5.   UB-04 Claim Form Version CMS-1450

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the UB-04 billing form and must be used in conjunction with the Mississippi Administrative Code Title 23. Institutional providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement The Administrative Code and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. Contact Gainwell's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for questions and assistance.

5.1.   Provider Types

The instructions for the UB-04 claim form are to assist the following types of providers:

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Hospitals
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Nursing Facilities
- Psychiatric Residential Treatment Facilities (PRTF)
- Swing-Bed

5.2.   Web Portal Reminder

Providers are encouraged to use the Mississippi MESA Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, seven days a week, 365 days a year via the Internet at https://portal.ms-medicaid-mesa.com/MS/Provider.

5.3.   Paper Claim Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original UB-04 claim form must be completed.
- No photocopied or fax claims are accepted.
- Do not include handwritten information on the claim form.
- Blue or black ink must be used to fill out the form.
- The information on the form must be legible.
- No highlighters should be used.
- Correction fluid or correction tape should not be used.
- Names, codes, numbers, etc. must print in the designated fields for proper alignment.
- Claim information must remain within the outlines of the data fields.
- Claim information includes:
  - Beneficiary Medicaid ID
  - Provider NPI

- o Diagnosis code

- o Type of Bill

- o At least one claim line detail

- Claim must include all required attachments when applicable. Attachments must be legible and paid date must be included on the EOB/EOMB.

5.4.   Multi-Page Paper Claims

When submitting UB-04 claims with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to ten pages with a maximum of 220 claim lines.

- The first form should not be totaled.

- Pages together must be clipped together.

- Indicate Page X of 10 in line 23

- Use code 0001 (total charges) on the last page. Enter the 0001 totals code in the box next to the number 23 on the last page.

- If reporting a Third-Party Liability (TPL) payment, indicate in FL 54 (Figure 97) on the first page.

- Only one copy of an attachment (e.g., EOB, EOMB, and Consent Form) is required per claim.

5.5.   Paper Claims with Attachments

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.

- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.

- For claims with third party payor source, all EOBs that relate to the claim should be included.

- MEDICARE DENIAL, SEE ATTACHED should be entered in FL 80 (Figure 124) for Medicare denials.

- TPL DENIAL, SEE ATTACHED should be entered in FL 80 for other insurance denials.

5.6.   Electronic UB-04 Claims

Electronic UB-04 claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature

- Using other proprietary software purchased by the provider

- Using a clearinghouse to forward claims to Mississippi Medicaid

Electronic UB-04 claims must be submitted in a format that is HIPAA compliant with the ANSI X12 837I claim standards.

5.7.   Claim Mailing Address

Once the claim form has been completed and checked for accuracy, the completed claim form can be mailed to:

Mississippi Medicaid Program

PO Box 23076

Jackson, MS 39225-3076

5.8.   UB-04 Claim Form Instructions – Institutional Claims

The field instructions are as follows:

Figure 61. FL 1 Required: Billing Provider Name, and Address

```
1  Sunny Hospital
   P.O. Box 5789
   Jackson, MS 39201-0015
```

Instructions: Enter the billing provider name and address (including the expanded ZIP Code+4) currently on file with DOM as follows:

- Line 1: Billing Provider Name
- Line 2: Billing Provider Street Address
- Line 3: Billing Provider City, State and Zip Code+4

Figure 62. FL 2 Situational: Service Location Information

```
2  Sunny Hospital
   321 Sun Lane Drive
   Jackson, MS 39201-0015
```

Instructions: This field is required when the billing provider has multiple Medicaid Provider ID numbers associated with the NPI. Enter the service location name and address (including the expanded ZIP Code+4) where the patient was seen (which must match the service location address currently on file with DOM for the billing provider where the service was rendered) as follows:

- Line 1: Billing Provider Name
- Line 2: Billing Provider Street Address
- Line 3: Billing Provider City, State and Zip Code+4

Figure 63. FL 3a Situational: Patient Control Number

```
3a PAT.
CNTL #   987562
```

Instructions: Enter the patient's unique account number assigned by the provider account number. Patient Control number must be 20 characters or less.

Figure 64. FL 3b Situational: Medical/Health Record Number

```
b. MED.
REC. #   HX1590Z1
```

Instructions: The number assigned to the patient's medical/health record by the provider. This is not the same information as FL 3a. Patient Medical/Health Record number must be 38 characters or less.

Figure 65. FL 4 Required: Type of Bill

```
4  TYPE
   OF BILL
   XXX
```

Instructions: Enter the appropriate Type of Bill (TOB) code. This code indicates the specific TOB being submitted and is critical to ensure accurate payment. This four-digit code requires a leading zero plus one digit from each of the four categories, written in the following sequence:

- First digit – Type of Facility

- Second digit – Bill Classification

- Third digit – Frequency

Example: TOB 111

- First digit – 1-Hospital

- Second digit – 1-Inpatient (Including Medicare Part A)

- Third digit – 1-Admit Through Discharge

The valid values for the first, second, and third digits are listed in the tables below.

Table 3.   Type of Facility (First Digit) Code Values

Type of Facility (First Digit)	Code
Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Specialty Facility	8
RESERVED for NATIONAL USE	9

Table 4.   Bill Classification – Except Clinics and Special Facilities (Second Digit) Code Values

Bill Classification – Except Clinics and Special Facilities (Second Digit)	Code
Inpatient (Including Medicare Part A)	1
Inpatient (Medicare Part B Only)	2
Outpatient	3
Other (for Hospital Referenced Diagnostic Services, or Home Health Not Under Plan of Treatment)	4
Intermediate Care - Level I	5
Intermediate Care - Level II	6
Subacute Inpatient (Revenue Code 19X Required)	7
Swing Beds	8
RESERVED for NATIONAL USE	9

Table 5.   Bill Classification – Clinics Only (Second Digit) Code Values

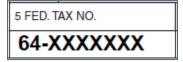| Bill Classification – Clinics Only (Second Digit)	Code
Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Outpatient Rehabilitation Facility (ORF)	4
Comprehensive Outpatient Rehabilitation Facilities (CORFS)	5
Community Mental Health Center	6
RESERVED for NATIONAL USE	7-8
Other	9

Table 6.   Bill Classification – Special Facilities Only (Second Digit) Code Values

Bill Classification – Special Facilities Only (Second Digit)	Code
Hospice (Non-Hospital Based	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center	3
Free Standing Birthing Center	4
Rural Primary Care Hospital	5
RESERVED for NATIONAL USE	6-8
Other	9

Table 7.   Frequency (Third Digit) Code Values

Frequency (Third Digit)	Code
Non-Payment/Zero Claim	0
Admit Through Discharge	1
Interim, First Claim	2
Interim, Continuing Claim	3
Interim, Last Claim	4
Late Charge(s) Only Claim	5
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8
RESERVED for NATIONAL USE	9

Figure 66. FL 5 Situational: Federal Tax Number

5 FED. TAX NO.
64-XXXXXXX

Instructions: This is the Tax Identification Number (TIN) of the entity to be paid for the submitted services.

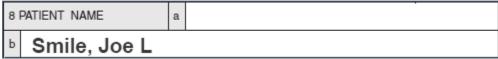**Figure 67. FL 6 Required: Statement Covers Period (From – Through)**

6 STATEMENT COVERS PERIOD	
FROM	THROUGH
01012022	01052022

Instructions: The date format is eight digits MMDDCCYY (e.g., 01012022). Enter the beginning service date in the "From" area and the end service date in the "Through" area of this field. For services received on a single day, enter that date on both the "From" and "Through" box.

Figure 68. FL 7 Not Required: Reserved for Assignment by the NUBC

```
7
```

Instructions: Leave this field blank.

Figure 69. FL 8a-b: Patient Name

8 PATIENT NAME	a	
b	Smile, Joe L	

Instructions: Enter the patients full name as follows:

- FL 8a: Patient's Identifier – Leave this field blank.

- FL 8b: Patient's Name – This is a required field. Enter the patient's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format.

Figure 70. Examples of Patient's Medicaid ID Card

Standard Blue Medicaid ID Card | Family Planning Waiver Yellow Medicaid ID Card

Figure 71. FL 9a-e Situational: Patient Address

9 PATIENT ADDRESS	a	402 Concourse Lane				
b	Meridian		c	MS	d	39207	e

Instructions: Enter the patient's full mailing address as follows:

- FL 9a: Patient's Street Address – Enter the patient's street address or PO Box.

- FL 9b: Patient's City – Enter the patient's city.

- FL 9c: Patient's State – Enter the patient's state.

- FL 9d: Patient's ZIP Code – Enter the patient's zip code.

- FL 9e: Patient's Country Code – Enter the patient's country code only required if the country is other than USA.

Figure 72. FL 10 Required: Patient Birth Date

10 BIRTHDATE
03201971

Instructions: Enter the month, day, and year of birth of patient. The date format is eight digits [MMDDCCYY (e.g., 03201971)].

Figure 73. FL 11 Required: Patient Sex

Instructions: Enter the sex of the patient. The valid values are:

- F – Female
- M – Male
- U – Unknown

Figure 74. FL 12 - 15 Situational: Admission Date, Hour, Type, and Source

Instructions: Enter the admission date, hour, type, and source as follows:

- FL 12: Admission Date – Enter the month, day, and year of the admission of the member.
  - The date format is eight digits [MMDDCCYY (e.g., 01012022)].
  - This field is required on inpatient claims.
- FL 13: Admission Hour – Enter the time of admission in military time (e.g., 06:00 p.m. is 18:00 in military time). This field is required on inpatient claims.
- FL 14: Admission Type – Enter the appropriate admission code. This field is required when patient is being admitted for inpatient services.
  - Valid values are:
    - 1 – Emergency

      The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions.
    - 2 – Urgent

      The patient requires immediate attention for the care and treatment of a physical or mental disorder.
    - 3 – Elective

      The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
    - 4 – Newborn

      Any newborn infant born within a hospital setting.
    - 5 - Trauma Center

      The patient visits a trauma center/hospital (as licensed or designated by the state or local government entity authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation).
    - 9 – Information Unavailable

      The provider is unable to clarify the type of admission; this is rarely used.

- FL 15: Admission Source – Enter the code indicating the source of the referral for the admission or visit. Required for all inpatient and outpatient services.

Table 8.   Admission Source Code Definitions

Code	Newborn Admission Sources/Definition
1-3	Discontinued
4	Born inside hospital
5	Born outside hospital

Code	Admission Sources/Definition
1	Non-healthcare Facility Point of Origin
*2	Clinic Referral
3	Discontinued
*4	Transfer from a Hospital (different facility)
5	Transfer from a Skilled Nursing Facility
*6	Transfer from another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	Reserved for Assignment by NUBC
B	Transfer from another home health agency
C	Readmission to same home health agency
D	Transfer from one distinct unit of hospital to another distinct unit of hospital
*E	Transfer from Ambulatory Surgical Center
*F	Transfer from Hospice

* require NPI in FL 76

Figure 75. FL 16 Not Required: Discharge Hour

16 DHR

Instructions: Leave this field blank.

Figure 76. FL 17 Required: Patient Discharge Status

17 ST AT
01

Instructions: Enter the member's disposition or discharge status at the end of service for the period covered on this bill, as reported in FL 6, (Figure 67). The valid values and their descriptions for this field are listed in the following table.

Table 9.   Patient Discharge Status and Description

Patient Status	Description
01	DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE)
02	DISCHARGED/TRANSFERRED TO A SHORT-TERM GENERAL HOSPITAL FOR INPATIENT CARE
03	DISCHARGED/TRANSFERRED TO SNF WITH MEDICARE CERTIFICATION IN ANTICIPATION OF COVERED SKILLED CARE
04	DISCHARGED/TRANSFERRED TO AN INTERMEDIATE CARE FACILITY (ICF)

Patient Status	Description
05	DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER OR CHILDRENS HOSPITAL
06	DISCHARGED/TRANSFERRED HOME UNDER CARE OF ORGANIZED HH SVC ORG IN ANTICIPATION OF COVD SKILLED CARE
07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE
08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF HOME IV PROVIDER
09	ADMITTED AS AN INPATIENT TO THIS HOSPITAL
20	EXPIRED
21	DISCH/TRANSF TO COURT/LAW ENFORCEMENT
30	STILL PATIENT
40	EXPIRED AT HOME
41	EXPIRED IN A MEDICAL FACILITY (E.G. HOSPITAL, SNF, ICF, OR FREE-STANDING HOSPICE)
42	EXPIRED - PLACE UNKNOWN
43	DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACILITY
50	HOSPICE - HOME
51	HOSPICE - MEDICAL FACILITY
61	DISCHARGED/TRANSFERRED TO HOSPITAL-BASED MEDICARE APPROVED SWING BED
62	DISCHARGED/TRANSFERRED TO IP REHAB FACILITY (IRF) INCLUDING REHAB DISTINCT PART UNITS OF A HOSPITAL
63	DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LONG TERM CARE HOSPITAL (LTCH)
64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT UNDER MEDICARE
65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART UNIT OF A HOSPITAL
66	DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL (CAH)
69	DISCH/TRANSF TO A DESIGNATED DISASTER ALTERNATIVE CARE SITE
70	DISCH/TRANSF TO ANOTHER TYPE OF INSTITUTION NOT DEFINED ELSEWHERE IN THIS CODE LIST

Figure 77. FL 18 -28 Situational: Condition Codes

				CONDITION CODES							
18	19	20	21	22	23	24	25	26	27	28	
02	40										

Instructions: Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. This field is required when there is a Condition Code that applies to this claim.

Figure 78. FL 29 Not Required: Accident State

29 ACDT STATE

Instructions: Leave this field blank.

Figure 79. FL 30 Not Required: Reserved

30

Instructions: Leave this field blank.

Figure 80. FL 31-34 Situational: Occurrence Codes/Date

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE
24	01152022						

Instructions: Enter the Occurrence code and date. The date format is eight digits [MMDDCCYY (e.g., 01012022)]. This field is required when there is a significant occurrence (event) relating to this claim. Event codes should be submitted in alphanumeric sequence.

Figure 81. FL 35-36 Situational: Occurrence Span Codes From and Through Dates

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH
74	01022022	01052022			

Instructions: Enter the Occurrence Span Code from and through dates. This field is required when there is a significant occurrence (event) relating to this claim. Event codes are two alpha-numeric digits; dates are shown numerically as MMDDCCYY through MMDDCCYY.

Figure 82. FL 37 Not Required: Reserved

37

Instructions: Leave this field blank.

Figure 83. FL 38 Not Required: Responsible party Name and Address

38

Instructions: Leave this field blank.

Figure 84. FL 39-41 Situational: Value Codes and Amounts

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	80	4				
b						
c						
d						

Instructions: Enter the Value Code and Amounts. The Value Code fields allow for the reporting of numeric expressions. These expressions can be categorized as monetary amounts as well as percentages, units, integers, and other identifiers. All numeric expressions except monetary amounts are left-justified. Monetary amounts are right justified with cents reported to the right of the dollar/cent's delimiter.

Figure 85. FL 42 Required: Revenue Code

42 REV. CD.
0110
0250
0450

Instructions: Enter the revenue code that identifies a specific service or item. The specific revenue codes can be taken from the revenue code section of the Uniform Billing Manual. Codes are also available from the National Uniform Billing Committee (NUBC) (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Note: 0001 is not a valid Revenue Code and should not be used.

Figure 86. FL 43 Required: Revenue Code Description

43 DESCRIPTION
Room and Board-Private
Pharmacy - General
Emergency Room - General

Instructions: Enter the standard abbreviated description of the related revenue code categories included on this bill. (See FL 42 for description of each revenue code category.) FL 43 is also used to report the NDC. The NDC must begin with 'N4' followed by the 11-digit NDC and the Unit Measure Qualifier. Unit Measure Qualifiers are:
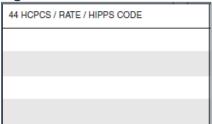
F2 – International Unit

GR – Gram

ME – Milligram

ML – Milliliter

UN - Unit

Example N400023114501UN

Figure 87. FL 44 Situational: HCPCS/Rate/HIPPS Code

Instructions: Enter the following when applicable:
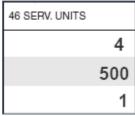
1. The HCPCS codes applicable to the ancillary service and outpatient bills

2. The accommodation rate for inpatient bills

3. The Health Insurance Prospective Payment System (HIPPS) rate codes that represent specific set of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems

Figure 88. FL 45 Required: Service Date

Instructions: Enter the month, day, and year the member service was provided The date format is eight digits [MMDDCCYY (e.g., 01012022)].

Figure 89. FL 46 Required: Service Units

Instructions: Enter the quantitative measure of services rendered for each procedure or revenue code for the total number of covered accommodation days, ancillary units of service, or visits, where appropriate. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

Figure 90. FL 47 Situational: Total Charges

Instructions: Enter the total charges for the related revenue or procedure code for the current billing period as entered in FL 6 (Figure 67) of the statement covers period.

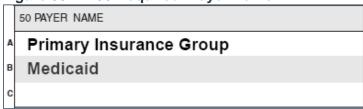**Figure 91. FL 48 Not Required: Non-Covered Charges**

48 NON-COVERED CHARGES

Instructions: Leave this field blank.

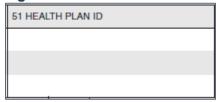**Figure 92. FL 49 Not Required: Reserved for Assignment by the NUBC**

49

Instructions: Leave this field blank.

Figure 93. FL 50 Required: Payer Name

50 PAYER NAME
A **Primary Insurance Group**
B Medicaid
C

Instructions: As applicable, enter the name of the member's primary, secondary, and tertiary insurance on Lines A, B and C, respectively. "Medicaid" information is entered on line A if the claim is submitted with no TPL.

Figure 94. FL 51 Situational: Payer ID

51 HEALTH PLAN ID

Instructions: Enter the number used to identify the payer. This field is required. If other payers are involved in potentially paying the claim, enter the ID number used to identify the payer.

If other insurance is involved in the payment of the claim, the EOB from the other insurance must be included with the submission of the claim

Figure 95. FL 52 Situational: Claim Filing Indicator Code

52 REL. INFO

Instructions: Enter the appropriate claim filing indicator code. Required for Medicare Advantage Part C/Medicare Part A and Part B claims.
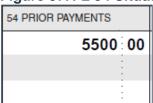
Note: Use a value of 'MA', 'MB' to identify Medicare Payers or '16' to identify Medicare C Advantages Plan. Any Commercial Insurance payer use a value of "CI" to identify TPL Payer.

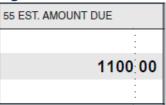**Figure 96. FL 53 Situational: Assignment of Benefits**

53 ASG. BEN.

Instructions: Enter the assignment of benefits. Valid values are "N" for No and "Y" for Yes.

Figure 97. FL 54 Situational: Prior Payments

54 PRIOR PAYMENTS
5500 : 00

Instructions: Enter payment(s) received from any other insurance carriers for claim services.

Figure 98. FL 55 Situational: Estimated Amount Due

55 EST. AMOUNT DUE
1100 : 00

Instructions: Enter the amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

Figure 99. FL 56 Required: NPI – Billing Provider
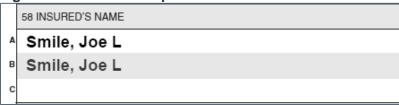
56 NPI	9874561230

Instructions: Enter the unique identification number assigned to the provider submitting the bill. This is a 10-digit number that will be used to identify you to your health care partners including all payers.

Figure 100.   FL 57 Situational: Other (Billing) Provider Identifier

57 OTHER PRV ID	

Instructions: Enter the other (billing) provider identifier. Identifiers can be: 0B,1B,1G, G2, LU, ZZ. Taxonomy code must be ten characters ending in X. Enter the qualifier ZZ followed by the Taxonomy code, if the NPI was used in FL 56 (Figure 99). This field may be used to report other provider identifiers as assigned by the health plan [as indicated in FL 50 Lines A-C (Figure 93)]. Use the qualifiers (0B,1B,1G, G2, and LU) to identify the other providers. (Example: G2 Provider Medicaid ID – 123456789 = G2123456789.)

Figure 101.   FL 58 Required: Insured's Name

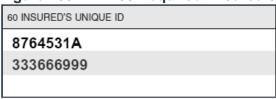| 58 INSURED'S NAME |
|---|
| A Smile, Joe L |
| B Smile, Joe L |
| C |

Instructions: Enter the name of the individual under whose name the insurance benefit is carried. Enter the policyholder's last name, first name, and middle initial.

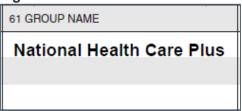**Figure 102.   FL 59 Not Required: Patient Relationship to Insured**

59 P.REL

Instructions: Leave this field blank.

Figure 103.   FL 60 Required: Insured's Unique Identifier

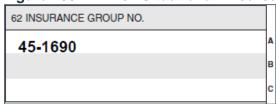| 60 INSURED'S UNIQUE ID |
|---|
| 8764531A |
| 333666999 |
| |

Instructions: Enter the unique number assigned by the health plan to the insured if there is another health plan, as well as entering the Members Medicaid ID.

Figure 104.   FL 61 Situational: Insured's Group Name

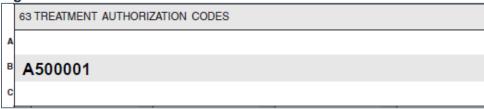| 61 GROUP NAME |
|---|
| National Health Care Plus |
| |
| |

Instructions: Enter the group name or plan providing the member's primary, secondary, and tertiary insurance on lines A, B, and C according to proper billing order, exactly as it appears on the health insurance card. Do not enter a group name on the line that shows payor, "Medicaid". This field is required when there is third party coverage.

Figure 105.   FL 62 Situational: Insured's Group Number

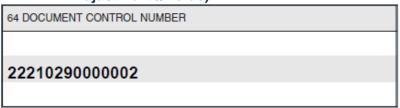| 62 INSURANCE GROUP NO.	
45-1690	A
	B
	C

Instructions: Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered. Enter the member's primary, secondary, and tertiary insurance on Lines A, B and C, according to proper billing order.

Figure 106.   FL 63 Situational: Treatment Authorization Codes

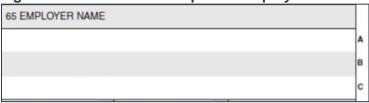| 63 TREATMENT AUTHORIZATION CODES |
| --- |
| **A** |
| **B** A500001 |
| **C** |

Instructions: Enter the authorization number in this field. Only one authorization number may be entered per claim. This field is required when an authorization code assigned by the Utilization Management Organization is required to be reported on the claim.

Figure 107.   FL 64 Situational: Document Control Number (Used for Submitting Adjustments/Voids)

64 DOCUMENT CONTROL NUMBER
22210290000002

Instructions: Enter the original claim ICN that is being requested to be replaced/adjusted or voided. This field is required when the TOB Frequency [FL 4 (Figure 65)] indicates this claim is a replacement/adjusted (7) or void (8) to a previously adjudicated claim.
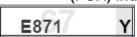
Figure 108.   FL 65 Not Required: Employer Name

65 EMPLOYER NAME	
	A
	B
	C

Instructions: Leave this field blank.

Figure 109.   FL 66 Required: Diagnosis and Procedure Code Qualifier (ICD Revision Indicator)

66 DX
0

Instructions: Enter the qualifier that denotes the revision of International Classification of Diseases (ICD) reported. Qualifier code "9" [ICD Ninth Revision (ICD-9-CM)] or "0" [ICD Tenth Revision (ICD-10-CM/ICD-9-PCS)] is required.

Figure 110.   FL 67 Required: Principal Diagnosis Code (DX) and Present on Admission (POA) Indicator

E871	Y

Instructions: Enter the ICD diagnosis code, appropriate to the ICD revision indicated in FL 66 (Figure 109) describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The DX is required; the POA is situational but required for Inpatient claims.

Figure 111.   FL 67(a – q) Situational: Other DX and POA Indicator

M810	Y	M4850XA	Y

Figure 112.   FL 68 Not Required: Reserved for Assignment by the NUBC

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68

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Instructions: Leave this field blank.

Figure 113.   FL 69 Situational: Admitting Diagnosis Code

69 ADMIT DX	E871

Instructions: Enter the ICD diagnosis code, appropriate to the ICD revision indicated in FL 66 (Figure 109), describing the patient's diagnosis at the time of admission. This field is required when claim involves an inpatient admission

Figure 114.   FL 70 Situational: Patient's Reason for Visit

70 PATIENT REASON DX	a	b	c

Instructions: Enter the ICD diagnosis codes, appropriate to the ICD revision indicated in FL 66 (Figure 109), describing the patient's stated reason for visit.

Figure 115.   FL 71 Not Required: Prospective Payment System (PPS) Code

71 PPS CODE	

Instructions: Leave this field blank.

Figure 116.   FL 72a – c Situational: External Cause of Injury (ECI) Code and POA Indicator

72 ECI	V8604XA	Y	b	c

Instructions: Enter the ICD diagnosis codes, appropriate to the ICD revision indicated in FL 66 (Figure 109), pertaining to the environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.

Figure 117.   FL 73 Not Required: Reserved for Assignment by the NUBC

73

Instructions: Leave this field blank.

Figure 118.   FL 74 Situational: Principal Procedure Code and Date

74	PRINCIPAL PROCEDURE CODE	DATE
	009A0ZZ	01022022

Instructions: Enter the ICD procedure code appropriate to the ICD revision indicated in FL 66 (Figure 109), that identifies the inpatient principal procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. This field is required on inpatient claims when a procedure was performed. The date format is eight digits MMDDCCYY (e.g., 01012022). If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

Figure 119.   FL 74a-e Situational: Other Procedure Codes and Dates

a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
009B3ZX	01022022		

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

Instructions: Enter the other procedure codes and dates. This field is required on inpatient claims when additional procedures must be reported. The date format is eight digits [MMDDCCYY (e.g., 01012022)]. The ICD procedure codes appropriate to the ICD revision indicated in FL 66 (Figure 109), that identify all significant procedures, other than the principal procedure, and the dates (identified by code) on which the procedures were performed.

Figure 120.   FL 75 Not Required: Reserved for Assignment by the NUBC

75

Instructions: Leave this field blank.

Figure 121.   FL 76 Situational: Attending Provider Name and Identifiers

76 ATTENDING	NPI 3575986110	QUAL	207Q00000X
LAST Murdoch		FIRST Sam	

Instructions: Enter the attending provider's NPI, Qualifier (ZZ)/Taxonomy, Last Name, and First Name. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Figure 122.   FL 77 Situational: Operating Physician Name and Identifiers

77 OPERATING	NPI	QUAL	
LAST		FIRST	

Instructions: Enter the name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Figure 123.   FL 78 – 79 Situational: Other Provider (Individual) Names and Identifiers

78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

Instructions: Enter the identification number and name of the other physician if applicable.

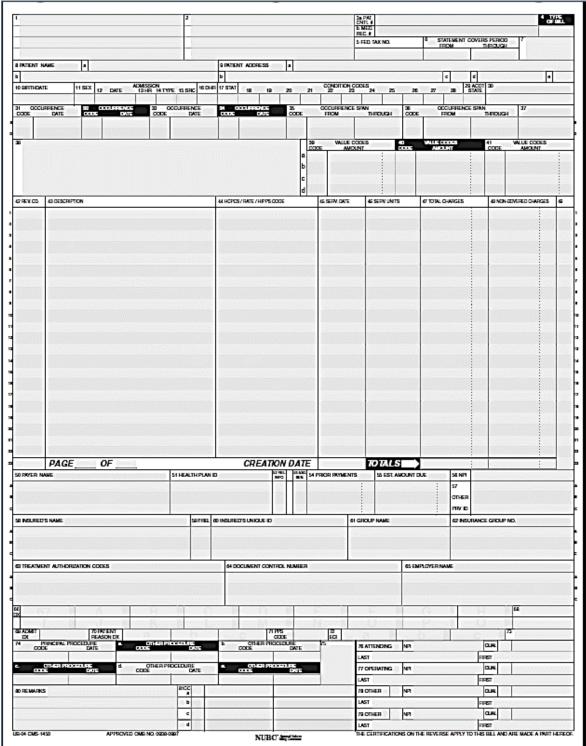**Figure 124.   FL 80 Situational: Remarks**

80 REMARKS

Instructions: Enter additional information necessary to adjudicate the claim.

Figure 125.   FL 81 Required: Code-Code Field

81CC a	B3	282N00000X	
b			
c			
d			

Instructions: Enter the billing provider taxonomy. This is a required field to report billing provider taxonomy.

Figure 126.   UB-Claim Form

5.9. Filing Medicare Part, A Crossover Claims on the UB-04

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

- The word "CROSSOVER" should be entered in FL 2 (Figure 62).

- The beneficiary's Medicare number should be entered in FL 50A (Figure 93).

- The beneficiary's nine-digit Medicaid number should be entered in FL 50B (Figure 93).

- The ten-digit NPI number should be entered in FL 56 (Figure 99).

- Optional: The nine-digit Medicaid provider number should be entered in FL 57A (Figure 100).

- The corresponding claim information should be circled on the EOMB and the EOMB attached to the back of the claim.

- Any prior payer payments should be reported in FL 54 (Figure 97) of the UB-04.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line outpatient data not applicable to the claim submitted.

- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.

- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).

The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

Note: The MISSISSIPPI CROSSOVER CLAIM FORM is no longer accepted.