

## 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

- Diagnosis code
- Type of Bill
- 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**

<b>1</b>	<b>Sunny Hospital</b>
	<b>P.O. Box 5789</b>
	<b>Jackson, MS 39201-0015</b>

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**

<b>2</b>	<b>Sunny Hospital</b>
	<b>321 Sun Lane Drive</b>
	<b>Jackson, MS 39201-0015</b>

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**

<b>3a PAT. CNTL #</b>	<b>987562</b>
---------------------------	---------------

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>b. MED. REC. #</b>	<b>HX1590Z1</b>
---------------------------	-----------------

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.
<b>64-XXXXXXX</b>

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
<b>01012022</b>	<b>01052022</b>

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**



**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**

11 SEX
M

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**

ADMISSION				
12	DATE	13 HR	14 TYPE	15 SRC
01022022	1800	1		2

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 STAT
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 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE 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 alphanumeric 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 Situational: Responsible Party Name and Address**

38 <b>Medicare</b>
-----------------------

Instructions: Enter “Medicare” in this field if the member has Medicare when billing a Medicare crossover claim.

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

39		40		41	
CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT
a	66 1000 00	80 15	81 5		
b	82 25				
c					
d					

**Correct:**

  

39		40		41	
CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT
a	80 25	A1 992 00	66 500 00		
b	A2 6200 00	82 25 00	81 0		
c					
d					

**Incorrect:**

Value Codes are NOT in numerical order.

This represents 2500 days, NOT 25!

Do not list Value Codes if zero.

Instructions: Value codes must be entered in numeric sequence, starting in Form Locators 39a through 41a, 39b through 41b, 39c through 41c, and lastly, 39d through 41d.

Please note that when entering days, place the number to the far right of the Value Code Amount (in the cents field). For example, 1 – 9 days would be entered in the same position you would enter 1 – 9 cents. Days 10 – 99 would be entered in the same positions you would enter ten to ninety-nine cents. Days 100 – 999 would be entered in the same positions you would enter one dollar to nine dollars and ninety-nine cents.

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](http://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**

44 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**

45 SERV. DATE
01012022
01012022
01012022

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**

46 SERV. UNITS
4
500
1

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**

47 TOTAL CHARGES	
4744	00
1742	79
800	00

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	<b>Primary Insurance Group</b>
B	<b>Medicaid</b>
C	

Instructions: As applicable, enter the name of the member's primary, secondary, and tertiary insurance on Lines A, B and C, respectively and to always include Medicaid. "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	<b>Smile, Joe L</b>
B	<b>Smile, Joe L</b>
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
<b>8764531A</b>
<b>333666999</b>

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
<b>National Health Care Plus</b>

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.	
<b>45-1690</b>	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. Additionally, please indicate "Adjustment" or "Void" in FL 80 of the claim form. See [Figure 126](#).

**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**

68

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
Adjustment or Void

Instructions: Enter “Adjustment” or “Void” here.



## 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 “Medicare” should be entered in [FL 38 \(Figure 83\)](#).
- The beneficiary’s Medicare number should be entered in [FL 60 \(Figure 103\)](#).
- The beneficiary’s nine-digit Medicaid number should be entered in [FL 60 \(Figure 93\)](#).
- 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 57 \(Figure 100\)](#).
- The corresponding claim information should be circled on the EOMB and the EOMB attached to the back of the claim.
- The claim detail information should match the individual EOMB detail level information.
- 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 out patient 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.