



UB-04 DHMP Billing Manual

Box 1- Billing Provider Name, Address, Phone Number

Inpatient - Required

Outpatient - Required

Enter the provider or agency name and complete mailing address of the provider who is billing for the services:

Street/Post Office Box, City, State, Zip Code
abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 2- Pay-to Name, Address, City, State

Inpatient – Required if different from Box 1

Outpatient - Required if different from Box 1

Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office Box, City, State, Zip Code
abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 3a- Patient Control Number

Inpatient - Required

Outpatient – Required

Up to 20 characters: Letters, Numbers or hyphens

Enter information that identifies the client or claim in the Provider's billing system. Submitted information appears on the Provider Claim Report.

Box 3b- Medical Record Number

Inpatient - Required

Outpatient - Required

Enter the 17 digits number assigned to the patient to assist in retrieval of medical records.

Box 4- Type of Bill

Inpatient - Required

Outpatient - Required

Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):

Digit 1 Type of Facility:

- 1 Hospital
- 2 Skilled Nursing Facility
- 3 Home Health
- 4 Religious Non-Medical Health Care, Institution, Hospital, Inpatient
- 5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services
- 6 Intermediate Care
- 7 Clinic-(Rural Health/FQHC/Dialysis Center)
- 8 Special Facility (Hospice, RTCs)

Digit 2 Bill Classification (Except clinics & special facilities):

- 1 Inpatient (Including Medicare Part A)
- 2 Inpatient (Medicare Part B only)
- 3 Outpatient
- 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
- 5 Intermediate Care Level I
- 6 Intermediate Care Level II
- 7 Sub-Acute Inpatient (revenue code 19X required with this bill type)
- 8 Swing Beds
- 9 Other

Digit 2 Bill Classification (Clinics Only):

- 1 Rural Health/FQHC
- 2 Hospital Based or Independent Renal Dialysis Center
- 3 Freestanding
- 4 Outpatient Rehabilitation Facility (ORF)
- 5 Comprehensive Outpatient Rehabilitation Facilities (COFRs)
- 6 Community Mental Health Center

Digit 2 Bill Classification (Special Facilities Only):

- 1 Hospice (Non-Hospital Based)
- 2 Hospice (Hospital Based)
- 3 Ambulatory Surgery Center
- 4 Freestanding Birthing Center
- 5 Critical Access Hospital
- 6 Residential Facility

Digit 3 Frequency:

- 0 Non-Payment/Zero Claim
- 1 Admit through discharge claim
- 2 Interim - First claim
- 3 Interim - Continuous claim
- 4 Interim - Last claim
- 7 Replacement of prior claim
- 8 Void of prior claim

Box 5- Federal Tax Number

Inpatient –Required

Outpatient - Required

Box 6- Statement Covers Period – From/Through

Inpatient - Required

Outpatient - Required

Enter the From (beginning) date and Through (ending) date of service covered by this bill using MM/DD/YY format

From MM/DD/YY –Through MM/DD/YY

For Example: January 1, 2008 = 010108

(Note: OP claims cannot span over a month's end)

Inpatient

“From” date is the actual admission date, or first date of an interim bill

“From” date cannot be prior to the date reported in Box 12 (Admission Date)

"Through" date is the actual discharge date, or final date of an interim bill.

If patient is admitted and discharged the same date, that date must appear in both form locators.

Interim bills may be submitted for Prospective Payment

System (PPS)-DRG claims, but must meet specific billing requirements.

Outpatient

This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete Box 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.

Box 8a- Patient Identifier

Submitted information is not entered into the claim processing system.

Box 8b- Patient Name

Inpatient - Required

Outpatient - Required

Enter the client's last name, first name and middle initial
From the DHMP Medical Card

Box 9a- Patient Address-Street

Inpatient - Required

Outpatient - Required

Enter the client's street/post office box exactly as it
appears on the DHMP eligibility verification or as determined
at the time of admission.

Box 9b- Patient Address-City

Inpatient - Required

Outpatient - Required

Enter the client's city exactly as it appears on the DHMP
eligibility verification or as determined at the time of
admission.

Box 9c- Patient Address- State

Inpatient - Required

Outpatient - Required

Enter the client's state exactly as it appears on the DHMP
eligibility verification or as determined at the time of
admission.

Box 9d- Patient Address-Zip

Inpatient - Required

Outpatient - Required

Enter the client's zip code exactly as it appears on the
eligibility verification or as determined at the time of
admission.

Box 9e- Patient Address-County Code

Inpatient – Optional

Outpatient – Optional

Box 10- Birth date**Inpatient - Required****Outpatient - Required**

Enter the client's birth date, using two digits for the month, two digits for the date, and four digits for the year

(MM/DD/CC/YY format)

Example: 01012008 for January 1, 2008

Use the birth date that appears on the DHMP eligibility verification or at the time of admission

Box 11- Patient Sex**Inpatient - Required****Outpatient - Required**

Enter an M (male) or F (female) to indicate the client's sex

Box 12- Admission Date**Inpatient - Required**

Enter the date client was admitted to the hospital. Use MM/DD/YY format for inpatient hospital claims

Outpatient – Conditional

Required for observation holding beds only

Box 13- Admission Hour**Inpatient - Required**

Enter the hour the client was admitted for inpatient care.

Code Time

00 12:00-12:59 am

01 1:00-1:59 am

02 2:00-2:59 am

03 3:00-3:59 am

04 4:00-4:59 am

05 5:00-5:59 am

06 6:00-6:59 am

07 7:00-7:59 am

08 8:00-8:59 am

09 9:00-9:59 am

10 10:00-10:59 am

11 11:00-11:59 am

12 12:00-12:59 pm

13 1:00-1:59 pm

14 2:00-2:59 pm

15 3:00-3:59 pm

16 4:00-4:59 pm

17 5:00-5:59 pm

18 6:00-6:59 pm

19 7:00-7:59 pm

20 8:00-8:59 pm

21 9:00-9:59 pm

22 10:00-10:59 pm

23 11:00-11:59 pm

99 Unknown

Outpatient – Optional

Required for observation holding beds only

Box 14- Admission Type

Inpatient - Required

Outpatient - Optional

Enter the following to identify the admission priority:

1 – Emergency

Client requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from copayment and PCP referral.

Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present.

This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.

2 - Urgent

The client requires immediate attention for the care and treatment of a physical or mental disorder.

3 - Elective

The client's condition permits adequate time to schedule the availability of accommodations.

4 - Newborn

Required for inpatient and outpatient hospital.

5 - Trauma Center

Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

Clinics

Required only for emergency visit.

Box 15- Source of Admission

Inpatient - Required

Outpatient - Required

Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with Box 14, Type of Admission).

1 Physician referral

2 Clinic referral

3 Referred from HMO

4 Transfer from a hospital

5 Transfer from a skilled nursing facility (SNF)

- 6 Transfer from another health care facility
- 7 Emergency Room
- 8 Court/Law Enforcement
- 9 Information not available
- A) Transfer from a Critical Access Hospital
- B) Transfer from another Home Health Agency
- C) Readmission to Same Home Health Agency

Newborns

- 1 Normal Delivery
- 2 Premature Delivery
- 3 Sick Baby
- 4 Extramural Birth (Birth in a non-sterile environment)

Box 16- Discharge Hour

Inpatient - Required

Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in Box 13 (Admission Hr.)

Box 17- Patient Discharge Status

Inpatient - Required

Outpatient – Conditional

Enter patient status as of discharge date.

- 01 Discharged to Home or Self Care (Dialysis is limited to code 01)
- 02 Discharged/transferred to another short term hospital
- 03 Discharged/transferred to a Skilled Nursing Facility (SNF)
- 04 Discharged/transferred to an intermediate Care Facility (ICF)
- 05 Discharged/transferred to another type institution
- 06 Discharged/transferred to home under care of organized Home And Community Based Services Program (HCBS)
- 07 Left against medical advice or discontinued care
- 08 Discharged/transferred to home under care of a Home Health provider
- 09 Admitted as an inpatient to this hospital
- 20 Expired
- 30 Still a patient or expected to return for outpatient services
- 31 Still a patient - Awaiting transfer to long term psychiatric hospital
- 32 Still a Patient - Awaiting placement by Colorado Medical Assistance Program
- 50 Hospice – Home
- 51 Hospice - Medical Facility
- 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital
- 71 Discharged/transferred/referred to another institution for outpatient services
- 72 Discharged/transferred/referred to this institution for outpatient services

Box 18-28- Condition Codes

Inpatient – Conditional

Outpatient - Conditional

Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing

Condition Codes:

- 01 Military service related
- 02 Employment related
- 04 HMO enrollees
- 05 Lien has been filed
- 06 ESRD patients - First 18 months entitlement
- 07 Treatment of non-terminal condition/hospice patient
- 17 Patient is homeless
- 25 Patient is a non-US resident
- 39 Private room(s) medically necessary
- 60 DRG (Day outlier)

Renal dialysis settings:

- 71 Full care unit
- 72 Self care unit
- 73 Self care training
- 74 Home care
- 75 Home care - 100 percent reimbursement
- 76 Back-up facility

Special Program Indicator Codes:

- A1 EPSDT/CHAP
- A2 Physically Handicapped Children's Program
- A4 Family Planning
- A6 PPV/Medicare
- A7 Induced Abortion - Danger to Life
- A8 Induced Abortion - Victim Rape/Incest
- A9 Second Opinion Surgery
- B3 Pregnancy Indicator

PRO Approval Codes:

- C1 Approved as billed
- C2 Automatic approval as billed - Based on focused review
- C3 Partial approval
- C4 Admission/Services denied
- C5 Post payment review applicable
- C6 Admission pre authorization
- C7 Extended authorization

Box 29- Accident State

Inpatient - Optional

Outpatient - Optional

Box 31-34- Occurrence Code/Date

Inpatient - Conditional

Outpatient - Conditional

Complete both the code and date of occurrence.

Enter the appropriate code and the date on which it occurred.

Enter the date using MMDDYY format.

Occurrence Codes:

- 01 Accident/Medical Coverage
- 02 Auto Accident - No Fault Liability
- 03 Accident/Tort Liability
- 04 Accident/Employment Related
- 05 Other Accident/No Medical Coverage or Liability Coverage
- 06 Crime Victim
- 20 Date Guarantee of Payment Began
- 24 Date Insurance Denied
- 25 Date Benefits Terminated by Primary Payer
- 26 Dates Skilled Nursing Facility Bed Available
- 27 Date of Hospice Certification or Recertification
- 40 Scheduled Date of Admission (RTD)
- 50 Medicare Pay Date
- 51 Medicare Denial Date
- 53 Late Bill Override Date
- 55 Insurance Pay Date
- A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made to payer A
- B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made to payer B
- C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made to payer C

NOTE: Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.

Box 35-36- Occurrence Span Code From/Through

Inpatient – If applicable

Outpatient – If applicable

Box 38- Responsible Party Name/Address

Submitted information is not entered into the claim processing system.

Box 39-41- Value Code-Code Value Code-Amount

Inpatient – Conditional

Outpatient - Conditional

If a value code is entered, a dollar amount or related numeric value must be entered.

Enter the appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers which are necessary for the processing of this claim.

Never enter negative amounts.

If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

01 Most common semiprivate rate (Accommodation Rate)
06 Medicare blood deductible
14 No fault including auto/other
15 Worker's Compensation
31 Patient Liability Amount
32 Multiple Patient Ambulance Transport
37 Pints of Blood Furnished
38 Blood Deductible Pints
40 New Coverage Not Implemented by HMO
45 Accident Hour
Enter the hour when the accident occurred
that necessitated medical treatment. Use
the same coding used in Box 18 (Admission Hour)
49 Hematocrit Reading - EPO Related
58 Arterial Blood Gas (PO2/PA2)
68 EPO-Drug
80 Covered Days
81 Non-Covered Days

Enter the deductible amount applied by indicated payer

A1 Deductible Payer A
B1 Deductible Payer B
C1 Deductible Payer C

Enter the amount applied to client's co-insurance by indicated payer

A2 Coinsurance Payer A
B2 Coinsurance Payer B
C2 Coinsurance Payer C

Enter the amount paid by indicated payer:

A3 Estimated Responsibility Payer A
B3 Estimated Responsibility Payer B
C3 Estimated Responsibility Payer C

Box 42- Revenue Code

Inpatient - Required

Outpatient - Required

Enter the revenue code which identifies the specific accommodation or ancillary service provided.

List revenue codes in ascending order

A revenue code must appear only once per date of service. If more than one of the same services is provided on the same day, combine the units and charges on one line accordingly.

When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS/CPT code cannot be repeated for the same date of service.

Refer to instructions under Box 44 (HCPCS/CPT/Rates)

Box 43- Revenue Code Description

Inpatient - Required

Outpatient – Required

Enter the revenue code description or abbreviated description

When reporting an NDC:

- Enter the NDC qualifier of “N4” in the first two positions on the left side of the field
- Enter the 11-digit NDC numeric code
- Enter the NDC unit of measure qualifier (examples include):
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Units
 - Enter the NDC unit of measure quantity

Box 44- HCPCS/Rates/ HIPPS Rate Codes

Inpatient - Optional

Outpatient - Conditional

Enter only the HCPCS/CPT code for each detail line. Use approved modifiers listed in this section for hospital based transportation services.

Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation.

When billing HCPCS codes, the appropriate revenue code must also be billed.

Services Requiring HCPCS/CPT

- Anatomical Laboratory: Bill with TC modifier
- Hospital Based Transportation
- Outpatient Laboratory: Use only HCPCS 80000s – 89000s
- Outpatient Radiology Services
- Enter HCPCS/CPT and revenue codes for each radiology line.
- The only valid modifier for OP radiology is TC.

With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services.

HCPCS/CPT codes must be identified for the following revenue codes:

- 32X Radiology – Diagnostic
- 33X Radiology – Therapeutic
- 34X Nuclear Medicine
- 35X CT Scan
- 40X Other Imaging Services
- 61X MRI

NOTE: HCPCS/CPT codes cannot be repeated for the same date of service

Combine the units in Box 46 (Service Units) to report multiple services
When CPT/HCPC is repeated more than once per day and billed on
separate lines, use modifier 76 to indicate this is a repeat procedure and
not a duplicate.

- 251 Generic Drugs
- 252 Non-Generic Drugs
- 253 Take Home Drugs
- 255 Drugs Incident to Radiology
- 257 Non-Prescription
- 258 IV Solutions
- 259 Other Pharmacy
- 260 IV Therapy General Classification
- 261 Infusion Pump
- 262 IV Therapy/Pharmacy Services
- 263 IV Therapy/Drug/Supply Delivery
- 264 IV Therapy/Supplies
- 269 Other IV Therapy
- 631 Single Source Drug
- 632 Multiple Source Drug
- 633 Restrictive Prescription
- 634 Erythropoietin (EPO) <10,000
- 635 Erythropoietin (EPO) >10,000
- 636 Drugs Requiring Detailed Coding

Box 45- Service Date

Inpatient – Leave blank

Outpatient – Required

For span bills only

Enter the date of service using MM/DD/YY format for each
detail line completed.

Each date of service must fall within the date span
entered in the Statement Covers Period

Not required for single date of service claims.

Box 46- Service Units

Inpatient - Required

Outpatient - Required

Enter a unit value on each line completed. Use whole
numbers only. Do not enter fractions or decimals and do
not show a decimal point followed by a 0 to designate
whole numbers (e.g., Do not enter 1.0 to signify one unit)
The grand total line (Line 23) does not require a unit value

For span bills, the units of service reflect only those visits,
miles or treatments provided on dates of service in Box 45

Box 47- Total Charges

Inpatient - Required

Outpatient - Required

Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges

Box 48- Non-Covered Charges

Inpatient – Conditional

Outpatient - Conditional

Enter incurred charges that are not payable by the DHMP
Non-covered charges must be entered in both Box 47
Total Charges and Box 48 Non-Covered Charges
Each column requires a grand total.
Non-covered charges cannot be billed for outpatient
hospital laboratory or hospital based transportation services.

Box 50- Payer Name

Inpatient- Required

Outpatient - Required

Enter the payment source code followed by name of
Each payer organization from which the provider might expect payment

Source Payment Codes

- B Workmen's Compensation
- C Medicare
- D Colorado Medical Assistance Program
- E Other Federal Program
- F Insurance Company
- G Blue Cross, including Federal Employee Program
- H Other - Inpatient (Part B Only)
- I Other

- Line A Primary Payer
- Line B Secondary Payer
- Line C Tertiary Payer

Box 51- Health Plan ID

Inpatient - Required

Outpatient - Required

Enter the provider's Health Plan ID for each payer name.

Enter DHMP Health Plan ID

Box 52- Release of Information

Submitted information is not entered into the claim processing system.

Box 53- Assignment of Benefits

Submitted information is not entered into the claim processing system.

Box 54- Prior Payments

Inpatient – Conditional

Outpatient – Conditional

Complete when there are third party payments

Box 55- Estimated Amount Due

Inpatient – Conditional

Outpatient – Conditional

Complete when there are third party payments

Beginning May 23, 2008, all identifiers submitted on the Form UB-04 Requires NPI's on all claims

Box 56- National Provider Identifier (NPI)

Inpatient – Required

Outpatient – Required

Enter the billing provider's 10-digit National Provider Identifier (NPI)

Box 57- Other Provider ID

Inpatient- Required

Outpatient- Required

Box 58- Insured's Name

Inpatient - Required

Outpatient - Required

Enter the client's name from DHMP Medical Card

Other Insurance

Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 60- Insured's Unique DHMP ID

Inpatient - Required

Outpatient - Required

Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the DHMP health insurance card. Include letter prefixes or suffixes shown on the card

Box 61- Insurance Group Name

Inpatient - Conditional

Outpatient – Conditional

Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the DHMP health insurance card

Box 62- Insurance Group Number

Inpatient – Conditional

Outpatient – Conditional

Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.

Box 63- Treatment Authorization Code

Inpatient – Conditional

Outpatient – Conditional

Complete when the service requires authorization. Enter the authorization number in this Box when patient has been approved for the services.

Box 64- Document Control Number

Inpatient- If applicable

Outpatient- If applicable

Box 65- Employer Name

Inpatient – Conditional

Outpatient – Conditional

Complete when there is third party coverage.

Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 66- Diagnosis Version Qualifier

Submitted information is not entered into the claim.

Box 67- Principal Diagnosis Code

Inpatient - Required

Outpatient - Required

Enter the exact ICD-9-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay.

Do not add extra zeros to the diagnosis code.

Box 67A- 67Q- Other Diagnosis

Inpatient - Required

Outpatient - Required

Enter the exact ICD-9-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay.

Do not add extra zeros to the diagnosis code.

Box 69- Admitting Diagnosis Code

Inpatient - Required

Outpatient - Optional

Enter the ICD-9-CM diagnosis code as stated by the physician at the time of admission.

Box 70- Patient Reason Diagnosis

Inpatient- If applicable

Outpatient- If applicable

Box 71- PPS Code

Submitted information is not entered into the claim

Box 72- External Cause of Injury Code (E-code)

Inpatient – Required

Outpatient – Required

Enter the ICD-9-CM diagnosis code for the external cause of an injury, such as poisoning, or adverse effect. This code must begin with an "E".

Box 74- Principal Procedure Code/Date

Inpatient – Conditional

Outpatient - Conditional

Enter the ICD-9-CM procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MM/DD/YY format.

Apply the following criteria to determine the principle procedure:

The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment.

The principal procedure is most related to the primary diagnosis.

Box 74A- Other Procedure Code/Date

Inpatient – Conditional

Outpatient – Conditional

Complete when there are additional significant procedure codes.

Enter the ICD-9-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed.

Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MM/DD/YY format.

Box 76- Attending NPI

Inpatient - Required

Outpatient – Required

Enter the 10-digit National Provider Identifier (NPI)

Box 77- Operating- NPI/QUAL/ID

Inpatient- Required

Outpatient- Required

Enter the 10-digit National Provider Identifier (NPI)

Box 78-79- Other NPI

Inpatient- Required

Outpatient- Required

Enter the 10-digit National Provider Identifier (NPI)

Box 78.-79- Other ID Last/First Name (Continued)

Inpatient- Required

Outpatient- Required

Enter the attending physician's last and first name

Box 80- Remarks

Enter specific additional information necessary to process the claim or fulfill reporting requirements.

Box 81- Code-Code QUAL/CODE/VALUE (a-d)

Submitted information is not entered into the claim