BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Filing Claims - Claim Forms

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

In this Section

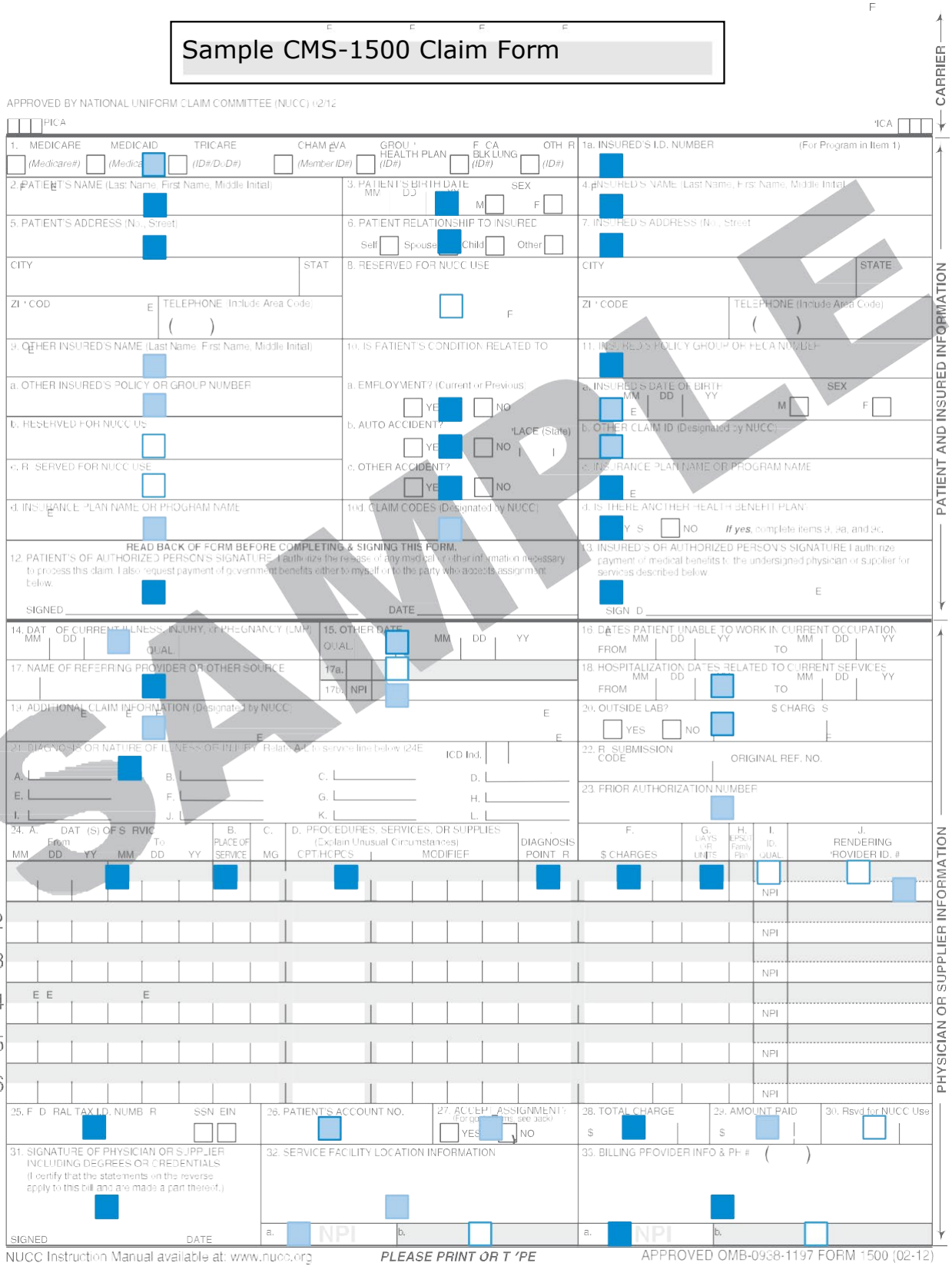
The following topics are covered in this section:

Blue Choice PPO and BlueHPN Provider Manual - Filing Claims - Claim Forms

Claim Form Overview	Blue Cross and Blue Shield of Texas recommends that providers submit claims electronically. For assistance, the following information is provided related to EDI and Claim forms.
EDI Transactions	EDI Transactions allow providers to submit, view, track and monitor claim status electronically. BCBSTX offers submission of claims via ANSI 837 Clams Transmissions for both institutional and professional providers. Refer to Electronic Commerce section of the provider website and section F(e) Filing Claims - Electronic Filing of this provider manual for more information.
CMS -1500 Claim Form	BCBSTX requires a CMS-1500 claim form as the only acceptable document for participating physicians and professional providers (except hospitals and related facilities) for filing paper claims. Detailed instructions and a sample of the CMS-1500 claim form can be found on the following pages. Note that each field on the form is numbered. The numbers in the instructions correspond to the numbers on the form and represent the National Standard Specifications for electronic processing.
Ordering Paper Claim Forms	***Electronic claim filing is preferred,*** but if you must file a paper claim, you will need to use the standard CMS-1500 claim form. Obtain claim forms by calling the American Medical Association at: **800-621-8335**
Required Elements for Clean Claims	BCBSTX requires all health care providers to file electronic claims using National Standard Format (NSF), American National Standards Institute (ANSI 837) or UB-04 format or paper claims utilizing the CMS-1500 or UB-04 forms. ALL paper claims for health care services MUST be submitted on one of these forms/formats. All claims must contain accurate and complete information. If a claim is received that is not submitted on the appropriate form or does not contain the required data elements set forth in Texas Department of Insurance Rules for Submission of Clean Claims and such other required elements as set forth in this Provider Manual and/ or the **Plan** provider bulletins or newsletters, the claim will be returned to the physician or professional provider/submitter with a notice of why the claim could not be processed for reimbursement. Please contact the **Plan's** Provider Customer Service for questions regarding paper or electronically submitted claims.
Return of Paper Claims with Missing NPI Number (Texas only)	Paper claims that do not have the billing provider's NPI number listed correctly in the appropriate block on the claim form will be returned to the provider. To avoid delays, please list your billing provider's NPI number in block 33 on the standard CMS-1500 claim form.

Blue Choice PPO and BlueHPN
Provider Manual - Filing Claims - Claim Forms

Sample CMS-1500 Claim Form



BlueCross BlueShield of Texas

CMS-1500 Key

KEY

- R — TDI REQUIREMENT
- C — TDI CONDITIONAL ELEMENT
- B — BCBSTX REQUESTED ELEMENT
- NR — NOT REQUIRED/NOT USED

1. **TYPE OF HEALTH INSURANCE COVERAGE** B
Claim Editing Indicator—For services being billed to Blue Shield of Texas, place "X" in the box marked (GROUP HEALTH PLAN). If the member has HMO or Commercial Insurance, select (OTHER)."

1a. **INSURED ID NUMBER** R
Enter the Identification number found on the insured's BCBS ID card.

2. **PATIENT'S NAME** R Enter patient's Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

3. **PATIENT'S BIRTH DATE/SEX** R
Enter patient's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate patient's sex.

4. **INSURED'S NAME** R Enter insured's Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

5. **PATIENT'S ADDRESS/TELEPHONE NUMBER** R
Enter patient's permanent mailing address and telephone number. Street, City, State, Zip Code.

6. **PATIENT'S RELATIONSHIP TO THE INSURED** R
Place an "X" in the appropriate box for patient's relationship to the insured.

7. **INSURED'S ADDRESS** R
Enter insured's Street, City, State, Zip Code (complete if different than patient's address).

8. **RESERVED FOR NUCC USE** NR

9. **OTHER INSURED'S NAME** C
Enter other insured's Last name, First name, Middle initial, if applicable. When the patient has other insurance coverage complete 9 through 9d. This information is necessary to coordinate benefits with other insurance companies.

9a. **OTHER INSURED'S POLICY OR GROUP NUMBER** C
Enter group number, group name, Medigap Policy Number, Employee ID number of other insured.

9b. **RESERVED FOR NUCC USE** NR
Other Insured's Date of Birth, Sex Enter other insured's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate insured's sex.

9c. **RESERVED FOR NUCC USE** NR
Enter other insured's employer.

9d. **INSURANCE PLAN NAME OR PROGRAM NAME** C
Enter other insured's group name.

10a-d. **IS PATIENT'S CONDITION RELATED TO:**

10a. **EMPLOYMENT:** For Employment Related Indicator, place an "X" in the appropriate box. R

10b. **AUTO ACCIDENT:** For Auto Accident Related Indicator, place an "X" in the appropriate box. If yes, enter the state in which the accident occurred. Use two-character abbreviation, i.e. TX. R

10c. **OTHER ACCIDENT:** For Other Accident Related Indicator, place an "X" in the appropriate box. R

10d. **CLAIM CODES (DESIGNATED BY NUCC)** C
If claim is a duplicate claim, a "D" is required. If claim is a corrected claim, a "C" is required.

(11 thru 11d, refer to BCBS subscriber coverage)

11. **INSURED'S POLICY GROUP OR FECA NUMBER** R
Enter the Group number from the subscriber's Blue Cross and Blue Shield Card.

11a. **INSURED'S DATE OF BIRTH, SEX** B
Enter insured's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate patient's sex.

11b. **OTHER CLAIM ID (DESIGNATED BY NUCC)** B
Enter insured's employer or school.

11c. **INSURANCE PLAN NAME OR PROGRAM NAME** R
Enter name of insured's insurance plan, include name of state, i.e., Blue Shield of TX.

11d. **IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN** R
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. **PATIENT OR AUTHORIZED PERSON'S SIGNATURE** R
Patient's or Authorized Person's Signature required but may indicate "Signature on File"

13. **INSURED OR AUTHORIZED PERSON'S SIGNATURE** R
Insured's or Authorized Person's Signature required but may indicate "Signature on File".

14. **DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)** C
Enter date using an eight-digit date format MM/DD/CCYY).

15. **OTHER DATE** B
Enter date using an eight-digit date format MM/DD/CCYY).

16. **DATES PATIENT UNABLE TO WORK: FROM DATE, TO DATE**
Enter date using an eight-digit date format MM/DD/CCYY), if applicable.

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE** R
Enter name (First, MI, Last name) and credentials of referring, ordering or supervising provider. Note: If none, enter "self-referral" or "none."

17a. **OTHER ID#** NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

17b. **NPI #** C
Enter the 10-digit NPI number of the referring, ordering or supervising provider.

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICE: FROM DATE, TO DATE** B
Enter inpatient hospital admission date and discharge date using an eight-digit date format MM/DD/CCYY).

19. **ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)** C
Description for NOC or NDC required, if applicable.

20. **OUTSIDE LAB/CHARGES** B
If laboratory work was performed outside the physician's office, place an "X" in "yes" box and enter the total charges.

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** R
Enter the ICD-9-CM Codes. The primary diagnosis should be first, followed by other diagnoses. Enter up to 4 ICD-9-CM Codes.

22. **RESUBMISSION**
Medicaid Resubmission Code.

23. **PRIOR AUTHORIZATION NUMBER** C
Required only if a Preauthorization or Verification is done.

24. **SHADED AREA – SUPPLEMENTAL INFORMATION –**
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's website at www.nucc.org.

24a. **DATE(S) OF SERVICE: FROM, TO** R
nter the dates of service using an eight-digit date format MM/DD/CCYY).

24b. **PLACE OF SERVICE** R
Enter the appropriate 2 digit Place of Service code.

24c. **EMG**
Emergency Indicator – Y for "Yes", leave blank if "No."

24d. **PROCEDURES, SERVICES, OR SUPPLIES** R
Enter the CPT or HCPCS code for the procedures, service or suppliers and enter a modifier, if applicable.

24e. **DIAGNOSIS CODE** R
Enter one ICD-9-CM diagnosis code for each procedure performed. Enter only one code per line of service.

24f. **CHARGES** R
Enter charge for each line of service. This should be original charge not the balance due or patient liability. Do not include discounts.

24g. **DAYS OR UNITS** R
Enter number of days or units.

24h. **EPSDT/FAMILY PLAN**
For Early & Periodic Screening, Diagnosis and Treatment. Shaded area qualifiers:
S2 – Under Treatment, ST–New Service Requested.

24i. **ID QUALIFIER - SHADED FIELD** NR
Not required, reserved for taxonomy code qualifier, "ZZ."

24j. **RENDERING PROVIDER ID. #**

SHADED FIELD NR
Not required, reserved for taxonomy code.

NON-SHADED FIELD C
Enter performing provider 10-digit NPI number.

25. **FEDERAL TAX ID NUMBER** R
Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.

26. **PATIENT ACCOUNT NUMBER** B
Enter account number assigned to the patient, if applicable.

27. **ACCEPT ASSIGNMENT** C
Enter "Yes" if the provider should be paid or enter "No" if the patient should be paid.

28. **TOTAL CHARGE** R
Enter total charges (total of all charges in 24f).

29. **AMOUNT PAID** C
Enter any amount paid by the patient.

30. **RSVD FOR NUCC USE** NR
Enter the difference, if any, between the total charge and amount paid.

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS** R
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/CCYY).

32. **SERVICE FACILITY LOCATION INFORMATION** C
Enter location where services were rendered. According to Texas state law, this field is required if the services were performed somewhere other than the patient's home.

32a. **NPI** C
Enter the 10-digit NPI number of the service facility location.

32b. **PROVIDER ID#** NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

33. **BILLING PROVIDER INFO AND PH#** R
Enter provider's or supplier's information that is requesting to be paid for services rendered.

33a. **NPI** R
Enter the 10-digit NPI number of the billing provider.

33b. **PROVIDER ID #** NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

BlueCross BlueShield of Texas

Blue Choice PPO and BlueHPN
Provider Manual - Filing Claims - Claim Forms
CMS-1500 Place of Service Codes, Instructions and Examples of Supplemental Information in Item Number 24 and Reminders

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Note: For more information on Place of Service Codes, see the National Uniform Claim Committee's website at www.nucc.org.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

For additional information for reporting NDC units, see the National Uniform Claim Committee's website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, ZIP code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSTX's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call 800-746-4614 or log on to bcbstx.com.

Completion of UB-04 Claim Form

How to Complete the UB-04 Claim Form

The UB-04 is the standardized billing form for institutional services. HMO offers this guide to help you complete the UB-04 form for your patients with HMO (Facility) coverage. Refer to the sample form and instructions on the following pages.

For information on the UB-04 billing form, or to obtain an Official UB-04 Data Specifications Manual, visit the National Uniform Billing Committee website at www.nubc.org.

Although electronic claim submission is preferred, institutional providers may submit claims in non-electronic format using the CMS Form UB-04. UB-04 is the required format for clean non-electronic claims by institutional providers under the TPPA.[22]

In order to be considered clean under the TPPA, claims submitted using the UB-04 must include all data elements specified by TDI rules.[23] The chart below details the data elements that are required and conditionally-required for clean claims submitted in this format. Claims that do not comply with these requirements will not be considered for TPPA penalty eligibility.

The chart also provides the UB-04 data elements that BCBSTX has identified as potentially necessary for claim adjudication (highlighted in blue). Failure to submit these elements could result in payment delays as BCBSTX may need to request the information from the provider in order to adjudicate the claim.

Each data element in the chart below is identified by its corresponding field in the UB-04 claim form, along with the applicable rule and any additional detail needed to clarify the requirement. Each type of rule is defined by the following key:

R - TDI Requirement
C - TDI Conditional Element
B - BCBTX Requested Element

All claims must include all information necessary for adjudication of claims according to the contract benefits. For submission of paper claims, mail to the following address:

Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, TX 75266-0044

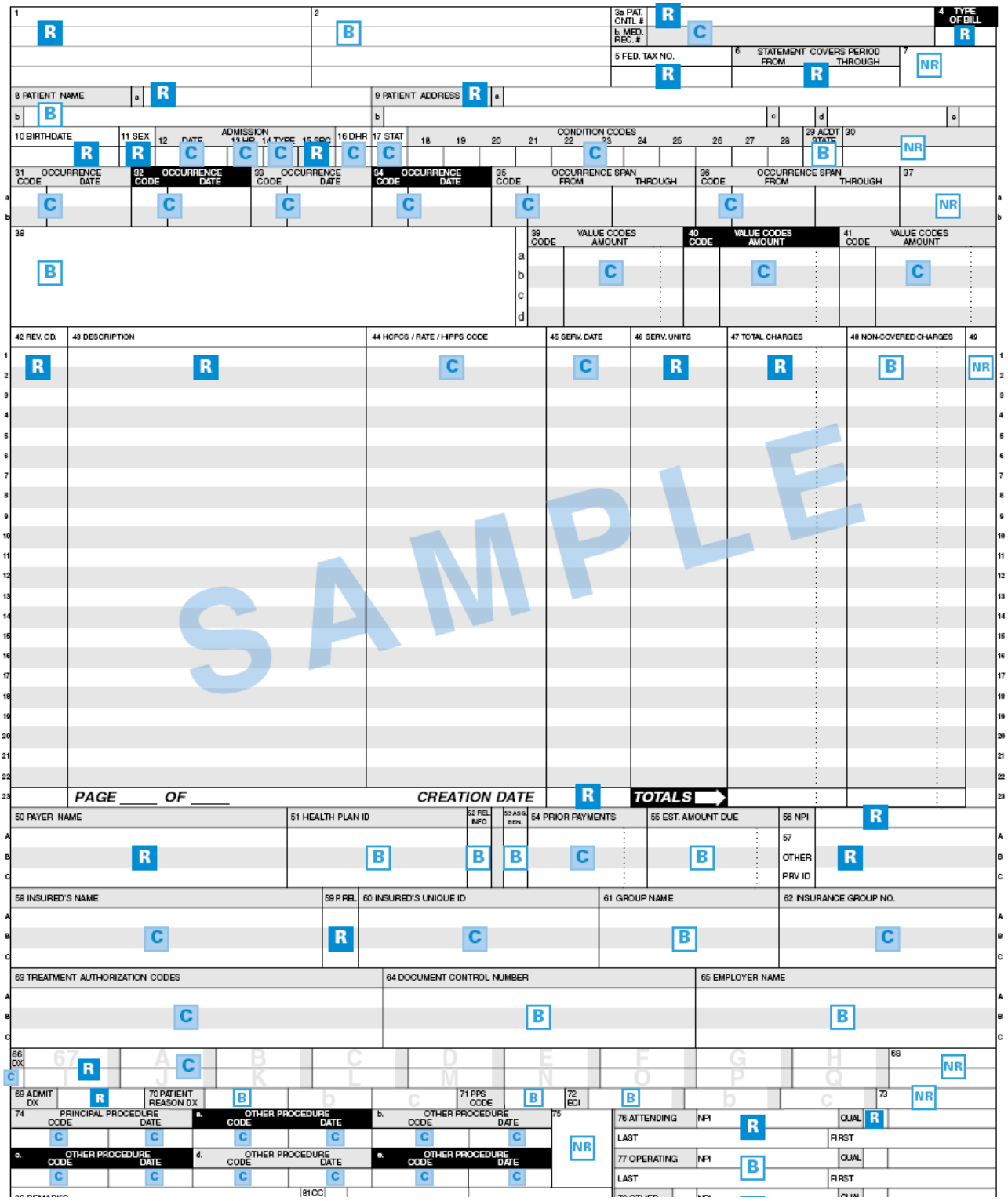
Note: Each field or block on the UB-04 claim form is referred to as a Form Locator.

What Forms are Accepted

The electronic ANSIX12N 8371-Institutional or the UB-04 claim form. A sample of the UB-04 is located on the next page.

[22] Ex. C, Tex. Ins. Code §1301.131(b).
[23] Ex.B, 28 Tex. Ins. Code §21.2803(b)(3).

Sample UB-04 Form



Blue Choice PPO and BlueHPN
Provider Manual - Filing Claims - Claim Forms
Procedure for Completing UB-04 Form

KEY

R = TDI REQUIREMENT
C = TDI CONDITIONAL ELEMENT
B = BCBSTX (HMO BLUE® TEXAS) REQUESTED ELEMENT
NR = NOT REQUIRED/NOT USED

1. BILLING PROVIDER NAME, ADDRESS & TELEPHONE NUMBER - R
Enter the billing name, street address, city, state, zip code and telephone number of the billing provider submitting the claim. Note: this should be the facility address.

2. PAY TO NAME AND ADDRESS - B
Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is required when information is different from the billing provider's information in form locator 1.

3a. **PATIENT CONTROL NUMBER - R**
Enter the patient's unique alphanumeric control number assigned to the patient by the provider.

3b. **MEDICAL RECORD NUMBER - C**
Enter the number assigned to the patient's medical health record by the provider.

4. TYPE OF BILL - R
Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc.
For more information on Type of Bill, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

5. FEDERAL TAX NUMBER - R
Enter the provider's Federal Tax Identification number.

6. STATEMENT COVERS PERIOD (From/Through) - R

Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.

7. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

8a. **PATIENT NAME/IDENTIFIER - R**
Enter the patient's identifier. Note: The patient identifier is situational/conditional, if different than what is in field locator 60 (Insured's/Member's Identifier).

8b. **PATIENT NAME - B**
Enter the patient's last name, first name and middle initial.

9. PATIENT ADDRESS - R
Enter the patient's complete mailing address (fields 9a – 9e), including street address (9a), city (9b), state (9c), zip code (9d) and country code (9e), if applicable to the claim.

10. PATIENT BIRTH DATE - R
Enter the patient's date of birth using an eight-digit date format (MMDDYYYY). For example: 01281970.

11. PATIENT SEX - R
Enter the patient's gender using an "F" for female, "M" for male or "U" for unknown.

Procedure for Completing UB-04 Form, cont'd

12. ADMISSION/START OF CARE DATE (MMDDYY) - C
Enter the start date for this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began.
Note: This is required on all inpatient claims.

13. ADMISSION HOUR - C
Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. **Required for all inpatient claims, observations and emergency room care.** For more information on Admission Hour, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

14. PRIORITY (TYPE) OF VISIT - C
Enter the appropriate code indicating the priority of this admission/visit. For more information on Priority (TYPE) of Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

15. POINT OF ORIGIN FOR ADMISSION OR VISIT - R
Enter the appropriate code indicating the point of patient origin for this admission or visit. For more information on Point of Origin for Admission or Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

16. DISCHARGE HOUR - C
Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. **Note: Required on all final inpatient claims**.

17. PATIENT DISCHARGE STATUS - C
Enter the appropriate two-digit code indicating the patient's discharge status.
Note: Required on all inpatient, observation, or emergency room care claims.

18-28. **CONDITION CODES - C**
Enter the appropriate two-digit condition code or codes if applicable to the patient's condition.

29. ACCIDENT STATE - B
Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.

30. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

31-34. **OCCURRENCE CODES/DATES (MMDDYY) - C**
Enter the appropriate two-digit occurrence codes and associated dates using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.

35-36. **OCCURRENCE SPAN CODES/DATES (From/Through) (MMDDYY) - C**
Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.

37. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

38. Enter the name, address, city, state and zip code of the party responsible for the bill. **B**

39-41. **VALUE CODES AND AMOUNT - C**
Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim.

42. REVENUE CODE - R
Enter the applicable Revenue Code for the services rendered. For more information on Revenue Codes, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

Claim Forms Procedure for Completing UB-04 Form, cont'd

43. REVENUE DESCRIPTION - R
Enter the standard abbreviated description of the related revenue code categories included on this bill. (See Form Locator 42 for description of each revenue code category.) **Note: The standard abbreviated description should correspond with the Revenue Codes as defined by the NUBC.** For more information on Revenue Description, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

44. HCPCS/RATES/HIPPS CODE - C
Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

45. SERVICE DATE (MMDDYY) - C
Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\PPS assessment date, or needed to report the creation date for line 23. **Note: Line 23 - Creation Date is Required.** For more information on Service Dates, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

46. SERVICE UNITS - R
Enter the number of units provided for the service line item.

47. TOTAL CHARGES - R
Enter the total charges using Revenue Code 0001. Total charges include both covered and non-covered services. For more information on Total Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

48. NON-COVERED CHARGES - B
Enter any non-covered charges as it pertains to related Revenue Code. For more information on Non-Covered Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

49. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

50. PAYER NAME - R
Enter the health plan that the provider might expect some payment from for the claim.

51. HEALTH PLAN IDENTIFICATION NUMBER - B
Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.

52. RELEASE OF INFORMATION - B
Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.

53. ASSIGNMENT OF BENEFITS - B
Enter a "Y", "N" or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.

54. PRIOR PAYMENTS - C
Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.

55. ESTIMATED AMOUNT DUE - B
Enter the amount estimated by the provider to be due from the payer.

Procedure for Completing UB-04 Form, cont'd

56. NATIONAL PROVIDER IDENTIFIER (NPI) - R
Enter the billing provider's 10-digit NPI number.

57. OTHER PROVIDER IDENTIFIER - R
Required on or after the mandatory NPI implementation date when the 10-digit NPI number is not used FL 56.

58. INSURED'S NAME - C
Enter the name of the individual (primary – 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).

59. PATIENT'S RELATIONSHIP TO INSURED - R
Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).

60. INSURED'S UNIQUE IDENTIFIER - C
Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).

61. INSURED'S GROUP NAME - B
Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).

62. INSURED'S GROUP NUMBER - C
Enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c). **Note: BCBSTX requires the group number on local claims.**

63. TREATMENT AUTHORIZATION CODES - C
Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

64. DOCUMENT CONTROL NUMBER (DCN) - B
Enter if this is a void or replacement bill to a previously adjudicated claim (64a – 64c).

65. EMPLOYER NAME - B
Enter when the employer of the insured is known to potentially be involved in paying claims. For more information on Employer Name, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

66. DIAGNOSIS AND PROCEDURE CODE QUALIFIER - C
Enter the required value of "9". Note: "0" is allowed if ICD-10 is named as an allowable code set under HIPAA.
For more information, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67. PRINCIPAL DIAGNOSIS CODE AND PRESENT ON ADMISSION (POA) INDICATOR - R
Enter the principal diagnosis code for the patient's condition. For more information on POAs, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67a-67q. **OTHER DIAGNOSIS CODES - C**
Enter additional diagnosis codes if more than one diagnosis code applies to claim.

68. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

Procedure for Completing UB-04 Form, cont'd

69. ADMITTING DIAGNOSIS CODE - R
Enter the diagnosis code for the patient's condition upon an inpatient admission.

70. PATIENT'S REASON FOR VISIT - B
Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).

71. PROSPECTIVE PAYMENT SYSTEM (PPS) CODE - B
Enter the DRG based on software for inpatient claims when required under contract grouper with a payer.

72. EXTERNAL CAUSE OF INJURY (ECI) CODE - B
Enter the cause of injury code or codes when injury, poisoning or adverse affect is the cause for seeking medical care.

73. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

74. PRINCIPAL PROCEDURE CODE AND DATE (MMDDYY) - C
Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient procedure. **Note: Required on inpatient claims.**

74a-e. **OTHER PROCEDURE CODES AND DATES (MMDDYY) - C**
Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure. **Note: Required on inpatient claims.**

75. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

76. ATTENDING PROVIDER NAME AND IDENTIFIERS - R
Enter the attending provider's 10 digit NPI number and last name and first name. Enter secondary identifier qualifiers and numbers as needed. *Situational: Not required for non-scheduled transportation claims. For more information on Attending Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

77. OPERATING PROVIDER NAME AND IDENTIFIERS - B
Enter the operating provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed. For more information on Operating Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

78-79. **OTHER PROVIDER NAME AND IDENTIFIERS - B**
Enter any other provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed. For more information on Other Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

80. **REMARKS - C**
Enter any information that the provider deems appropriate to share that is not supported elsewhere.

81CC a-d. **CODE-CODE FIELD - C**
Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. To further identify the billing provider (FL01), enter the taxonomy code along with the "B3" qualifier. For more information on requirements for Form Locator 81, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

Line 23. The 23rd line contains an incrementing page and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.