

UB04 Claim Form and Instructions



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 locator 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 locator UB04	Description	Inpatient	Outpatient
44	HCP/CS/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

Inpatient

1	2	3a PAT CNTL #	3b MED REC #	4 TYPE OF BILL
8 PATIENT NAME	9 PATIENT ADDRESS	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE
15 SRC	16 DHR	17 STAT	18	19
20	21	22	23	24
25	26	27	28	29 ACDT STATE
30	31 OCCURRENCE DATE	32 CODE	33 OCCURRENCE DATE	34 CODE
35 OCCURRENCE DATE	36 CODE	37	38	39
40	41	42	43	44
45	46	47	48	49
50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS
55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	58 INSURED'S NAME	59 P REL
60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME	66	67	68	69
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