UB04 Claim Form and Instructions

MEMORIAL HERMANN® Health Plan

The Office of Management and Budget and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form. The UB-04 claim form accommodates the National Provider Identifier (NPI) and has incorporated other important changes. Sample UB-04 forms for inpatient and outpatient claims can be found on pages 3 and 4.

The UB-04 claim form and NPI

The UB-04 claim form includes several fields that accommodate the use of your NPI. Although the form accommodates the NPI, you may continue to report your current provider identification numbers in the appropriate areas of the form until otherwise notified. If you have obtained your NPIs and submitted them to us, you must report them on the UB-04 claim form.

If you have any questions regarding the UB-04 claim form, please call your Provider Relations Representative or Customer Service at 855-645-8448.

UB-04 data field requirements

Field locater UB04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
	NDC Code	Required, if applicable	Required, if applicable

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Field locater UB04	Description	Inpatient	Outpatient
44	HCPCS/Rates	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (By Rev. Code)	Required	Required
48	Non-Covered Charges	Required, if applicable	Required, if applicable
49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification Number	Situational	Situational
52	Release of Info Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required, if applicable	Required, if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured Group Name	Situational	Situational
62	Insured Group Number	Situational	Situational
63	Treatment Authorization Codes	Required, if applicable	Required, if applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required, if applicable	Required, if applicable
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required, if applicable
70	Patient's Reason for Visit Code	Situational	Situational
71	PPS Code	Situational	Situational
72	External Cause of Injury Code	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required, if applicable	Required, if applicable
75	Future Use	N/A	N/A
76	Attending Name/ID-Qualifier 1G	Required	Required
77	Operating ID	Situational	Situational
78-79	Other ID	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code Field/Qualifiers		
	*0-A0	N/A	N/A
	*A1-A4	Situational	Situational
	*A5-AB	N/A	N/A
	AC - Attachment Control number	Situational	Situational
	AD-B0	N/A	N/A
	*B1-B2	Situational	Situational
	*B3	Required	Required

MEMORIAL HERMANN Health Plan

UB 04 Claim Submission Sample

Inpatient

MEMORIAL HERMANN
Health Plan

1		2			3a PAT. CNTL #		4 TYPE OF BILL
					b. MED. REC. #		
					5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a		9 PATIENT ADDRESS	a			
b			b			c	d	e

| 10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | CONDITION CODES 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 CODE SPAN FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

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
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	*PAGE ___ OF ___*	*CREATION DATE*		**TOTALS** ➡			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57 OTHER PRV ID	A
B								B
C								C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
		I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI	QUAL
				LAST FIRST	
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI	QUAL
				LAST FIRST	
80 REMARKS	81CC a			78 OTHER NPI	QUAL
	b			LAST FIRST	
	c			79 OTHER NPI	QUAL
	d			LAST FIRST	

OUTPATIENT

1		2			3a PAT. CNTL #		4 TYPE OF BILL
					b. MED REC. #		
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a		9 PATIENT ADDRESS	a				
b			b			c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 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 CODE SPAN FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES 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
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
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18							18
19							19
20							20
21							21
22							22
23	*PAGE ___ OF ___*	**CREATION DATE**		**TOTALS** ➤			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57 OTHER PRV ID	A
B								B
C								C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
		I	J	K	L	M	N	O	P	Q
69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73						

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING	NPI		QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST		FIRST	
				77 OPERATING	NPI		QUAL
80 REMARKS	81CC a			LAST		FIRST	
	b			78 OTHER	NPI		QUAL
	c			LAST		FIRST	
	d			79 OTHER	NPI		QUAL
				LAST		FIRST	