

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 <u>OR</u> Non- Standardized Claim	Outpatient (applies when using the Standardized Claim Form <u>OR</u> Non- Standardized Claim Form)
1	Provider Name and Address	Required Address cannot be a PO Box or Lock Box Zip code must be 9 digits	Required Address cannot be a PO Box or Lock Box Zip code must be 9 digits
2	Pay-to-Name and Address	Situational Address can be a PO Box or Lock Box	Situational 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

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Claim Form Field		Inpatient (applies when using	Outpatient (applies when using
Location (on the Standardized		the Standardized	the Standardized
	Description		
		Claim Form <u>OR</u> Non-	Claim Form <u>OR</u> Non-
Claim Form)		Standardized Claim	Standardized Claim
		Form)	Form)
4.6	D: 1	Required on all final	
16	Discharge Hour	inpatient bill, except	Not Required
		for Type of Bill 021x	
17	Patient Discharge Status	Required	Required
		Situational	Situational
		Required when there	Required when there
18 – 28	Condition Codes	is a Condition Code	is a Condition Code
		that applies to the	that applies to the
		claim	claim
		Situational	Situational
29	Accident State	Two-digit state	Two-digit state
29	Accident State	abbreviation where	nere abbreviation where
		accident occurred	accident occurred
30	Untitled, data entered will be ignored	Not Required	Not Required
		Situational	Situational
		Required when there	Required when there
31 - 34	Occurrence Codes and Dates	is an Occurrence Code	is an Occurrence Code
		that applies to the	that applies to the
		claim	d when there currence Code oplies to the Required when there is an Occurrence Code that applies to the
		Situational	Situational
25.25		Include when an	Include when an
35 - 36	Occurrence Span Codes and Dates	Occurrence Span Code	Occurrence Span Code
		is used	is used
27	Untitled, data entered will be		
37	ignored	Not Required	Not Required
20	Responsible Party Name and	Nat Day 1 and	Nat Day 1 and
38	Address	Not Required	Not Required
39 - 41		Situational	Situational
	Value Codes and Amounts	Required when there	Required when there
		is a Value Code that	is a Value Code that
		applies to the claim	applies to the claim
42	Revenue Code	Required	Required
		·	

		Inpatient	Outpatient
Claim Form Field		(applies when using	(applies when using
Location		the Standardized	the Standardized
(on the Standardized Claim Form)	Description	Claim Form OR Non-	Claim Form <u>OR</u> Non-
		Standardized Claim	Standardized Claim
Claim Tormy		Form)	Form)
		Paper Claims	Paper Claims
		Required if –	Required if –
		■ Billing using an	Billing using an
		NDC number. NDC	NDC number. NDC
		number must be	number must be
		preceded by N4.	
		■ If billing for	·
		revenue codes	_
		096x, 097x, &	
		098x <u>and</u> the	
		rendering provider	
		is different from fields 78-79, include individual is different from fields 78-79, include individual	
		provider NPI.	If billing for revenue codes 096x, 097x, & 098x and the rendering provider is different from fields 78-79, include individual provider NPI. Claims an ober. NDC must be d by N4. If billing for revenue codes 096x, 097x, & 096x, 097x, & 096x and the rendering provider is different from fields 78-79, include individual provider NPI. Electronic Claims Required if — Billing using an NDC number. NDC number must be preceded by N4.
		p. 5	P • • • • • • • • • • • • • • • • • • •
		Electronic Claims	Electronic Claims
43	Revenue Description	Required if –	
	•	Billing using an	-
		NDC number. NDC	
		number must be	number must be
		preceded by N4.	preceded by N4.
		If billing for	If billing for
		revenue codes	revenue codes
		096x, 097x, &	096x, 097x, &
		098x <u>and</u> the	098x <u>and</u> the
		rendering provider	rendering provider
		is different from	is different from
		fields 78-79,	fields 78-79,
		include individual	include individual
		provider NPI.	provider NPI.
		Refer to X12	Refer to X12
		Companion Guide for	Companion Guide for
		specific segments	specific segments
		used	used

		Inpatient	Outpatient
Claim Form Field		(applies when using	(applies when using
Location		the Standardized	the Standardized
(on the Standardized	Description	Claim Form OR Non-	Claim Form OR Non-
,		Standardized Claim	Standardized Claim
Claim Form)			
4.4	LICECC / Data / LUDDC Carle	Form)	Form)
44	HCPCS/Rate/HIPPS Code	See below	See below
		 Required when an 	 Required when an
		appropriate	appropriate
		HCPCS or HIPPS	HCPCS or HIPPS
		code exists for the	code exists for the
		service line.	service line.
	HCPCS / HIPPS	■ HIPPS** codes	■ HIPPS** codes
		must always be	must always be
		present when	present when
		Revenue Code	Revenue Code
		0022, 0023, or	0023 is billed.
		0024 is billed.	
	Accommodation Rate	Not Required	Not Required
		Required when a	Required when a
		modifier clarifies or	modifier clarifies or
	HCPCS Modifiers	improves the	improves the
	HCPCS Modifiers	reporting accuracy of	reporting accuracy of
		the associated	the associated
		procedure codes	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	Not Poquired	Not Poquired
45	ignored	Not Required	Not Required
50 A-C	Payer Identification	A = Required	A = Required
JU A-C	r ayer identification	B-C = Situational	B-C = Situational
51 A-C	Health Plan ID	A = Required	A = Required
31 A-C	Health Flan 10	B-C = Situational	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
	2.555.00	Required	Required
		Atypical providers	Atypical providers
56	National Provider ID	must submit	must submit
		1234567893	1234567893
57	Other Provider ID	Not Required	Not Required
58	Insured's Name	Required	Required

		Inpatient	Outpatient
Claim Form Field		(applies when using	(applies when using
Location		the Standardized	the Standardized
(on the Standardized	Description	Claim Form OR Non-	Claim Form OR Non-
Claim Form)		Standardized Claim	Standardized Claim
Claim Formy		Form)	Form)
		,	,
F0	Dationt/s Dalationship to Incomed	Required	Required
59	Patient's Relationship to Insured	Should be Self	Should be Self
		(code 18)	(code 18)
		Required	Required
60	Insured's Unique ID	Should be PeakTPA	Should be PeakTPA
		member ID number	member ID number
61	Insured's Group Name	Not Required	Not Required
62	Insured's Group Number	Not Required	Not Required
		Required if -	Required if –
63	Total and A. Harindia Cada	An authorization	An authorization
63	Treatment Authorization Code	number is issued for	number is issued for
		the services	the services
		Required if –	Required if –
		Type of Bill (FL 04)	Type of Bill (FL 04)
		indicates claim is a	indicates claim is a
		replacement or void	replacement or void
64	Document Control Number	· ·	· · · · · · · · · · · · · · · · · · ·
		to a previously	to a previously
		adjudicated claim	adjudicated claim
		(type of bill 0xx7 or	(type of bill 0xx7 or
		0xx8)	0xx8)
65	Employer Name	Not Required	Not Required
66	Diagnosis and Procedure Code	Not Required	Not Required
	Qualifier	·	·
		Principal Diagnosis =	Principal Diagnosis =
		Required	Required
		POA = Situational	POA = Situational
	Principal Diagnosis Code and	Each diagnosis	Each diagnosis
67 A-Q	Present on Admission (POA)	code should only	code should only
	Indicator (shaded area)	be listed once	be listed once
	, ,	List all diagnosis	List all diagnosis
		codes applicable	codes applicable to
		to the services	the services
		rendered	rendered
	Untitled, data entered will be		
68	ignored	Not Required	Not Required
69	Admitting Diagnosis	Required	
	7.6	■ Except Type of Bill	
		028x, 065x, 066x	
		& 086x	
			Not Required
		 External Cause 	
		Diagnosis codes	
		cannot be used in	
		this field	

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Location		the Standardized	the Standardized
(on the Standardized	Description	Claim Form OR Non-	Claim Form OR Non-
Claim Form)		Standardized Claim	Standardized Claim
,		Form)	Form)
			Situational
			Refer to the Medicare
70 A-C	Patient's Reason for Visit	Not Required	Transmittal 3435***
7040	ratione 3 reason for visit	Not negatica	or subsequently
			published
			documentation
71	PPS Code (DRG)	Situational	Not Required
		Situational	Situational
		■ ECI Code:	■ ECI Code:
		Required when an	Required when an
	External Cause of Injury Code and	injury, poisoning, or adverse effect	injury, poisoning, or adverse effect
72 A-C	Present on Admission (POA)	is the cause for	is the cause for
	Indicator (shaded area)	seeking medical	seeking medical
		treatment	treatment
		■ POA: Follow Field	■ POA: Not
		67 instructions	Required
73	Untitled, data entered will be ignored	Not Required	Not Required
	-	Required if -	
		If a procedure was	
74 A-E	Principal Procedure Code and Date	performed <u>or</u>	Not Required
		Revenue Code	
	Haristan data antono di ililia	036x is present	
75	Untitled, data entered will be ignored	Not Required	Not Required
	ignored	Required	Required
		Required	Required
		Name: Required	Name: Required when
			claim contains
76	Attending Provider Name and	NPI: Required	services other than
	Identifiers (including NPI)		non-scheduled
			transportation
		<u> </u>	NPI: Required
		Situational	Situational
		Name: Required only	Name: Required only
77	Operating Provider Name and	when a surgical	when a surgical
	Identifiers (including NPI)	procedure is listed	procedure is listed
		p. 30000.0 10 110000	p. 3000.0.0 10 110000
		<u>NPI</u> : Required	<u>NPI</u> : Required

		Inpatient	Outpatient
Claim Form Field		(applies when using	(applies when using
Location (on the Standardized Claim Form)		the Standardized	the Standardized
	Description	Claim Form OR Non-	Claim Form OR Non-
		Standardized Claim	Standardized Claim
Cidilii i Oi III)		Form)	Form)
		Situational	Situational
		Situational	Situational
		Used to report	Used to report
		Referring, Other	Referring, Other
		Operating Physician	Operating Physician
		(Assistant Surgeon),	(Assistant Surgeon),
		Rendering Provider, or	Rendering Provider, or
		Ordering Provider	Ordering Provider
		_	
70 70	Other Provider Name and	Use the following	Use the following
78 – 79	Identifiers (including NPI)	Qualifiers, if	Qualifiers, if
		applicable:	applicable:
		DN – Referring	DN – Referring
		Provider	Provider
		ZZ – Other Operating	ZZ – Other Operating
		Physician	Physician
		82 – Rendering	82 – Rendering
		Provider	Provider
		DK – Ordering	DK – Ordering
		Provider	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
		Required	Required
	B3 – provider taxonomy code	use the appropriate	use the appropriate
	provider taxonomy code	taxonomy for the	taxonomy for the
		service rendered	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 <u>also</u> refer to your State guidelines for billing instructions.

<u>Additional Instructions for Paper Billers:</u>

- 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

01/12/22: Billing guidelines published

01/19/24: Revised fields 39-41