SECTION 2
UB-04 CLAIM FILING INSTRUCTIONS
INPATIENT HOSPITAL

The following instructions pertain to inpatient hospital claims which are being filed to MO HealthNet on a paper UB-04 claim form. The requirements for filing an electronic version of the UB-04 claim form for inpatient services are slightly different. If filing claims electronically via the Wipro Infocrossing Internet service at emomed.com, refer to the help link (?) at the top of the electronic UB-04 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-04 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims for hospital inpatient care are mailed to:

Wipro Infocrossing Healthcare Services, Inc.
P.O. Box 5200
Jefferson City, MO 65102

MO HealthNet forms, for claims processing can be obtained at:
http://manuals.momed.com/manuals/presentation/forms.jsp

NOTE: An asterisk (*) beside field numbers indicates required fields on all inpatient UB-04 forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
1.*	Provider Name, Address, Telephone Number	Enter the provider name, address and telephone number.
2.	Unlabeled Field	Leave blank.
3.	Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
4.*	Type of Bill	The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
		The allowed values for each of the digits found in the type of bill are listed below: Type of Facility: 1st digit: (1) Hospital Bill Classification: 2nd digit: (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit: (1) Admit thru Discharge Claim (2) Interim Bill - First claim (3) Interim Bill - Continuing claim (4) Interim Bill - Last claim
5.	Federal Tax Number	Enter the provider's federal tax number.
6.*	Statement Covers Period ("From" and "Through" dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format. It **should** include the discharge date as the through date when billing for the entire stay. Unless noted below, it **should** include all days of the hospitalization. It **should not** include date(s) of participant ineligibility. It **should not** include inpatient days that were **not** certified by Xerox such as preoperative days or days beyond the cease payment date.
7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the participant's 8-digit MO HealthNet DCN identification number. **NOTE:** The MO HealthNet DCN identification number is **required** in field 60.
8b.*	Patient's Name	Enter the participant's name in the following format: last name, first name, middle initial

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
9.	Patient's Address	Enter the participant's full mailing address, including street number and name, post office box number, or RFD, city, state, and zip code.
10.	Patient's Birth Date	Enter the participant's date of birth in MMDDYY format.
11.	Patient's Sex	Enter the participant's sex, "M" (male) or "F" (female).
12.*	Admission Date	Enter in MMDDYY format the date that the patient was admitted for inpatient care. This should be the actual date of admission regardless of the participant's eligibility status on that date or Xerox certification/denial of the admission date.
13.	Admission Hour	Leave blank.
14.*	Admission Type	Enter the appropriate type of admission; the allowed values are: 1-Emergency 2-Urgent 3-Elective 4-Newborn
15. **	Source of Admission (SRC)	If this is a transfer admission, complete this field. The allowed values are: 4-Transfer from a hospital 5-Transfer from a skilled nursing facility 6-Transfer from another health care facility.
16.	Discharge Hour	Leave Blank.
17.*	Patient Status	Enter the 2-digit patient status code that best describes the patient's discharge status. Common values are: 01-Discharged to home or self-care 02-Discharged/transferred to another short-term general hospital for inpatient care 03-Discharged/transferred to skilled nursing facility

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
17.*Patient Status (continued)	04-Discharged/transferred to an intermediate care facility 05-Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06-Discharged/transferred to home under care of organized home health service 07-Left against medical advice, or discontinued care 08-Discharged/transferred to home under care of Home IV provider 20-Expired 30-Still a patient 63-Discharged/transferred to a Medicare certified long-term care hospital (LTCH)
18*-24*Condition Codes	Enter the appropriate two-character condition code(s). The values applicable to MO HealthNet are: C1-Approved as billed. Indicates the facility's Utilization Review authority has certified all days billed. C3- Partial Approval. The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. If C3 is entered, field 35 must be completed. **NOTE:** Code C1 or C3 is required.
18*-24*Condition Codes (continued)	A1-Healthy Children & Youth/EPSDT If this hospital stay is a result of an HCY referral or is an HCY related stay, this condition code must be entered on the claim A4-Family Planning. If family planning services occurred during the inpatient stay, this condition code must be entered

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled Field	Leave blank.
31-34.**Occurrence Codes Dates	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01 - Auto accident 02 - No Fault Insurance 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim 42 - To be entered when "Through" date in field 6 (Statement Covers Period) is **not** equal to the discharge date and the frequency code in field 4 indicates this is a final bill.
35. ** Occurrence Span Code & Dates	Required if C3 is entered in fields 18-24. Enter code "MO" and the first and last days that were approved by Utilization Review.
36. Occurrence Span Code & Date	Leave blank.
37. Unlabeled Field	Leave blank.
38. Responsible Party Name and Address	Leave blank.
39-41* Value Codes & Amounts	Enter the appropriate codes(s) and unit amount(s) to identify the information necessary for the processing of the claim. 80-Covered Days Enter the number of days shown in field 6, minus the date of discharge. The discharge date is not a covered day and should not be included in the calculation of this field.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
39-41* Value Codes & Amounts (continued)	The through date of service in field 6 is included in the covered days, if the patient status code in field 17 is equal to "30-still a patient." **NOTE:** The units entered in this field must be equal to the number of days in "Statement Covers Period", less day of discharge. If patient status is "still a patient," units entered include through day. 81-Non-covered Days If applicable, enter the number of non-covered days. Examples of non-covered days are those days for which the participant is ineligible. **NOTE:** The total units entered in this field must be equal to the total accommodation units listed in field 46.
42.* Revenue Code	List appropriate accommodation revenue codes first in chronological order. Ancillary codes should be shown in numerical order. Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to ICU to general. A private room must be medically necessary and the medical need must be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

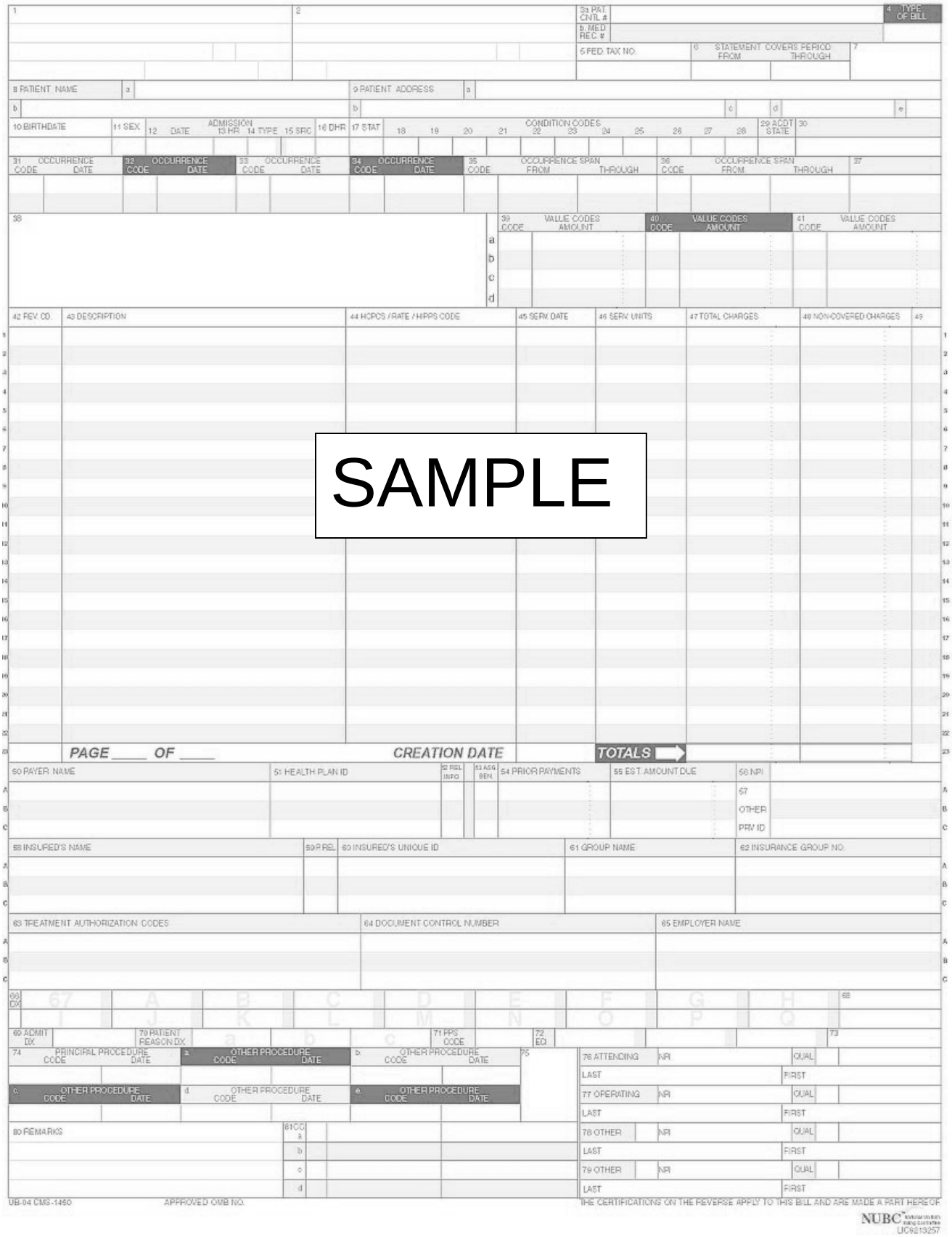
FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
42.*Revenue Code (Continued)		If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in field 47. Enter the difference between the private room total charge and the semi-private room total charge in field 48, "non-covered charges" After all revenue codes are shown, skip a line and list revenue code 001 which represents the total charges.
43.	Revenue Description	Leave blank.
44.*	HCPCS/Rates/ HIPPS Code	Enter the daily room and board rate to coincide with the accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use separate lines to report each rate.
45.	Service Date	Leave blank.
46.*	Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days. **NOTE:** The number of units in fields 39-41 must equal the number of units in this field.
47.*	Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 001. **NOTE:** The room rate multiplied by the number of units must equal the charge entered for room accommodation(s).

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
48. ** Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in fields 39-41. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was not medically necessary should be shown as non-covered in this field.
49. Unlabeled Field	Leave blank.
50.* Payer Name	The primary payer is always listed first. If the participant has insurance, the insurance plan is the primary payer and "MO HealthNet" is listed last.
51. Health Plan ID	Leave blank.
52. Release of Information Certification Indicator	Leave blank.
53. Assignment of Benefits Certification of Indicator	Leave blank.
54. ** Prior Payments	Enter the amount the hospital received toward payment of this bill from all other health insurance companies. Payments **must** correspond with the appropriate payer entered in field 50. *Do not enter a previous MO HealthNet payment, Medicare payment or co-pay amount received from the patient in this field.*
55. Estimated Amount Due	Leave blank.
56. National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number.
57.* Other Provider ID	Leave blank.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
59.	Patient's Relationship to the Insured	Leave blank.
60.*	Insured's Unique ID	Enter the participant's 8-digit MO HealthNet DCN identification number. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61. **	Insurance Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured.
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered.
63. **	Treatment Authorization Code	For claims requiring certification, enter the unique 7-digit certification number supplied by Xerox.
64. **	Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65.	Employer Name	If the participant is employed, the employer's name may be entered here.
66.	Diagnosis & Procedure Code Qualifier	Leave blank.
67.*	Principal Diagnosis Code	Enter the complete ICD-9-CM diagnosis code for the condition established after study to be chiefly responsible for the admission. Remember to code to the highest level of specificity shown in the current version of the ICD-9-CM diagnosis code book.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
67. ** A-D. Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received or the length of stay.
67. E-Q. Other Diagnosis Codes	Leave blank.
68. Unlabeled Field	Leave blank.
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment System (PPS) Code	Leave blank.
72. External Cause of Injury Code (E code)	Leave blank.
73. Unlabeled Field	Leave blank.
74. ** Principal Procedure Code & Date	Enter the full ICD-9-CM procedure code of the principal surgical procedure. The date on which the procedure was performed must be shown. Only the month and day are required.
74. ** A-E. Other Procedure Codes & Dates	Identify and date any other procedures that may have been performed.
75. Unlabeled Field	Leave blank.
76.* Attending Provider Name & Identifiers	Physician's NPI is required. Enter the attending physician's name, last name first.
77. ** Operating Provider Name & Identifiers	Physician's NPI number. Enter the operating physician's name, last name first.
78-79. ** Other Provider Name & Identifiers	Physician's NPI number. Enter the physician's name, last name first.
80. ** Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
81CC. Code-Code Field	Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy Code for the NPI number reported in field 56. The appropriate qualifier is: B3- Healthcare Provider Taxonomy Code.


SAMPLE
1
2
3a PAT. CNTL #
b MED REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28
CONDITION CODES
29 ACDT STATE
30
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
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
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
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC
a
b
c
d
UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF
NUBC
UC9213257