OUTPATIENT

1	2	3a Pat. CNTL#		4 TYPE OF BILL
		b. Pat. CNTL#		
		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 SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37

38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 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
10									10
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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	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	81 CC a.	78 OTHER NPI	QUAL
	b.	LAST FIRST	
	c.	79 OTHER NPI	QUAL
	d.	LAST FIRST	

REQUIRED   **SITUATIONAL**   **NOT REQUIRED**

UB04 OUTPATIENT: SITUATIONAL FIELDS

FIELD	DESCRIPTION

12   **ADMISSION DATE**
Admission/Start of Care Date Required for Inpatient and Home Health. Enter the date admitted for inpatient care, or the date of the outpatient service.

13   **ADMISSION HR -** This field is required if applicable.
Enter the hour during which the patient was admitted for inpatient or outpatient care. This field is required if applicable.

16   **DHR -** This field is required if applicable.
DHR refers to the code indicating the discharge hour of the patient from inpatient care. This field is required if applicable.

18-28   **CONDITION CODES -** This field is required if applicable.
The condition codes indicate any conditions/events relating to this bill that may affect processing. This field is required if applicable.

31-34   **OCCURRENCE CODE AND DATES -** This field is required if applicable.
The occurrence code indicates a significant event relating to this bill that may affect processing. This field is required if applicable.

35-36   **OCCURRENCE SPAN -** This field is required if applicable.
The occurrence span code identifies an event that relates to the payment of the claim. This field is required if applicable.

38   The name and address of the party responsible for the bill. This field is required if applicable.

39-41   **VALUE CODES AND AMOUNTS**
The Value Code refers to a code to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization.

43   **DESCRIPTION**
Please fill in the standard abbreviated description of the related revenue code included on this bill. The NDC Code is required in this field when billing for injectables, drugs and family planning pharmaceuticals.

44   **HCPCS/RATE/HIPPS CODE -** This field is required if applicable.
HCPCS or Healthcare Common Procedure Coding. The accommodation rate for inpatient bills. HIPPS or Health Insurance Prospective Payment System.

48   **NON-COVERED CHARGES -** This field is required if applicable.
This field reflects the non-covered charges for the destination payer as it pertains to the related revenue code.

51   **HEALTH PLAN ID -** This field is required if applicable.
A-C   This is the alphanumeric identifier used by the health plan to identify itself.

54   **PRIOR PAYMENTS -** This field is required if applicable.
This field should reflect any payment from the health plan for this bill.

55   **EST. AMOUNT DUE**
This field should reflect the estimate how much is due from the payer (estimate less prior payments).

57   **OTHER / PRV ID**
The Provider Medicare ID is required when billing for services rendered to a DualChoice Member or if reimbursement is based on Medicare rates.

61-62   **GROUP NAME/ INSURANCE GROUP NUMBER**
This is the group/plan name through which the insurance is provided to the insured along with the control number/code assigned by the carrier to identify the group under which the individual is covered.

63   **TREATMENT AUTHORIZATION CODES**
An indicator that designates the treatment indicated on this bill has been authorized by the payer.

65   **EMPLOYER NAME**
The name of the insured's employer.

67   **OTHER DIAGNOSIS CODE -** This field is required when applicable
A-Q   Other conditions that coexist or develop during the patient's treatment.

69   **ADMIT DX -** Required on inpatient. Required on outpatient if applicable
The Admitting Diagnosis Code (ICD) which describes the patient's diagnosis at the time of admission.

70   **PATIENT REASON DX -** This field is required when applicable
Is this an unscheduled outpatient visit? If so, please fill in the ICD code that reflects the patient's reason for visit at the time of outpatient registration.

71   **PPS CODE -** This field is required when applicable
Fill in the Prospective Payment System code for the applicable claim type.

72   **ECI -** This field is required when applicable
A-C   Was the cause for treatment due to injury or poisoning? If so please enter the ECI which is the External Cause of Injury. This is indicated by an ICD code.

74   **PRINCIPAL PROCEDURE -** This field is required when applicable
A-E   This field should indicate the ICD code that identifies the inpatient principal procedure performed at the claim level during the period

77-79   **OPERATING/OTHER -** This field is required for surgery
This field should be filled with the individual who has primary responsibility for performing the surgical procedure(s). Utilize fields 78-79 for other provider names and identifiers.

80   **REMARKS -** This field is required when applicable. This area may be used to capture any additional information needed to adjudicate the claim.