

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 <i>(on the Standardized Claim Form)</i>	Description	Inpatient <i>(applies when using the Standardized Claim Form OR Non-Standardized Claim Form)</i>	Outpatient <i>(applies when using the Standardized Claim Form OR Non-Standardized Claim Form)</i>
1	Provider Name and Address	Required <ul style="list-style-type: none"> Address cannot be a PO Box or Lock Box Zip code must be 9 digits 	Required <ul style="list-style-type: none"> 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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16	Discharge Hour	Required on all final inpatient bill, except for Type of Bill 021x	Not Required
17	Patient Discharge Status	Required	Required
18 – 28	Condition Codes	Situational Required when there is a Condition Code that applies to the claim	Situational Required when there is a Condition Code that applies to the claim
29	Accident State	Situational Two-digit state abbreviation where accident occurred	Situational Two-digit state abbreviation where accident occurred
30	Untitled, data entered will be ignored	Not Required	Not Required
31 - 34	Occurrence Codes and Dates	Situational Required when there is an Occurrence Code that applies to the claim	Situational Required when there is an Occurrence Code that applies to the claim
35 - 36	Occurrence Span Codes and Dates	Situational Include when an Occurrence Span Code is used	Situational Include when an Occurrence Span Code is used
37	Untitled, data entered will be ignored	Not Required	Not Required
38	Responsible Party Name and Address	Not Required	Not Required
39 - 41	Value Codes and Amounts	Situational <u>Paper Claims</u> Required when there is a Value Code that applies to the claim <u>Electronic Claims</u> N/A	Situational <u>Paper Claims</u> Required when there is a Value Code that applies to the claim <u>Electronic Claims</u> N/A
42	Revenue Code	Required	Required

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<p style="text-align: center;">43</p>	<p style="text-align: center;">Revenue Description</p>	<p style="text-align: center;"><u>Paper Claims</u> Required if –</p> <ul style="list-style-type: none"> ▪ Billing using an NDC number. NDC 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 provider NPI. <p style="text-align: center;"><u>Electronic Claims</u> Required if –</p> <ul style="list-style-type: none"> ▪ Billing using an NDC number. NDC 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 provider NPI. <p style="text-align: center;">Refer to X12 Companion Guide for specific segments used</p>	<p style="text-align: center;"><u>Paper Claims</u> Required if –</p> <ul style="list-style-type: none"> ▪ Billing using an NDC number. NDC 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 provider NPI. <p style="text-align: center;"><u>Electronic Claims</u> Required if –</p> <ul style="list-style-type: none"> ▪ Billing using an NDC number. NDC 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 provider NPI. <p style="text-align: center;">Refer to X12 Companion Guide for specific segments used</p>

Claim Form Field Location <i>(on the Standardized Claim Form)</i>	Description	Inpatient <i>(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)</i>	Outpatient <i>(applies when using the Standardized Claim Form <u>OR</u> Non-Standardized Claim Form)</i>
44	HCPCS/Rate/HIPPS Code	See below	See below
	HCPCS / HIPPS	<ul style="list-style-type: none"> ▪ Required when an appropriate HCPCS or HIPPS code exists for the service line. ▪ HIPPS** codes must always be present when Revenue Code 0022, 0023, or 0024 is billed. 	<ul style="list-style-type: none"> ▪ Required when an appropriate HCPCS or HIPPS code exists for the service line. ▪ HIPPS** codes must always be present when Revenue Code 0023 is billed.
	Accommodation Rate	Not Required	Not Required
	HCPCS Modifiers	Required when a modifier clarifies or improves the reporting accuracy of the associated procedure codes	Required when a modifier clarifies or improves the reporting accuracy of the associated procedure codes
45	Service Date	Required	Required
46	Units of Service	Required	Required
47	Total Charges	Required	Required
48	Non-Covered Charges	Situational	Situational
49	Untitled, data entered will be ignored	Not Required	Not Required
50 A-C	Payer Identification	A = Required B-C = Situational	A = Required B-C = Situational
51 A-C	Health Plan ID	A = Required B-C = Situational	A = Required B-C = Situational
52	Release of Info Certification	Not Required	Not Required
53	Assignment of Benefit Certification	Not Required	Not Required
54	Prior Payments	Situational	Situational
55	Estimated Amount Due from Patient	Not Required	Not Required
56	National Provider ID	Required Atypical providers must submit 1234567893	Required Atypical providers must submit 1234567893
57	Other Provider ID	Not Required	Not Required
58	Insured's Name	Required	Required

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59	Patient's Relationship to Insured	Required Should be Self (code 18)	Required Should be Self (code 18)
60	Insured's Unique ID	Required Should be PeakTPA member ID number	Required Should be PeakTPA member ID number
61	Insured's Group Name	Not Required	Not Required
62	Insured's Group Number	Not Required	Not Required
63	Treatment Authorization Code	Required if - An authorization number is issued for the services	Required if - An authorization number is issued for the services
64	Document Control Number	Required if - Type of Bill (FL 04) indicates claim is a replacement or void to a previously adjudicated claim (type of bill 0xx7 or 0xx8)	Required if - Type of Bill (FL 04) indicates claim is a replacement or void to a previously adjudicated claim (type of bill 0xx7 or 0xx8)
65	Employer Name	Not Required	Not Required
66	Diagnosis and Procedure Code Qualifier	Not Required	Not Required
67 A-Q	Principal Diagnosis Code and Present on Admission (POA) Indicator (shaded area)	Principal Diagnosis = Required POA = Situational <ul style="list-style-type: none"> ▪ Each diagnosis code should only be listed once ▪ List all diagnosis codes applicable to the services rendered 	Principal Diagnosis = Required POA = Situational <ul style="list-style-type: none"> ▪ Each diagnosis code should only be listed once ▪ List all diagnosis codes applicable to the services rendered
68	Untitled, data entered will be ignored	Not Required	Not Required
69	Admitting Diagnosis	Required <ul style="list-style-type: none"> ▪ Except Type of Bill 028x, 065x, 066x & 086x ▪ External Cause Diagnosis codes cannot be used in this field 	Not Required

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70 A-C	Patient's Reason for Visit	Not Required	Situational Refer to the Medicare Transmittal 3435*** or subsequently published documentation
71	PPS Code (DRG)	Situational	Not Required
72 A-C	External Cause of Injury Code and Present on Admission (POA) Indicator (shaded area)	Situational <ul style="list-style-type: none"> ▪ ECI Code: Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment ▪ POA: Follow Field 67 instructions 	Situational <ul style="list-style-type: none"> ▪ ECI Code: Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment ▪ POA: Not Required
73	Untitled, data entered will be ignored	Not Required	Not Required
74 A-E	Principal Procedure Code and Date	Required if - <ul style="list-style-type: none"> ▪ If a procedure was performed <u>or</u> ▪ Revenue Code 036x is present 	Not Required
75	Untitled, data entered will be ignored	Not Required	Not Required
76	Attending Provider Name and Identifiers (including NPI)	Required <u>Name</u> : Required <u>NPI</u> : Required	Required <u>Name</u> : Required when claim contains services other than non-scheduled transportation <u>NPI</u> : Required
77	Operating Provider Name and Identifiers (including NPI)	Situational <u>Name</u> : Required only when a surgical procedure is listed <u>NPI</u> : Required	Situational <u>Name</u> : Required only when a surgical procedure is listed <u>NPI</u> : Required

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

Additional Information

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

**FL 44 HIPPS Codes - Refer to guidance found at: [HIPPS Codes | CMS](#)

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

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

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

Additional Instructions for Paper Billers:

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

Audit History

01/12/22: Billing Guidelines published