REVISION DATES: 11/23/2018; 10/1/2018; 7/10/2018; 7/3/2018; 6/27/2018; 4/20/2018; 4/13/2018; 10/15/2015; 09/15/2015; 10/01/2014

General Information on the UB-04 Claim Form & Claim Submissions

Please read the below section in full, prior to proceeding to the section called *Completing the UB-04 Claim Form*.

The following instructions explain how to complete the UB-04 Claim Form and whether a field is "Required," "Required if applicable," or "Not required." These instructions are to be supplemented with the information and codes in the *Uniform Billing Manual for the UB-04*.

These instructions are only applicable to filling out a **paper UB-04 claim form, *for DRG-excluded facilities*.**

- NOTE: The preferred method of claims submission remains the HIPAA-compliant 837 transaction process. If a provider is not set up to perform the 837 transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

  For information on how to submit claims using the HIPAA-compliant 837 transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate Implementation Guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinics, nursing homes, free-standing birthing centers, residential treatment centers, and hospice services also are billed on the UB-04 claim form. Claims for IHS and Tribally owned and/or operated 638 facilities, requesting reimbursement at the All-Inclusive Rate (AIR) are also submitted on the UB-04.

Revenue codes:

- Are used to bill line-item services provided in a facility,
- Must be valid for the service provided, and
- Must be valid for the bill type on the claim.

ICD-10 codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

All claims must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

ICD-10 codes must be used to identify surgical procedures billed on the UB-04.

CPT/HCPCS codes and modifiers must be used to identify other services rendered.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 53.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-22) under fields 42-48 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

Refer to Chapter 11, Hospital Services APR-DRG, of the Fee-For-Service Provider Billing Manual for facilities excluded from the APR-DRG reimbursement methodology.

> **Note:** Effective October 1, 2014, AHCCCS determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology.
>
> Refer to FFS Chapter 11 Hospital Services APR-DRG for specific billing requirements of the DRG reimbursement methodology.

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

Completing the UB-04 Claim Form

1. Provider Data **Required**

Enter the name, address, and phone number of the provider rendering the service.

1
Arizona Hospital 123 Main Street Scottsdale, AZ 85252

2. Billing Provider's Designated Pay-to Address **Required if applicable**

Report this only when it is different from the address reported in Field 1.

3.a PAT CNTL # (Patient Control No.) **Required**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

3.b MED REC. # (Medical/Health Record No.) **Required if applicable**

4. Type of Bill **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See the *UB-04 Manual* for codes. Note: Do not add an extra zero to the 3 digit number. Adding a 4th digit will result in the claim to deny.

2.	3a PATIENT CONTROL NO.	4. TYPE OF BILL
	3b MED REC #	111

5. Fed Tax No. — Required

Enter the facility's federal tax identification number. This should be a 9 digit number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
861234567			

6. Statement Covers Period — Required

Enter the beginning and ending dates of the billing period.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
	MM/DD/CCYY MM/DD/CCYY		

Or

	MM/DD/CCYY MM/DD/CCYY	

7. Blank Field **Not Required**

8. Patient Name/Identifier **Required**

Enter the member's last name, first name, and middle initial as they appear on the AHCCCS ID card.

8a. Enter the member's identification number, from their AHCCCS ID card.
8b. Enter the member's name.

8 Patient Name	a
b	

9. Patient Address **Required**

9a. Enter the member's street number and street address.
9b. Enter the member's city.
9c. Enter the member's State
9d. Enter the member's zip code.
9e. Enter the member's country.

9 Patient Address	a		
b	c	d	e

10. Birthdate **Required**

Member's date of birth.

11. Sex **Required if applicable**

Member's sex, if applicable.

12. Date (Admission Start of Care Date) **Required**

This is the admission start of care date.

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY			

13. HR (Admission Hour) — Required if applicable

Enter the hour in which the patient is admitted for inpatient or outpatient care, using Military Standard Time (00-23) in top-of-hour times only.

Note: **Admission hour requires a 2 digit number.** See example times under field 16, DHR (Discharge Hour).

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY	08		

14. Type (Priority of Admission/Visit) — Required

This is required for all claims. Enter the code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

- 1 for Emergency
- 2 for Urgent
- 3 for Elective
- 4 for Newborn
- 5 for Trauma

Admission			
12 Date	13	14	15 SRC

	HR	Type	
MM/DD/CCYY	08	1	

15. Point of Origin for Admission or Visit **Required**

This indicates the point of patient origin for the admission or visit. It is the source of referral for the admission or visit, and will always be entered in as 1 character. (Example: 1 will be 1, not 01.)

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY	08	1	8

16. DHR (Discharge Hour) **Required if applicable**

Enter the time (two digits), which best indicates the member's time of discharge. This is required for inpatient claims when the member has been discharged. See the *UB-04 Manual* for code structure.

12:00 a.m. = 00	6:00 a.m. = 06	12:00 p.m. = 12	6:00 p.m. = 18
1:00 a.m. = 01	7:00 a.m. = 07	1:00 p.m. = 13	7:00 p.m. = 19
2:00 a.m. = 02	8:00 a.m. = 08	2:00 p.m. = 14	8:00 p.m. = 20
3:00 a.m. = 03	9:00 a.m. = 09	3:00 p.m. = 15	9:00 p.m. = 21
4:00 a.m. = 04	10:00 a.m. = 10	4:00 p.m. = 16	10:00 p.m. = 22
5:00 a.m. = 05	11:00 a.m. = 11	5:00 p.m. = 17	11:00 p.m. = 23

17. STAT (Patient discharge status) **Required**

Required for all claims. Enter the 2 digit code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

18-28 Condition Codes **Required if applicable**

Enter the appropriate condition codes that apply to this bill. See the *UB-04 Manual* for codes.

Examples:
In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.

29. ACDT State (Accident State) **Required if applicable**

31-34 Occurrence Codes and Dates **Required if applicable**

35-36. Occurrence Span Codes and Dates **Required if applicable**

38. Responsible Party Name and Address **Required if applicable**

39-41 Value Codes and Amounts **Required if applicable**

Value codes identify special circumstances that may affect the processing of the claim. See the NUBC manual for specific codes.

42. Revenue Code **Required**

Enter the appropriate 4 digit revenue code(s) that describe the service(s) provided. See the *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in

ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

If this field is left blank the claim will be returned to the provider.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0132		
2	0251		
3	0258		
4			

43. Revenue Code Description/NDC (effective 7/1/12) Required/NDC if applicable

Enter the description of the revenue code billed in Field 42. See the *UB-04 Manual* for the descriptions of revenue codes.

*To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens or spaces.
- The NDC Unit of Measurement Qualifier*
    - UN = Unit
    - ML = Milliliters
    - GR = Gram
    - F2 = International Unit
- The NDC Unit Quantity is the amount of medication administered. **<u>If</u>** it includes a decimal point, a decimal point **<u>must</u>** be used and a blank space cannot be left in place of the decimal point. There is a **limit** of 3 characters to

the right of the decimal point. (i.e. 1234.456). Any unused spaces are left blank.

IMPORTANT NOTE: If the NDC Unit Quantity has a space in it, it can result in errors.

Example 1 (Incorrect Example): A provider is attempting to bill for 20 milliliters, and enters the following on their claim:

N412345678901ML20 500

This would be read as **20500**.000 and not as **20.5**00

To correct the above example, the provider would enter:
N412345678901ML20.500

Example 2 (Incorrect Example):
A provider is attempting to bill for 1 unit, and enters the following on their claim.

N412345678901ML1 000

This would be read as **1000**.000 and not as **1**.000

To correct the above example, the provider would enter:
N412345678901ML1.000 *or* **N412345678901ML1**

Example 3 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N40007411527 ML10	J1642	2.00
2				
3				

Example 4 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

NOTE: The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

*Refer to the AHCCCS Pharmacy webpage for billing details at:
https://azahcccs.gov/Resources/GuidesManualsPolicies/pharmacyupdates.html

44. HCPCS/Rates **Required if applicable**

Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services (See Chapter 11, Hospital Services).

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1			95901
2			85595
3			9590025
4			

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

45. Service Date **Required**

The dates indicated that outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46. Service Units **Required**

Number of units for ALL services must be indicated.

If accommodation days are billed, the number of units billed must be consistent with the patient discharge status field (Field 17, STAT) and statement covers period (Field 6). If the member has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the member expired or has not been discharged, AHCCCS covers the admission date through last date billed.

46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
2			
3			
30			

- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2
2				
3				

47. Total Charges **Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99.

In line 23, the total charges are represented by revenue code 0001. In Field 47, the total charges must be the last entry. Total charges on one claim cannot exceed $999,999,999.99.

On the UB-04 form also indicate the corresponding page number of the claim.

Note: For multi-page claims, **all lines (1-22) must be completed on the first page, before proceeding to the second page** of the claim. AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and filled in first.**

	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	0250	N400074115278 ML10	J1642	MM/DD/CCYY	2	589	20				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
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16											16
17											17
18											18
19											19
20											20
21											21
22											22
23	0001	PAGE 2 OF 2	CREATION DATE		TOTALS	20102	29	0	00		23

46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
	2,176	00			
	104	26			
	529	92			

48. Non-Covered Charges — Required if applicable

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 0001. Do not subtract this amount from total charges.

50. (A–C) Payer Name — Required

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the member and from

which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

	50. PAYER NAME	51. Health Plan Identification.	52. REL INFO		53. ASG BEN
A	AHCCCS				
B	Medicare Part B				
C					

51. (A–C) Health Plan Identification No. Required

Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility's six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

	50. PAYER NAME	51. Health Plan Identification No.	52. REL INFO		53. ASG BEN
A		654321			
B					
C					

52. (A–C) REL INFO (Release of Information) Not required

53. (A–C) ASG BEN (Assignment of Benefits) Not required

54. (A–C) Prior Payments Required if applicable

Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If

the member has other insurance but no payment was received, enter "Ø." The " Ø " indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

55. (A–C) Est. Amount Due **Not required**

56. NPI - National Provider Identifier - Billing Provider **Required**

57. Other (Billing) Provider Identifier **Required if applicable**

58. (A–C) Insured's Name **Not Required**

Enter the name of insured (AHCCCS member) covered by the payer(s) in Field 50.

	58. INSURED'S NAME	59. P.REL.	60. INSURED'S UNIQUE ID
A	Doe, John		
B			
C			

59. (A–C) P Rel. (Patient's Relationship To Insured) **Not required**

60.A. Insured's Unique ID **Required**

Enter the member's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Member Eligibility and Enrollment).

Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. –SSN - HIC. - ID NO.
A			A99999999

B			
C			

61. (A–C) Group Name **Not required**

60. CERT. –SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.

62. (A–C) Insurance Group Number **Not required**

63. (A–C) Treatment Authorization **Not required**

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 8, Authorizations, of the Fee-For-Service Provider Billing Manual for information on prior authorization.

64. Document Control Number **Required if applicable**

If the claim is a replacement or void, the original CRN shall be entered in this field.

65. (A–C) Employer Name **Not required**

66. DX (Diagnosis and Procedure Code Qualifier) **Required**

Note: ICD Ind. Field: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

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

67. Principal Diagnosis Code **Required**

Enter the **principal** *ICD diagnosis code*.

Behavioral health providers must **not** use DSM-4 diagnosis codes.

Note: In each diagnosis code box there is a grayed out area. This is the diagnosis indicator area. If a diagnosis code is entered in, please enter in the appropriate diagnosis indicator (i.e. Y or N).

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

69. Admitting Diagnosis **Required**

This field is required for inpatient bills. Enter the ICD diagnosis code that represents the significant reason for admission.

70. Patient Reason DX (Patient's Reason for Visit) **Required if applicable**

71. PPS Code **Required if applicable**

Enter the DRG diagnosis code for the claim in this field.

72 ECI (E-Codes) Required if applicable

Enter the trauma diagnosis code, if applicable.

74. Principal Procedure Code and Dates Required if applicable

Enter the principal ICD procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/CCYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

For fields concerning provider information:

After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members. This applies to *all* providers, including attending providers.

For additional information on this requirement, refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

76. Attending Provider name and identifiers Required if applicable

NPI, ID (QUAL), First and Last name.

77. Operating Physician Name and Identifiers Required if applicable

NPI, ID (QUAL), First and Last name.

78. Referring Provider Required if applicable

NPI, ID (QUAL), First and Last name.

79. Other Physician **Not required**

NPI, ID (QUAL), First and Last name.

80. Remarks **Required if applicable**

This field is required on replacements, adjustments, and voids.

Enter the CRN of the claim that is being replaced by this resubmission, adjustment, or void. For resubmissions of denied claims, write "Resubmission" in this field.

81. a Other Procedure Codes **Required if applicable**

Enter taxonomy code

81. b-d Other Procedure Codes **Not required**

Revision History

Date	Description of changes	Page(s)
11/23/2018	The order of the examples in Field 16 was updated, so that midnight (12 a.m.) is now first. Field 43 comprehensively updated to clarify how the unit quantity should be entered.	7 9-11
10/1/2018	Field 66 updated to add clarifying information regarding diagnosis code qualifiers. The following was removed: "When submitting claims via fax it is recommended to fax in the following order: ADA 2012 claim form first, the Explanation of Benefits (EOB) second (if applicable), and any applicable medical documentation third. "	16-17 1
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	All
7/3/2018	A multi-page requirement was removed from Field 47 in regards to total charges.	12-13
6/27/2018	The following clarification was added to field 13: "Note: **Admission hour requires a 2 digit number.** See example times under field 16, DHR (Discharge Hour)." Correction to DHR example.	6 7

4/20/2018	Clarifications added regarding the need to have lines 1-22 filled out (under fields 42-48) in entirety before proceeding to the second page.	2 & 12-13
4/13/2018	Clarification added to the General Information on the UB-04 Claim Form & Claim Submissions section, including that this chapter applies to paper claims only, the preferred font type and size, the preferred methods of claims submissions (HIPAA-Compliant 837 transaction process and AHCCCS Online provider portal), and information on what can make a claim deny. Clarification added to Fields 3a, 3b, 4, 5, and 7-12. Clarification added to Field 13, including examples on the use of military standard time. Clarification added to Field 14, including examples of the admission type codes. Clarification added to Field 15, including examples of how the point of origin code should be entered. Clarification added to Field 16, including examples on the use of military standard time. Clarification added to Field 17. Clarification added to Field 29. Clarification added to Fields 39-42, and revenue codes updated to a 4 digit format. Clarification added to Field 43, including examples of the accepted abbreviations for the NDC Unit of Measurement Qualifier. Clarification added to Field 44. Clarification added to Fields 46-51. Clarification added to Fields 52 and 53. Clarification added to Fields 63 and 64. Example and clarification added to Field 67. Clarification added to Fields 70, 71, 72, 76, 77, 78, and 79. Clarification on provider registration requirements added to field 76. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated UB-04 Claim Form. Formatting	1-2 3-6 6 6-7 7 7 7-8 8 8-9 9 10 11-14 15 16 17 17-18 18 All All All
10/15/2015	Field 43: added AHCCCS Pharmacy website address for NDC billing information Correction to fields: 60 - Required 71 – added 78, 79 split into 2 separate items 81 split into 2 separate items	7 13 14 15 15

09/15/2015	New format "ICD-9" replaced with "ICD"	All multiple
10/01/2014	APR-DRG effective	All