SECTION 5
UB-04 CLAIM FILING INSTRUCTIONS
OUTPATIENT HOSPITAL

The following instructions pertain to outpatient 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 outpatient services are slightly different. If filing claims electronically via the Wipro Infocrossing Internet service, 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 outpatient care are to be 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 outpatient UB-04 claim 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.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
4.*	Type of Bill	For an outpatient claim, the only allowed type of bill is “131”.
5.	Federal Tax Number	Enter the provider's federal tax number or leave blank.
6.	Statement Covers Period	Indicate the beginning and ending dates being being billed on this claim form. Enter in the MMDDYY or MMDDYYYY numeric format or leave blank.
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.
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	Leave blank.
13.	Admission Hour	Leave blank.
14.**	Admission Type	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type 1. Condition code AJ also must be listed in field 24 to exempt the patient from the $3 cost sharing amount for the service.
15.	Source of Admission (SRC)	Leave blank.
16.	Discharge Hour	Leave blank.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
18-24.** Condition Codes.	Enter the applicable two-character condition code. The values are: A1 - HCY/EPSDT. If this service is the result of an HCY referral or is an HCY related visit, enter this condition code. A4 - Family Planning If the family planning service occurred during the visit, enter this condition code. Do *not* bill family planning services on the same claim with non-family planning services. AJ - Payer not Responsible for Co-payment If the visit is the result of an emergency or therapy services are provided, then this condition code must be entered to exempt the patient from the $3 cost sharing amount.
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled Field	Leave blank.
31-34.** Occurrence Codes	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. 01 - Auto Accident 02 - No Fault 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim
35-36. Occurrence Span Code and Dates	Leave blank.
37 Unlabeled Field	Leave blank.
38. Responsible Party Name and Address	Leave blank.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
39-41.	Value Codes and Amounts	Leave blank
42.**	Revenue Codes	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies, and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s). If reporting a surgical procedure enter the appropriate 4-digit surgical revenue code for the surgery.
43.	Revenue Description	Leave blank.
44.*	HCPCS/Rates/HIPPS	Only enter the CPT or HCPCS procedure code(s) if for services *other* than outpatient facility codes listed in field 42. If reporting a surgical procedure enter the appropriate surgical CPT code for the surgery.
45.*	Service Date	Enter the date of service on each line in the MMDDYY format.
46.*	Service Units	Enter the number of units for each procedure, code or revenue code. Facility revenue codes 0450, 0459, 0490, 0510 and supply codes 0260, 0270 and 0274 should always be billed with a unit of "1". The outpatient observation code 0762 should be billed with the appropriate number of hours the participant was in observation status. If reporting a surgical procedure enter a unit of “1”.
47.*	Total Charges	Enter the total charge for each line item. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001. If reporting a surgical procedure the charged amount must be zero ($0.00).
48.	Non-covered Charges	Leave blank.
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.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
51.	Health Plan ID	Leave blank.
52.	Release of Information Certification Ind.	Leave Blank.
53.	Assignment of Benefits Certification Ind.	Leave Blank.
54.**	Prior Payments	Enter the amount the provider 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 a co-pay amount from the patient in this field.*
55.	Estimated Amount Due From Patient	Leave blank.
56.	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number.
57.*	Other Payer ID	Leave blank.
58.**	Insured's Name	Complete if the insured's name is different from the participant's name.
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	Leave blank.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
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 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 for which the services were provided. Remember to code to the highest level of specificity shown in the current version of the ICD-9 diagnosis code book.
67. A-D** Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received.
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 and Date	Leave blank. [Now reported at the detail line with the appropriate surgical revenue code, surgical CPT code, quantity of “1”, and charged amount of zero ($0.00)].

FILED NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
74. A-E ** Other Procedure Codes and Dates	Leave blank. [Now reported at the detail line of the claim with the appropriate surgical revenue code, surgical CPT code, quantity of “1”, and charged amount of zero ($0.00)].
75. Unlabeled Field	Leave blank.
76. ** Attending Provider Name and Identifiers	Physician's NPI is required. Enter the attending physician’s name, last name first.
77.** Operating Provider Name and Identifiers	Physician's NPI number. Enter the operating physician's name, last name first.
78-79. ** Other Provider Name and 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.
81. CC 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.


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 ADMISSION
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
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
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
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 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 a b c
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