UB-04 claims submission guide

05/2017

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 your Network Coordinator or Customer Service at 1-800-275-2583.

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

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. • 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). • Enter all required data. • All patient details are required (ID number with prefix, last name, first name, and date of birth). • 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.	• Do not include handwriting anywhere on the claim form. • Do not use stamped data in any field (NPI, provider names, signatures, corrections, etc.). • Do not print claim data out of the designated field; it may not be captured. • Do not print from an older DOT matrix printer; it may not be captured.

Inpatient

Field	Content
1	Any Hospital / 123 Any Street / Anytown PA 08999
2	Any Hospital / 456 Any Street / Anytown PA 08999
3a PAT. CNTL #	1234
b. MED. REC. #	98765
4 TYPE OF BILL	0111
5 FED. TAX NO.	221234567
6 STATEMENT COVERS PERIOD FROM / THROUGH	11 03 06 / 11 04 06
7	RESERVED
8 PATIENT NAME a	Patient ID if different from Sub
8 b	Doe, John
9 PATIENT ADDRESS a	1234 Main Street
9 b / c / d	Anytown / PA / 08999 / Country code if other than USA
10 BIRTHDATE	03 20 1971
11 SEX	M
12 ADMISSION DATE	11 03 06
13 HR	08
14 TYPE	3
15 SRC	3
16 DHR	12
17 STAT	01
18–28 CONDITION CODES	Condition Codes Required Identifying Events
29 ACDT STATE	PA
30	RESERVED
31–36 OCCURRENCE / OCCURRENCE SPAN	Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing
37	FUTURE USE
38	John Doe / 1234 Main Street / Anytown, PA 08999
39 VALUE CODES a	A1 952 00
39–41 VALUE CODES b	Value Codes and amounts required when necessary to process claim

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	
	PAGE 1 OF 1	CREATION DATE		TOTALS	550 00	0 00	

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

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI / 57 OTHER PRV ID
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	2222222222 / 1234567890
B	Secondary Payer						Secondary
C	Tertiary Payer						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

Field	Content
66 DX	67 (A–Q)
68	Reserved
69 ADMIT DX	4280
70 PATIENT REASON DX	
71 PPS CODE	DRG
72 ECI	May be used to report external cause of injury
73	Reserved
74 PRINCIPAL PROCEDURE CODE / DATE	3749 / 11 03 06
75	Reserved
76 ATTENDING NPI	2222222222
76 LAST / FIRST	Smith / David
77 OPERATING	
78 OTHER	
79 OTHER	
80 REMARKS	May be used to report additional information.
81CC a	B3 282N00000X
81CC b	Secondary
81CC c	Tertiary

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Outpatient

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Any Hospital 123 Any Street Anytown PA 08999	Any Hospital 456 Any Street Anytown PA 08999	1234 b. MED. REC. # 98765	0131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
221234567	11 03 06	11 04 06	RESERVED

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

Country code if other than USA

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	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
b						

38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 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
1	0310	Laboratory N400093723106	88173	11 03 06	1	100 00	0 00	Future Use
2	0402	Ultrasoud	76942	11 04 06	1	100 00	0 00	
3	0360	OR Services	3749	11 04 06	1	100 00	0 00	
4–22								
23	PAGE 1 OF 1		CREATION DATE		TOTALS	300 00	0 00	

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

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	1234567890
B Secondary Payer						OTHER PRV ID	Secondary
C Tertiary Payer							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	A	B	C	D	E	F	G	H	68
	67								Reserved
	I	J	K	L	M	N	O	P	Q

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

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
			Reserved
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI 2222222222	QUAL	
LAST Smith		FIRST David	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
May be used to report additional information.	a	B3	282N00000X
	b		Secondary
	c		Tertiary
	d		