



Creating solutions, One person at a time

PBH UB04 Billing Instructions

Medicaid requires that certain services be billed on a UB04 billing form. Please see instructions below:

Box 1- Billing Provider: The information in this box is automatically populated from the billing system.

Box 2 – Pay to Provider: The information in this box is automatically populated from the billing system.

Box 3a- Patient Control Number: This field is reserved for the number assigned by the provider to facilitate retrieval, tracking, and filing of patient’s account (receivables).

Box 3b – Medical Record Number: This field is reserved for the number assigned by the provider to the patient’s medical record.

Box 4- Type of Bill: The Type of Bill code is comprised of three parts; a leading “0”, the facility type code and the Bill Frequency Type code. This field should be four digits when completed. The first two digits following the zero indicate the type of facility. The final digit indicates the type of bill. Below are all acceptable codes.

0111 – Hospital Inpatient – Admit though Discharge
0112 – Hospital Inpatient – First Claim
0113 – Hospital Inpatient – Continuing Claim
0114 – Hospital Inpatient – Last Claim
0117 – Hospital Inpatient – Replacement Claim
0118 – Hospital Inpatient – Void Claim

0651 – Intermediate Care – Admit through Discharge
0652 – Intermediate Care – First Claim
0653 – Intermediate Care – Continuing Claim
0654 – Intermediate Care – Last Claim
0657 – Intermediate Care – Replacement Claim
0658 – Intermediate Care – Void Claim

0891 – Residential - Admit through Discharge
0892 – Residential – First Claim
0893 – Residential – Continuing Claim
0894 – Residential – Last Claim

0897 – Residential – Replacement Claim

0898 – Residential – Void Claim

Box 5- Federal Tax ID Number: The information in this box is automatically populated from the billing system.

Box 6- Statement Period From and Through Dates: Enter the eight digit beginning service date in the “From” block and the eight digit ending service date in the “To” block. Dates are to be entered in the “mm/dd/yyyy” format.

Example: Enter the date of service January 31, 2005 as 01/31/2005.

Box 8a- Patient Name: Recipient’s full name as shown on the MID card (last name, first name, middle initial). This field will be automatically populated from the billing system.

Box 10- Patient Date of Birth: This information is auto-populated from the billing system.

Box 11- Patient Sex: Valid characters are M or F. This information is auto-populated from the billing system.

Box 12- Admission Date: Enter the eight digit date for the start of care. If the admission date is unknown please use the earliest service date being billed in this box. Dates are to be entered in the “mm/dd/yyyy” format.

Box 14 – Type (Priority) of Visit: This field requires the one digit type code indicating the urgency/priority of the admission. ****Inpatient hospitalization only**

Box 15 – Source of Referral for Admission: Indicate the source using the one digit code that represents the source of referral for admission. ****Inpatient hospitalization only**

Box 16 – Discharge Hour (DHR) This field requires two digit codes indicating the discharge hour. ****Inpatient hospitalization only**

Box 17 – Patient Discharge Status: This code indicates the discharge status of the patient when service ended. This will be a two digit number:

Valid Discharge Codes:

01 - Discharged to Home or Self Care (Routine Discharge)

02 - Discharged to Short Term General Hospital for Inpatient Care

03 - Discharged to Skilled Nursing Facility

04 - Discharged to Intermediate Care Facility (ICF)

05 - Discharged to Undefined Medical Facility/Health Care Institute

07 - Left Against Medical Advice or Discontinued Care

20 - Expired

30 - Still Patient

40 – Expired at Home

Box 38- Insured Name and Address: This information is automatically populated from the billing system.

****Box 39-41; a-d – Value Codes and Amounts:** Use these form locators to indicate codes and amounts essential to the proper adjudication of the submitted claim. Each form locator contains a three digit field in which to key the indicator code, and a larger free text field in which to designate an applicable amount.

Patient Responsibility - Key “31” in the code box of this field to identify the value code as a Patient Liability. Key the amount of PML due in the Amt. box.

Covered Days – Key “80” in the code box and the number of covered days in the amount.

Non-covered days - Key “81” for the code and the number of non-covered days as the amount.

Box 42- Revenue Code: For general hospitals, please use the appropriate revenue code(s) beginning with a leading zero followed by the 3 digit service code(s). The revenue code will have four digits when filled in correctly. *Ex. 0100*

Box 43- Description: This field will populate based on the revenue code entered in box 42 once the claim is saved.

Box 44- HCPCS/Rate: For general hospitals, please repeat the revenue codes indicated in box 42.

For all other types of facilities:

When billing therapeutic leave for the following residential services:

- H0019
- S5145
- H2020

Use the HCPCS code indicated on the authorization letter for therapeutic leave

****For services 04/01/05 and forward:**

- Enter revenue code 100 for ICF billing
- Enter revenue code 911 for Psychiatric Residential Treatment Facility (PRTF)
- Enter HCPCS code H0019 when revenue code 902 is used for residential billing
- Enter revenue code 183 for therapeutic leave for ICF only. Note: No auths are required for t/l for ICF therefore there will not be a “Y” code authorized.
- Enter codes YA254-YA259 as authorized for therapeutic leave authorized for residential providers.

Box 45- Service Date: If using span billing, please leave *the service date (box 45) blank*. If you entered a value in block 6 (Statement Covers Period; From, Through) you have used span billing and must leave block 45 blank.

****Note: Do not list individual days if using span billing. This will cause your claim to adjudicate incorrectly.**

****Note: If billing span includes Therapeutic Leave charges, please follow the example given below:**

If billing for the month of January with two days of therapeutic leave (1/15-1/16); ***your billing will need to be submitted using three separate claims***. One claim for Residential charges (1/1-1/14); one claim for the Therapeutic Leave charges (1/15-1/16); and a final claim covering the remainder of the month's Residential charges (1/17-1/31).

Otherwise, enter the individual eight digit service date for each line item billed. Dates are to be entered in the "mm/dd/yyyy" format.

Box 46- Service Units: Enter the number of units provided for each individual service entered in box 42 on the claim form.

Box 47- Total Charges: For general hospitals enter the charges for the total number of units billed for each service indicated. Otherwise, enter the 06/07 rate for the charge being billed.

****Note: If using span billing enter the total amount for the number of days being billed.**

****If necessary, add additional billing lines by typing in the number of lines you will need into the box that prompts for this. Make sure that all services are represented on their own line.****

Box 50- Primary Payer: This is a required field. Select the health plan that has primary responsibility for the costs incurred during service date from the drop down menu.

Box 50 (additional lines)- Secondary Payer: If the insured has a secondary payer such as Medicare or a managed care payer such as Aetna or Blue Cross of NC, enter the name of the plan in this box.

Box 51 (and additional lines if applicable) - Health Plan ID number: enter the number(s) from the claim used by the health plan(s) to identify itself.

Box 52- Release of Information: *This box will auto populate if/when a payer is selected in box 50 - each payer line will have a separate Release of Information marker box***

****Note: Check line B boxes 52 and 53 to indicate signature on file if there are secondary payers.**

Box 53- Assignment of Benefits: *****This box will auto populate if/when a payer is selected in box 50 - each payer line will have a separate Assignment of Benefits marker box***

*****Note: Check line B boxes 52 and 53 to indicate signature on file if there are secondary payers.***

Box 54- Prior Payments-Secondary Payer: Enter other insurance payment amounts as applicable.

Box 55- Estimated Amount Due: Enter the estimated amount due from each indicated payer in box 50.

Box 56 – NPI: This field will be automatically populated based on the provider/clinician/physician selected from the NPI dropdown on the previous page (client search page in client gateway).

Box 58 - Insured Name: Enter the Name of the policyholder for the health plan indicated as Primary Payer in box 50

*****Note: All information on “line A” applies to the primary policy holder.***

Box 58 (additional lines) - Insured Name: Enter the name of the policyholder for the secondary insurance if applicable.

*****Note: All information on “line B” and other additional lines applies to other insurance on file.***

Box 59- Patient Relationship: Identify the relationship of the patient to the primary insurance policyholder using the following two digit codes:

Title:

01- Spouse

18- Self

19- Child

20- Employee

21- Unknown

53- Life Partner

G8- Other Relationship

*****Note – This is the relationship of the patient to the policy holder, so if the patient’s parents are the policy holders, the subsequent relationship would be “19-Child”.***

Box 59 (additional lines) - Patient Relationship: This box identifies the relationship of the patient to the secondary insurance policyholder if applicable. Enter the two digit code from the list above.

Box 60- Insured ID Number: Enter the number assigned by the primary health plan to identify the specific policy of the insured.

Box 60 (additional lines) - Insured ID Number: Enter the insured identification number (or policy number) for the secondary insurance if applicable.

Box 63- Treatment Authorization Codes: Enter the appropriate authorization number for services provided. (Optional)

Box 64A – Document Control Number: If the bill type indicates a replacement or void claim, enter the PBH claim number of the original submitted claim in this field. You will find the claim number on your Remittance Advice.

Box 67- Principal Diagnosis Code: Enter the primary diagnosis code in this box marked with an asterisk (*).

Boxes 67 (additional fields) - Secondary diagnosis code(s): Enter secondary diagnosis code(s) as applicable.

Box 69 – Adm. Diagnosis Code (inpatient hospital only): Enter the diagnosis code describing the patient’s diagnosis at the time of admission.

Box 81CCa – Taxonomy Code: Enter the taxonomy code in box 81CCa of the UB04. The value “B3” will be hard coded into the first field. This identifies the value to be entered as the Provider’s Taxonomy Code. Enter the Taxonomy code in the box to the right of where “B3” is located.

Once you have completed all required fields, click “Save”. Once you click “Save”, if you have made any syntax errors you will be notified at the top of the page in RED. You will NOT be able to save your claim unless all errors are addressed and corrected.

If you have not received syntax error messages, you can now save your claim and review prior to submission. If changes must be made, click “Edit” to return. If all information is correct, click “Submit” to enter the claim into the PBH billing system for processing. You may wish to print your submitted claim for your records.



UB04 Cheat-Sheet

Many fields on the UB04 are automatically populated. Below are the “un-populated fields” you will be required to enter to submit a completed UB04 form:

| Box Number | Description | Info Required |
|-------------------------------------|------------------------|--|
| Box 3a (optional) | Patient Control Number | Provider assigned patient acct # |
| Box 3b (optional) | Medical Record Number | Provider assigned medical records # |
| Box 4 | Type of Bill | 0111 – Hospital Inpatient – Admit though Discharge 0112 – Hospital Inpatient – First Claim 0113 – Hospital Inpatient – Continuing Claim 0114 – Hospital Inpatient – Last Claim 0117 – Hospital Inpatient – Replacement Claim 0118 – Hospital Inpatient – Void Claim 0651 – Intermediate Care – Admit through Discharge 0652 – Intermediate Care – First Claim 0653 – Intermediate Care – Continuing Claim 0654 – Intermediate Care – Last Claim 0657 – Intermediate Care – Replacement Claim 0658 – Intermediate Care – Void Claim 0891 – Residential - Admit through Discharge 0892 – Residential – First Claim 0893 – Residential – Continuing Claim 0894 – Residential – Last Claim 0897 – Residential – Replacement Claim 0898 – Residential – Void Claim |
| Box 6 | Statement period | Begin and end dates for service period being billed; must be in 8 digit format (mm/dd/yyyy) |
| Box 12 | Admission Date | Eight digit start of service date. |
| Box 14 (inpatient hospital only) | Type of Visit | One digit priority/urgency of visit code |
| Box 15 (inpatient hospital only) | Source of referral | One digit code to indicate the source of the referral for visit |

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| Box 16 | Discharge Hour | Two digit code indicating the discharge hour of the patient from inpatient care. |
| Box 17 | Patient Discharge Status | Two digit code to indicate the discharge status of the patient when service ended Valid Discharge Codes: 01 - Discharged to Home or Self Care (Routine Discharge) 02 - Discharged to Short Term General Hospital for Inpatient Care 03 - Discharged to Skilled Nursing Facility 04 - Discharged to Intermediate Care Facility (ICF) 05 - Discharged to Undefined Medical Facility/Health Care Institute 07 - Left Against Medical Advice or Discontinued Care 20 - Expired 30 - Still Patient 40 – Expired at Home |
| Box 39 - 41; a-d | Value Codes & Amounts | To designate Patient Responsibility; Enter the value “31” in the <i>code</i> box and the amount of the PML in the <i>Amt.</i> box. To designate Covered Days; Enter the value “80” in the <i>code</i> box and the number of covered days in the <i>Amt.</i> box. To designate Non-Covered Days; Enter the value “81” in the <i>code</i> box and the number of non-covered days in the <i>Amt.</i> box. |
| Box 42 | Revenue Code | Revenue codes must begin with a leading “0”. Enter the three digit revenue code for the service provided. |
| Box 43 | Description | This field will auto-populate based on the value entered in box 42 once the claim is saved. |
| Box 44 | HCPCS Code | Enter the appropriate HCPCS code unless the billing is for inpatient hospitalization services and/or an appropriate HCPCS code does not exist; in that case, use the same value entered for box 42 (Revenue Code) |
| Box 45 | Service Date | **Leave this field empty if billing for date span** ; for all other billing, enter the 8 digit date of service (mm/dd/yyyy) |
| Box 46 | Service Units | Enter the number of units billed for each service provided. |
| Box 47 | Total Charges | Enter the total amount of charges incurred for each individual service during the indicated service period. |
| Box 50 | Payer Name | Select the primary payer responsible for charges incurred during the service period from the drop down menu. |
| Box 50 | Payer Name (secondary) | Select additional secondary payer(s) from the drop down menu |
| Box 51 | Health Plan ID | Enter the number(s) used by the health plan(s) to identify itself. |
| Box 52 | Release of | <i>This box will be checked automatically when a payer is</i> |

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| | Information | <i>selected; however it can be deselected if necessary.</i> Mark this box for each payer that it applies to. |
| Box 53 | Assignment of Benefits | <i>This box will be checked automatically when a payer is selected; however it can be deselected.</i> Mark this box for each payer that it applies to. |
| Box 54 | Prior Payments - secondary | Enter prior insurance payment amounts received as applicable. |
| Box 55 | Estimated Amount Due | Enter the estimated amount due from each payer indicated. If payment has been received, leave this field blank. |
| Box 56 | NPI | Check to ensure that the appropriate NPI number has been populated to this field. |
| Box 58 | Insured's Name | Enter the name of the policy holder of the primary insurance plan. If applicable, enter the name of the policy holder of any secondary insurance in the additional lines below. |
| Box 59 | Patient Relationship | Enter the code representative of the relationship of the patient to the policy holder of primary and if applicable any secondary insurance. 01- Spouse 18- Self 19- Child 20- Employee 21- Unknown 53- Life Partner G8- Other Relationship |
| Box 60 | Insured's ID number | Enter the unique policy number assigned by the health plan indicated to the insured. Do this for each payer identified. |
| Box 63 | Treatment Authorization Codes (optional) | Enter the 10 digit (will have a leading "0") code(s) assigned to the prior authorization(s) received for services billed when applicable. |
| Box 64A | Document Control Number | If the bill type indicates a replacement or void claim, enter the PBH claim number of the original submitted claim in this field. You will find the claim number on your Remittance Advice. |
| Box 67 | Principle Diagnosis code(s) | Enter the principle diagnosis in the field marked with an asterisk (*). Enter all secondary diagnosis codes in the additional fields provided. |
| Box 69 | Admission Diagnosis code (inpatient hospitalization only) | Enter the code describing the patient's diagnosis at the time of admission. |
| Box 81CCa | Taxonomy code | The descriptor "B3" will be hard coded by the billing system to identify this field as the Provider's Taxonomy code. Beside it, enter the Taxonomy Code |

