UB-04 claims submission guide

The UB-04 claim form, also known as the CMS-1450 form, is approved by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee for facility and ancillary paper billing. Sample UB-04 forms for inpatient and outpatient claims can be found on pages 4 and 5.

If you have any questions regarding the UB-04 claim form, please call Provider Services at 1-888-YOUR-AH1 (1-888-968-7241) for AmeriHealth members in New Jersey or 1-800-275-2583 for AmeriHealth members in Pennsylvania.

UB-04 data field requirements

Field location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
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	Required	Required
7	Future Use	N/A	N/A
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, if applicable
13	Admission Hour	Required	Required, if applicable
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
	NDC Code	Required, if applicable	Required, if applicable
44	HCPCS/Rates	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (By Revenue Code)	Required	Required

Field location UB-04	Description	Inpatient	Outpatient
48	Non-Covered Charges	Required, if applicable	Required, if applicable
49	Future Use	N/A	N/A
50	Payer Name	Required	Required
51	Health Plan ID	Situational	Situational
52	Release of Information Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required, if applicable	Required, if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured's Group Name	Situational	Situational
62	Insured's Group Number	Situational	Situational
63	Treatment Authorization Codes	Required, if applicable	Required, if applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required	Required
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required, if applicable
70	Patient's Reason for Visit Code	N/A	Situational
71	PPS Code	Situational	Situational
72	External Cause of Injury Code	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required, if applicable	N/A
75	Future Use	N/A	N/A
76	Attending Provider Name/NPI	Required	Required
77	Operating Physician Name/NPI	Situational	Situational
78-79	Other Provider Name/NPI	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code Field/Qualifiers		
	0-A0	N/A	N/A
	A1-A4	Situational	Situational
	A5-AB	N/A	N/A
	AC - Attachment Control number	Situational	Situational
	AD-B0	N/A	N/A
	B1-B2	Situational	Situational
	B3 Taxonomy Code Qualifier	Required	Required

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Readability requirements

To ensure that all claims are processed against the same requirements, paper claims are converted to an electronic format. However, system limitations can cause data elements to be misinterpreted during the conversion process.

Follow these guidelines to ensure your claims are successfully converted:

Do	Don't
• Use red drop on UB-04 paper forms only.	• Do not include handwriting anywhere on the claim form.
• Replacement/corrected claims require a Type of Bill with a Frequency Code "7" (field 4) and claim number in the Document Control Number (field 64).	• Do not use stamped data in any field (NPI, provider names, signatures, corrections, etc.).
• Enter all required data.	• Do not print claim data out of the designated field; it may not be captured.
• All patient details are required (ID number with prefix, last name, first name, and date of birth).	• Do not print from an older DOT matrix printer; it may not be captured.
• Separate the subscriber/patient last name and first name with a comma.	
• Ensure the use of proper coding (ICD-10 HIPAA codes, dates of service, and correcting a prior claim).	
• Use standard fonts and sizes.	

Inpatient

1 Any Hospital				2 Any Hospital			3a PAT. CNTL # 1234		4 TYPE OF BILL
123 Any Street				456 Any Street			b. MED. REC. # 98765		0111
Anytown		PA	08999	Anytown		PA 08999	5 FED. TAX NO. 221234567	6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06	7 RESERVED

8 PATIENT NAME	a Patient ID if different from Sub	9 PATIENT ADDRESS	a 1234 Main Street			
b Doe, John					c PA	d 08999

Country code if other than USA

10 BIRTH DATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25	26 27 28	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3	12	01	Condition Codes Required Identifying Events			PA	RESERVED

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing						FUTURE USE

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
John Doe 1234 Main Street Anytown, PA 08999	a	A1 952 00		
	b	Value Codes and amounts required when necessary to process claim		
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0129	Semi-Private	200.00		2	400 00	0 00	FUTURE
0250	Pharmacy			1	50 00	0 00	USE
0360	OR Services				100 00	0 00	

Red = Required
Black = Situational/Required, if applicable/Optional

PAGE 1 OF 1	CREATION DATE	TOTALS ➡	550 00	0 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 2222222222
A AmeriHealth	Report HIPAA National Health Plan Identifier when mandatory	Y	Y	Required when indicated payer has paid amount to Provider	Amount estimated to be due	57 OTHER 1234567890 Secondary
B Secondary Payer						PRVID Tertiary
C Tertiary Payer						

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, John	18	ABC1234567800	Watch Repair, Inc.	1234
B Secondary				
C Tertiary				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 02468	491234	Watch Repair, Inc.
B Secondary		
C Tertiary		

Use the appropriate ICD indicator and code set

66 DX 67	A	B	C	D	E	F	G	H	68 Reserved
	I	J	K	L	M	N	O	P	Q

69 ADMIT DX 4280	70 PATIENT REASON DX a b c	71 PPS CODE DRG	72 ECI	73 Reserved

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 2222222222 QUAL
3749 11 03 06			Reserved	LAST Smith FIRST David
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST

80 REMARKS	81CC a B3 282N00000X	78 OTHER NPI QUAL
May be used to report additional information.	b Secondary	LAST FIRST
	c Tertiary	79 OTHER NPI QUAL
	d	LAST FIRST

UB-04 CMS-1450   APPROVED OMB NO.   NUBC National Uniform   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Outpatient

1 Any Hospital	2 Any Hospital	3a PAT. CNTL. # 1234	4 TYPE OF BILL
123 Any Street	456 Any Street	b. MED. REC. # 98765	0131
Anytown PA 08999	Anytown PA 08999	5 FED. TAX NO. 221234567	6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06	7 RESERVED

8 PATIENT NAME	a Patient ID if different from Sub	9 PATIENT ADDRESS	a 1234 Main Street		
b Doe, John		b Anytown		c PA d 08999	Country code if other than USA

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3		01	Condition Codes Required Identifying Events	PA	RESERVED

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing						FUTURE USE

38	39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
John Doe 1234 Main Street Anytown, PA 08999	a A1 952 00 b Value Codes and amounts required when necessary to process claim c d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0310	Laboratory N400093723106	88173	11 03 06	1	100 00	0 00	Future
0402	Ultrasoud	76942	11 04 06	1	100 00	0 00	Use
0360	OR Services	3749	11 04 06	1	100 00	0 00	

Red = Required
Black = Situational/Required, if applicable/Optional

23	PAGE 1 OF 1	CREATION DATE	TOTALS ⟹	300 00	0 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 2222222222
A AmeriHealth	Report HIPAA National Health Plan Identifier when mandatory	Y	Y	Required when indicated payer has paid amount to Provider	Amount estimated to be due	57 OTHER 1234567890
B Secondary Payer						OTHER Secondary
C Tertiary Payer						PRV ID Tertiary

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, John	18	ABC1234567800	Watch Repair, Inc.	1234
B Secondary				
C Tertiary				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 02468	491234	Watch Repair, Inc.
B Secondary		
C Tertiary		

Use the appropriate ICD indicator and code set

66 DX	67	A	B	C	D	E	F	G	H	68 Reserved
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	4280	70 PATIENT REASON DX	May be used to report reason for visit	71 PPS CODE	DRG	72 ECI	May be used to report external cause of injury	73 Reserved

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 2222222222	QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	Reserved	LAST Smith FIRST David	

80 REMARKS	81CC a B3 282N00000X	77 OPERATING NPI	QUAL
May be used to report additional information.	b Secondary	78 OTHER NPI LAST FIRST	QUAL
	c Tertiary	79 OTHER NPI LAST FIRST	QUAL
	d		

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