Instructions for Completing the UB-04 Claim Form

The UB04 claim form is used to submit claims for inpatient and outpatient services by institutional facilities (for example, outpatient departments, Rural Health Clinics, chronic dialysis and Adult Day Health Care). A UB04 with field descriptions and instructions is included in the link below:

UB-04 Field Location	Required Field?		Description and Requirements
	Inpatient	Outpatient	
1	**Required**	**Required**	Rendering Provider Name and Address - Enter the provider name, address and zip code and telephone number this section.
2	**Required**	**Required**	Pay-To Provider Name and Address - Enter the provider name, address and zip code and telephone number this section.
3a	optional	optional	Patient Control Number - This number is reflected on the Explanation of Benefits for reconciling payments if populated.
3b	not required	not required	Medical Record Number - Not required. This number will not be reflected on EOB if populated.
4	**Required**	**Required**	Type of Bill - Enter the appropriate **four**-character type of bill code as specified in the National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual.
5	**Required**	**Required**	Federal Tax Number - Enter the Federal Tax ID for the billing facility. (Note: If vendor tax ID # is shared between two or more individual vendors, the provider must submit claims using a SFHP-issued 3-digit suffix addition to the Tax ID number)
6	**Required**	**Required**	Statement Covers Period - Enter the "From" and "Through" dates of services covered on the claim if claim is for inpatient services.
7	not required	not required	Future Use
8a	not required	not required	Patient Name - Enter patient's name in 8b

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8b	**Required**	**Required**	Patient Name – Enter patient's last name, first name and middle initial if known. When submitting claim for a newborn using the mother's ID, enter the infant's name in box 8b. If the infant is unnamed, write the mother's last name followed by "baby boy" or "baby girl". If billing for multiple births, use "twin A", "twin B", etc. on separate claim forms.
9	not required	not required	Patient Address
10	**Required**	**Required**	Patient Birthdate – Enter the patient's date of birth in an eight digit format, Month, Date, Year (MMDDYYYY) format.
11	**Required**	**Required**	Patient Sex – Use the capital letter "M" for male, or "F" for female.
12	**Required**	**Required**	Admission Date – Enter in a six-digit format (MMDDYY), enter the date of hospital admission.
13	**Required**	**Required**	Admission Hour – Enter hour of patient's admission.
14	**Required**	**Required**	Admission/Visit Type – Enter the numeric code indicating the necessity for admission to the hospital. 1 – Emergency 2 – Elective
15	***If Applicable***	***If Applicable***	Admission Source – If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. 1 – Non-Healthcare Facility Point of Origin 2 – Clinic 4 – Transfer from a Hospital (Different Facility) 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 – Transfer from Another Healthcare Facility 7 – Emergency Room 8 – Court/Law Enforcement 9 – Information Not Available B – Transfer from Another Healthcare Facility C – Readmission to the same Home Health Agency D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E – Transfer from Ambulatory Surgery Center F – Transfer from Hospice and is under a hospice plan of care or enrolled in a hospice program
16	**Required**	n/a	Discharge Hour – Enter the discharge hour. For

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			Inpatient only.
17	**Required**	**Required**	Patient Discharge Status
18 – 28	optional	optional	Condition Codes – Enter the Medi-Cal codes used to identify the condition relating to this bill and affect payer processing. Condition Codes covered by SFHP: 80 – Other Coverage 81 – Emergency Certification A1 – CHDP Screening Related A3 – Family Planning/Sterilization A4 – Family Planning/Other
29	***If Applicable***	***If Applicable***	Accident State – If visit or stay is related to an accident, enter in which state accident occurred.
30	n/a	n/a	Future Use
31 – 34	***If Applicable***	***If Applicable***	Occurrence Codes and Dates – Enter the codes and associated dates that define the significant even related to the claim. Occurrence Codes covered by SFHP: 01 – Auto Accident 02 – No Fault Insurance Involvement – Including Auto Accident/Other 03 – Accident/Tort Liability 04 – Employment Related 05 – Other Accident 06 – Crime Victim
35 –36	not required	not required	Occurrence Span Codes and Dates
37	not required	not required	Internal Control Number/Document Control Number
38	***If Applicable***	***If Applicable***	Responsible Party Name and Address – Enter the name and address of the party responsible for payment if different from name in box 50
39 – 41	not required	not required	Value Codes and Amounts
42	**Required**	**Required**	Revenue Code – For inpatient billing, enter the **four**-digit revenue code for the services provided, e.g. room and board, obstetrics, etc.
43	**Required**	**Required**	Revenue Description – Identify the description of the particular revenue code in box 42 or HCPCS code in box 44. Include NDC/UPN Codes here, when applicable.

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44	**Required**	**Required**	HCPCS/Rates - Enter the applicable HCPCS codes and modifiers. For outpatient billing do not bill a combination of HCPCS and Revenue codes on the same claim form. When billing for professional services, use CMS 1500 form.
45	**Required**	**Required**	Service Date - Enter the service date in MMDDYY format for outpatient billing.
46	**Required**	**Required**	Units of Service -Enter the actual number of times a single procedure or item was performed or provided for the date of service.
47	**Required**	**Required**	Total Charges (By Rev. Code)
48	not required	not required	Non-Covered Charges
49	n/a	n/a	Future Use
50	**Required**	**Required**	Payer Identification (Name) - Enter "San Francisco Health Plan" and the corresponding medical group that the member belongs to.
51	not required	not required	Health Plan ID
52	not required	not required	Release of Info Certification
53	not required	not required	Assignment of Benefit Certification
54	***If Applicable***	***If Applicable***	Prior Payments - Enter any prior payments received from Other Coverage in full dollar amount.
55	not required	not required	Estimated Amount Due
56	**Required**	**Required**	NPI - Enter NPI number
57	not required	not required	Other Provider IDs
58	***If Applicable***	***If Applicable***	Insured's Name -Enter the mother's name if billing for an infant using the mother's ID. If any other circumstance, leave blank.
59	***If Applicable***	***If Applicable***	Patient's Relation to Insured -Enter "03" (child) if billing for an infant using the mother's Identification Number

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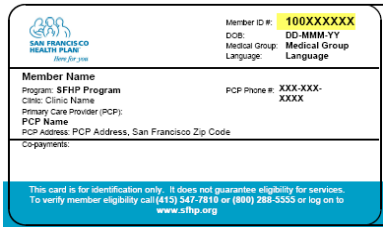
60	**Required**	**Required**	Insured's Unique ID – Enter the patient's 11-digit SFHP ID number as it appears in the member's ID card. Enter the mother's ID number in this section for a newborn infant for the month of birth and the month after only. Do not use the SSN or CIN. 
61	not required	not required	Insured Group Name
62	not required	not required	Insured Group Number
63	***If Applicable***	***If Applicable***	Treatment Authorization Code – Enter any authorizations numbers in this section. It is not necessary to attach a copy of the authorization to the claim. Member information from the authorization must match the claim.
64	not required	not required	Document Control Number
65	not required	not required	Employer Name
66	**Required**	**Required**	Diagnosis/Procedure Code Qualifier – Enter Diagnosis/Procedure Code Qualifier
67	**Required**	**Required**	Principal Diagnosis Code/ Other Diagnosis Codes – Enter all letters and/or numbers of the ICD-9 CM code for the primary diagnosis including the fourth and fifth digit if present.
68	***If Applicable***	***If Applicable***	Other Diagnosis Codes – Enter all letters and/or numbers of the secondary ICD-9 CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
69	***If Applicable***	***If Applicable***	Admitting Diagnosis Code
70	optional	optional	Patient's Reason for Visit Code
71	optional	optional	PPS Code
72	not required	not required	External Cause of Injury Code
73	not required	not required	Future Use

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74	*If Applicable*	*If Applicable*	Principal Procedure Code/Date
75	n/a	n/a	Future Use
76	*If Applicable*	*If Applicable*	Attending Name/ ID-Qualifier 1G
77	*If Applicable*	*If Applicable*	Operating ID
78 - 79	*If Applicable*	*If Applicable*	Other ID
80	*If Applicable*	*If Applicable*	Remarks
81CC	not required	not required	Code-Code Field/Qualifiers

Expired Medi-Cal Codes - 1/15/11 – 10/15/11

For your convenience, the attached link includes a list of the CPT codes that have been cancelled and/or expired for Medi-Cal. These codes should not be used on claims submitted to SFHP. Claims systems at SFHP have been updated and only valid codes will be accepted. The usage of cancelled or expired codes for services will result in a claim denial.

Include link here