e	(unlabeled field)	Required	This field is for entering the patient's Country Code.
10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Sex	Required	Use this field to identify the sex of the patient.
12	Admission Date / Start of Care Date	Required	Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.
13	Admission Hour	Required	Enter the hour in which the patient is admitted for inpatient or outpatient care. NOTE: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section.
14	Priority (Type) of Visit	Required	Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.
15	Source of Referral for Admission or Visit	Required	This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.). See valid codes at the end of this section.
16	Discharge Hour	Conditional	This field is used for reporting the hour the patient is discharged from inpatient care. NOTE: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section.
17	Patient Discharge Status	Required	Use this field to report the status of the patient upon discharge – required for institutional claims. See valid codes at the end of this section.
18 – 28	Condition Codes	Conditional	Use these fields to report conditions or events related to the bill that may affect the processing of it. See valid codes at the end of this section.

Field	Field description	Field type	Instructions
29	Accident State	Conditional	When appropriate, assign the two-digit abbreviation of the state in which an accident occurred.
30	Reserved for Assignment by the NUBC	Not Required	N/A
31 – 34	Occurrence Codes and Dates	Conditional	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.).
35 – 36	Occurrence Span Codes and Dates	Conditional	This field is for reporting the beginning and end dates of the specific event related to the bill.
37	Reserved for Assignment by the NUBC	Not Required	N/A
38	Responsible Party Name and Address	Required	This field is for reporting the name and address of the person responsible for the bill.
39 - 41	Value Codes and Amounts	Required	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers.
42	Revenue code	Required	Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001.
43	Revenue Description	Optional	This field is used to report the abbreviated revenue code categories included in the bill.
44	HCPCS / Rate / HIPPS Code	Conditional	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.
45	Service Date	Conditional	Indicates the date the outpatient service was provided and the date the bill was created using the six-digit format (MMDDYY).
46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.
47	Total Charges	Required	This field reports the total charges – covered and non-covered – related to the current billing period.

Field	Field description	Field type	Instructions
48	Non-Covered Charges	Conditional	This field indicates charges that are non-covered charges by the payer as related to the revenue code.
49	Reserved for Assignment by the NUBC	Not Required	N/A
50a, b, c	Payer Name	Required	Enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification Number	Required	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.
52a, b, c	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement form the member to release information. Refer to Attachment B for valid codes.
53a, b, c	Assignment of Benefits Certification Indicator	Required	Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.
54a, b, c	Prior Payments	Conditional	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.
55a, b, c	Estimated Amount Due	Not required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.
56	National Provider Identifier – Billing Provider	Required	This field is for reporting the unique provider identifier assigned to the provider.
57	Other Provider Identifier – Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field.
58a, b, c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial.
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a, b, c	Insured's Unique Identification	Required	This is the unique number the health plan assigns to the insured individual. The ID Number from the Member's Insurance Card should be entered.

Field	Field description	Field type	Instructions
61a, b, c	Group Name	Required	Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured.
62a, b, c	Insurance Group Number	Conditional	Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the insured.
63a, b, c	Treatment Authorization Codes	Optional	Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized.
64a, b, c	Document Control Number	Not Required from the Provider	This number is assigned by the health plan to the bill for their internal control.
65a, b, c	Employer Name (of the Insured)	Conditional	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Required	This qualifier is used to indicate the version of ICD-9-CM being used. A "9" is required in this field for the UB-04.
67	Principal Diagnosis Code	Required	Enter the valid ICD-9-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered.
67 a - q	Other Diagnosis Codes	Conditional	This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay.
68	Reserved for Assignment by the NUBC	Not Required	N/A
69	Admitting Diagnosis	Required	Enter a valid ICD-9-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission.
70 a - c	Patient's Reason for Visit	Conditional	The ICD-9-CM codes that report the reason for the patient's outpatient visit is reported here.
71	Prospective Payment System (PPS) Code	Not required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan.
72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse affects, the appropriate ICD-9-CM diagnosis code is reported in this field.

Field	Field description	Field type	Instructions
73	Reserved for Assignment by the NUBC	Not Required	N/A
74 a – e	Other Procedure Codes and Dates	Conditional	This field is used to report the principal ICD-9-CM procedure code covered by the bill and the related date.
75	Reserved for Assignment by the NUBC	Not Required	N/A
76	Attending Provider Names and Identifiers	Required	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim.
77	Operating Physician Name and Identifiers	Conditional	Report the name and identification number of the physician responsible for performing surgical procedure in this field.
78 – 79	Other Provider Names and Identifiers	Conditional	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.
80	Remarks Field	Not Required	This field is used to report additional information necessary to process the claim.
81 a – d	Code – Code Field	Conditional	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set.

UB04 (CMS-1450) REFERENCE MATERIAL¹

Type of Bill Codes (Field 4)

This is a four-digit code; each digit is defined below.

First Digit- Leading Zero Second Digit – Type of Facility	Description of First Digit
01XX	Hospital
02XX	Skilled Nursing
03XX	Home Health Facility
04XX	Religious Non-medical Health Care Institutions (RNHCI) – Hospital Inpatient
05XX	Reserved for National Assignment
06XX	Intermediate Care
07XX	Clinic (Requires Special Reporting for the Second Digit)
08XX	Special Facility or ASC Surgery (Requires Special Reporting for the Second Digit)
09XX	Reserved for National Assignment

Third Digit – Bill Classification	Description of Third Digit Except for Clinics and Special Facilities
X1X	Inpatient (Including Medicare Part A)
X2X	Inpatient (Medicare Part B Only) (Includes HHA Visits Under a Part B Plan of Treatment)
X3X	Outpatient (Includes HHA Visits Under a Part A Plan of Treatment Including DME Under Part A)
X4X	Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment
X5X	Intermediate Care Level I
X6X	Intermediate Care Level II
X7X	Reserved for National Assignment
X8X	Swing Beds
X9X	Reserved for National Assignment

Third Digit – Bill Classification	Description of Third Digit Classification for Clinics Only
X1X	Rural Health Clinic
X2X	Clinic – Hospital Based or Independent Renal Dialysis Center
X3X	Freestanding
X4X	ORF
X5X	CORF
X6X	CMHC
X7X	Reserved for National Assignment
X8X	Reserved for National Assignment
X9X	Other

Third Digit – Bill Classification	Description of Third Digit Classification for Special Facility Only
X1X	Hospice (Non-hospital based)
X2X	Hospice (Hospital based)
X3X	Ambulatory Surgery Center
X4X	Freestanding Birthing Center
X5X	Critical Access Hospital
X6X	Residential Facility (Not used for Medicare)
X7X	Reserved for National Assignment
X8X	Reserved for National Assignment
X9X	Other (Not used for Medicare)

Fourth Digit – Frequency of the Bill	Description of Fourth Digit Frequency of the Bill
XX0	Nonpayment / Zero Claim
XX1	Admit through Discharge Claim
XX2	Interim – First Claim
XX3	Interim – Continuing Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX4	Interim – Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX5	Late Charges Only Claim
XX6	Reserved National Assignment
XX7	Replacement of Prior Claim
XX8	Void / Cancel of a Prior Claim
XX9	Final Claim for a Home Health PPS Episode

¹ Ingenix © Uniform Billing Editor, December, 2006

Sex Codes (Field 11)

Code	Definition
M	Male
F	Female
U	Unknown

Type of Admission Codes (Field 14)

Code	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6 – 8	Reserved for National Assignment
9	Information Not Available

Source of Admission Codes Except Newborns (Field 15)

Code	Definition
1	Physician Referral
2	Clinic Referral
3	Discontinued
4	Transfer From a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility or Intermediate Care Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Reserved
B	Transfer from Another HHA
C	Readmission to Same HHA
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer
E	Transfer from Ambulatory Surgery Center
F	Transfer from Hospice and is Under Hospice Plan of Care or Enrolled in a Hospice Program
G – Z	Reserved for National Assignment

Additional Source of Admission Codes for Newborns (Field 15)

Code	Definition
1-4	Discontinued
5	Born inside this Hospital
6	Born Outside this Hospital

7-8	Reserved National Assignment
9	Discontinued

Patient Status (Field 17)

Code	Definition
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged / Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged / Transferred to a SNF with Medicare Certification in Anticipation of Covered Skilled Care
04	Discharged / Transferred to an Intermediate Care Facility
05	Discharged / Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in This Code List
06	Discharged / Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
08	Reserved for National Assignment
09	Admitted as an Inpatient to This Hospital
10 – 19	Reserved for National Assignment
20	Expired
21 - 29	Reserved for National Assignment
30	Still a Patient
31-39	Reserved for National Assignment
40	Expired at Home (for hospice care only)
41	Expired in a Medical Facility such as a Hospital, SNF, ICF or Free-Standing Hospice (for hospice care only)
42	Expired, Place Unknown (for hospice care only)
43	Discharged / Transferred to a Federal Health Care Facility
44 – 49	Reserved for National Assignment
50	Discharged to Hospice, Home
51	Discharged to Hospice, Medical Facility
52 – 60	Reserved for National Assignment
61	Discharged / Transferred Within This Institution to a Hospital-Based Medicare Approved Swing Bed
62	Discharged / Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63	Discharged / Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged / Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare

Code	Definition
65	Discharged / Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharges / Transfers to a Critical Access Hospital
67 – 69	Reserved for National Assignment
70	Discharged / Transferred to Another Type of Healthcare Institution Not Elsewhere Defined in this Code List (Effective October 1, 2007)
71 – 99	Reserved for National Assignment

Release of Information Indicator Codes (Field 52)

Code	Definition
Y	Yes
R	Restricted or Modified Release
N	No Release

Member's Relationship to the Insured Codes (Field 59)

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Member's Relationship to the Insured Codes for 837i only

Code	Definition
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child

20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where insured Has No Financial Responsibility
53	Life Partner
G8	Other Relationship

Valid Taxonomy Codes

100000000X	BH & SOCSERV PROVIDERS
101YA0400X	BH & SOCIAL SERVICE, COUNSELOR, ADDICTION (SUBSTAN
101YM0800X	BH & SOCIAL SERVICE, COUNSELOR, MH
101YP1600X	BH & SOCIAL SERVICE, COUNSELOR, PASTORAL
101YP2500X	BH & SOCIAL SERVICE, COUNSELOR, PROFESSIONAL
101YS0200X	BH & SOCIAL SERVICE, COUNSELOR, SCHOOL
101Y00000X	BH & SOCIAL SERVICE, COUNSELOR
103GC0700X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST, CLINICAL
103G00000X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST
103TA0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADDICTION (SUBS
103TA0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADULT DEVELOPME
103TB0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, BEHAVIORAL
103TC0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CLINICAL
103TC1900X	BH & SOCIAL SERVICE, PSYCHOLOGIST, COUNSELING
103TC2200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CHILD, YOUTH &
103TE1000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EDUCATIONAL
103TE1100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EXERCISE & SPOR
103TF0000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FAMILY
103TF0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FORENSIC
103TH0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, HEALTH
103TM1700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MEN & MASCULINI
103TM1800X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MENTAL RETARDAT
103TP0814X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOANALYSIS
103TP2700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY
103TP2701X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY,
103TR0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, REHABILITATION
103TS0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, SCHOOL
103TW0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, WOMEN

103T00000X	BH & SOCIAL SERVICE, PSYCHOLOGIST
1041C0700X	BH & SOCIAL SERVICE, SOCIAL WORKER, CLINICAL
1041S0200X	BH & SOCIAL SERVICE, SOCIAL WORKER, SCHOOL
104100000X	BH & SOCIAL SERVICE, SOCIAL WORKER
106H00000X	BH & SOCIAL SERVICE, MARRIAGE & FAMILY THERAPIST
160000000X	NURSING SERVICE
163WA0400X	NURSING SERVICE, RN, ADDICTION (SUBSTANCE USE DISO
163WA2000X	NURSING SERVICE, RN, ADMINISTRATOR
163WC0200X	NURSING SERVICE, RN, CRITICAL CARE MEDICINE
163WC0400X	NURSING SERVICE, RN, CASE MANAGEMENT
163WC1400X	NURSING SERVICE, RN, COLLEGE HEALTH
163WC1500X	NURSING SERVICE, RN, COMMUNITY HEALTH
163WC1600X	NURSING SERVICE, RN, CONTINUING EDUCATION/STAFF DE
163WC2100X	NURSING SERVICE, RN, CONTINENCE CARE
163WC3500X	NURSING SERVICE, RN, CARDIAC REHABILITATION
163WD0400X	NURSING SERVICE, RN, DIABETES EDUCATOR
163WD1100X	NURSING SERVICE, RN, DIALYSIS, PERITONEAL
163WE0003X	NURSING SERVICE, RN, EMERGENCY
163WE0900X	NURSING SERVICE, RN, ENTEROSTOMAL THERAPY
163WF0300X	NURSING SERVICE, RN, FLIGHT
163WG0000X	NURSING SERVICE, RN, GENERAL PRACTICE
163WG0100X	NURSING SERVICE, RN, GASTROENTEROLOGY
163WG0600X	NURSING SERVICE, RN, GERONTOLOGY
163WH0200X	NURSING SERVICE, RN, HOME HEALTH
163WH0500X	NURSING SERVICE, RN, HEMODIALYSIS
163WH1000X	NURSING SERVICE, RN, HOSPICE
163WI0500X	NURSING SERVICE, RN, INFUSION THERAPY
163WI0600X	NURSING SERVICE, RN, INFECTION CONTROL
163WL0100X	NURSING SERVICE, RN, LACTATION CONSULTANT
163WM0102X	NURSING SERVICE, RN, MATERNAL NEWBORN
163WM0705X	NURSING SERVICE, RN, MEDICAL-SURGICAL
163WM1400X	NURSING SERVICE, RN, NURSE MASSAGE THERAPIST (NMT)
163WN0002X	NURSING SERVICE, RN, NEONATAL INTENSIVE CARE
163WN0003X	NURSING SERVICE, RN, NEONATAL, LOW-RISK
163WN0300X	NURSING SERVICE, RN, NEPHROLOGY
163WN0800X	NURSING SERVICE, RN, NEUROSCIENCE
163WN1003X	NURSING SERVICE, RN, NUTRITION SUPPORT
163WP0000X	NURSING SERVICE, RN, PAIN MANAGEMENT
163WP0200X	NURSING SERVICE, RN, PEDIATRICS
163WP0218X	NURSING SERVICE, RN, PEDIATRIC ONCOLOGY
163WP0807X	NURSING SERVICE, RN, PSYCH/MH, CHILD & ADOLESCENT
163WP0808X	NURSING SERVICE, RN, PSYCH/MH
163WP0809X	NURSING SERVICE, RN, PSYCH/MH, ADULT
163WP1700X	NURSING SERVICE, RN, PERINATAL
163WP2201X	NURSING SERVICE, RN, AMB CARE
163WR0400X	NURSING SERVICE, RN, REHABILITATION
163WR1000X	NURSING SERVICE, RN, REPRODUCTIVE ENDOCRINOLOGY/IN
163WS0121X	NURSING SERVICE, RN, PLASTIC SURGERY
163WS0200X	NURSING SERVICE, RN, SCHOOL
163WU0100X	NURSING SERVICE, RN, UROLOGY

163WW0000X	NURSING SERVICE, RN, WOUND CARE
163WW0101X	NURSING SERVICE, RN, WOMEN'S HC, AMB
163WX0002X	NURSING SERVICE, RN, OBSTETRIC, HIGH-RISK
163WX0003X	NURSING SERVICE, RN, OBSTETRIC, INPATIENT
163WX0106X	NURSING SERVICE, RN, OCCUPATIONAL HEALTH
163WX0200X	NURSING SERVICE, RN, ONCOLOGY
163WX0601X	NURSING SERVICE, RN, OTORHINOLARYNGOLOGY & HEAD-NE
163WX0800X	NURSING SERVICE, RN, ORTHOPEDIC
163WX1100X	NURSING SERVICE, RN, OPHTHALMIC
163WX1500X	NURSING SERVICE, RN, OSTOMY CARE
163W00000X	NURSING SERVICE, RN
164W00000X	NURSING SERVICE, LICENSED PRACTICAL NURSE
164X00000X	NURSING SERVICE, LICENSED VOCATIONAL NURSE
167G00000X	NURSING SERVICE, LICENSED PSYCHIATRIC TECHNICIAN
190000000X	GROUP
193200000X	GROUP, MULTI-SPECIALTY
193400000X	GROUP, SINGLE SPECIALTY
207LA0401X	PHYSICIAN, ANESTHESIOLOGY, ADDICTION MEDICINE
207LC0200X	PHYSICIAN, ANESTHESIOLOGY, CRITICAL CARE MEDICINE
207PE0004X	PHYSICIAN, EMERGENCY MEDICINE, EMERGENCY MEDICAL S
207PP0204X	PHYSICIAN, EMERGENCY MEDICINE, PEDIATRIC EMERGENCY
207P00000X	PHYSICIAN, EMERGENCY MEDICINE
207QA0401X	PHYSICIAN, FAMILY PRACTICE, ADDICTION MEDICINE
207RA0401X	PHYSICIAN, INTERNAL MEDICINE, ADDICTION MEDICINE
2080P0006X	PHYSICIAN, PEDIATRICS, DEVELOPMENTAL BEHAVIORAL
2084A0401X	PHYSICIAN, PSYCH & NEUR, ADDICTION MEDICINE
2084F0202X	PHYSICIAN, PSYCH & NEUR, FORENSIC PSYCHIATRY
2084N0600X	PHYSICIAN, PSYCH & NEUR, CLINICAL NEUROPHYSIOLOGY
2084P0005X	PHYSICIAN, PSYCH & NEUR, NEURODEVELOPMENTAL DISABI
2084P0800X	PHYSICIAN, PSYCH & NEUR, PSYCHIATRY
2084P0802X	PHYSICIAN, PSYCH & NEUR, ADDICTION PSYCHIATRY
2084P0804X	PHYSICIAN, PSYCH & NEUR, CHILD & ADOLESCENT PSYCHI
2084P0805X	PHYSICIAN, PSYCH & NEUR, GERIATRIC PSYCHIATRY
220000000X	RESP, REHAB, & REST SERVICE PROVIDERS
221700000X	RESP, REHAB, & REST SERVICE, ART THERAPIST
225A00000X	RESP, REHAB, & REST SERVICE, MUSIC THERAPIST
225400000X	RESP, REHAB, & REST SERVICE, REHABILITATION PRACTI
225600000X	RESP, REHAB, & REST SERVICE, DANCE THERAPIST
225800000X	RESP, REHAB, & REST SERVICE, RECREATION THERAPIST
226300000X	RESP, REHAB, & REST SERVICE, KINESIOTHERAPIST
250000000X	AGENCIES
251B00000X	AGENCIES, CASE MANAGEMENT
251C00000X	AGENCIES, DAY TRAINING, DEVELOPMENTALLY DISABLED S
251E00000X	AGENCIES, HOME HEALTH
251F00000X	AGENCIES, HOME INFUSION
251G00000X	AGENCIES, HOSPICE CARE, COMMUNITY BASED
251J00000X	AGENCIES, NURSING CARE
251K00000X	AGENCIES, PUBLIC HEALTH OR WELFARE
260000000X	AMB HC FACILITIES
261QA1903X	AMB HC FACILITIES, CLINIC/CENTER, AMB SURGICAL

261QC0050X	AMB HC FACILITIES, CLINIC/CENTER, CRITICAL ACCESS
261QC1500X	AMB HC FACILITIES, CLINIC/CENTER, COMMUNITY HEALTH
261QC1800X	AMB HC FACILITIES, CLINIC/CENTER, CORPORATE HEALTH
261QD1600X	AMB HC FACILITIES, CLINIC/CENTER, DEVELOPMENTAL DI
261QE0002X	AMB HC FACILITIES, CLINIC/CENTER, EMERGENCY CARE
261QF0400X	AMB HC FACILITIES, CLINIC/CENTER, FEDERALLY QUALIF
261QH0100X	AMB HC FACILITIES, CLINIC/CENTER, HEALTH
261QM0801X	AMB HC FACILITIES, CLINIC/CENTER, MH (INCLUDING CO
261QM0850X	AMB HC FACILITIES, CLINIC/CENTER, ADULT MH
261QM0855X	AMB HC FACILITIES, CLINIC/CENTER, ADOLESCENT AND C
261QM1300X	AMB HC FACILITIES, CLINIC/CENTER, MULTI-SPECIALTY
261QM2800X	AMB HC FACILITIES, CLINIC/CENTER, METHADONE CLINIC
261QP0904X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, F
261QP0905X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, S
261QR0400X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION
261QR0401X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR0405X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR1300X	AMB HC FACILITIES, CLINIC/CENTER, RURAL HEALTH
261Q00000X	AMB HC FACILITIES, CLINIC/CENTER
270000000X	HOSPITAL UNITS
273R00000X	HOSPITAL UNITS, PSYCHIATRIC UNIT
273Y00000X	HOSPITAL UNITS, REHABILITATION UNIT
276400000X	HOSPITAL UNITS, REHABILITATION, SUBSTANCE USE DISO
280000000X	HOSPITALS
282NC0060X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CRITICAL A
282NC2000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CHILDREN
282NR1301X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, RURAL
282NW0100X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, WOMEN
282N00000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL
283Q00000X	HOSPITALS, PSYCHIATRIC HOSPITAL
283XC2000X	HOSPITALS, REHABILITATION HOSPITAL, CHILDREN
283X00000X	HOSPITALS, REHABILITATION HOSPITAL
284300000X	HOSPITALS, SPECIAL HOSPITAL
290000000X	LABORATORIES
291U00000X	LABORATORIES, CLINICAL MEDICAL LABORATORY
293D00000X	LABORATORIES, PHYSIOLOGICAL LABORATORY
310000000X	NURS & CUST CARE FACILITIES
3104A0625X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
3104A0630X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310400000X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310500000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
311ZA0620X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311Z00000X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311500000X	NURS & CUST CARE FACILITIES, ALZHEIMER CENTER (DEM
313M00000X	NURS & CUST CARE FACILITIES, NURSING FACILITY/INTE
3140N1450X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
314000000X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
315D00000X	NURS & CUST CARE FACILITIES, HOSPICE, INPATIENT
315P00000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
320000000X	RTC FACILITIES

320800000X	RTC FACILITIES, COMMUNITY BASED RTC FACILITY, MENT
320900000X	RTC FACILITIES, COMMUNITY BASED RESIDENTIAL TREATM
322D00000X	RTC FACILITIES, RTC FACILITY, EMOTIONALLY DISTURBE
323P00000X	RTC FACILITIES, PSYCHIATRIC RTC FACILITY
3245S0500X	RTC FACILITIES, SA REHABILITATION FACILITY, SA TRE
324500000X	RTC FACILITIES, SA REHABILITATION FACILITY
326000000X	RTC FACILITIES, RTC FACILITY, MENTAL RETARDATION A
330000000X	SUPPLIERS
340000000X	TRANSPORTATION SERVICES
3416A0800X	TRANSPORTATION SERVICES, AMBULANCE, AIR TRANSPORT
3416L0300X	TRANSPORTATION SERVICES, AMBULANCE, LAND TRANSPORT
3416S0300X	TRANSPORTATION SERVICES, AMBULANCE, WATER TRANSPOR
341600000X	TRANSPORTATION SERVICES, AMBULANCE
343800000X	TRANSPORTATION SERVICES, SECURED MEDICAL TRANSPORT
343900000X	TRANSPORTATION SERVICES, NON-EMERGENCY MEDICAL TRA
344600000X	TRANSPORTATION SERVICES, TAXI
347B00000X	TRANSPORTATION SERVICES, BUS
347C00000X	TRANSPORTATION SERVICES, PRIVATE VEHICLE
347D00000X	TRANSPORTATION SERVICES, TRAIN
347E00000X	TRANSPORTATION SERVICES, TRANSPORTATION BROKER
360000000X	PA & APN PROVIDERS
363AM0700X	PA & APN PROVIDERS, PA, MEDICAL
363A00000X	PA & APN PROVIDERS, PA
363LA2100X	PA & APN PROVIDERS, APN, ACUTE CARE
363LC1500X	PA & APN PROVIDERS, APN, COMMUNITY HEALTH
363LP0808X	PA & APN PROVIDERS, APN, PSYCH/MH
363L00000X	PA & APN PROVIDERS, APN
364SA2200X	PA & APN PROVIDERS, CLIN NURSE SPEC, ADULT HEALTH
364SC1501X	PA & APN PROVIDERS, CLIN NURSE SPEC, COMMUNITY HEA
364SP0807X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0808X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH
364SP0809X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, ADU
364SP0810X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0811X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHR
364SP0812X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, COM
364SP0813X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, GER
364SR0400X	PA & APN PROVIDERS, CLIN NURSE SPEC, REHABILITATIO
364S00000X	PA & APN PROVIDERS, CLIN NURSE SPEC
367500000X	PA & APN PROVIDERS, NURSE ANESTHETIST, CERTIFIED R
380000000X	RESPITE CARE FACILITY
385HR2050X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE
385HR2055X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2060X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2065X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385H00000X	RESPITE CARE FACILITY, RESPITE CARE