

UB04 Claim Form Electronic Submission Requirements

1 [Red box around Patient Name and Address fields]

2 [Red box around Patient Address and Pay To fields]

Block 1 of the UB04 Claim Form
Requires the "Physical" address
(No P.O. Boxes)

Block 2 of the UB04 Claim Form
Requires the "Pay To" address

Loop & Segments for Blocks 1 & 2 of the UB04 Claim Form					
Block #	Description	Mapping Loop	Segment	Data Element # Qualifier	DATA Status
1	Line 1	Provider Name	Loop 2010AA	NM103	Required
2	Line 2	Physical Street	Loop 2010AA	N301	Required
3	Line 3	Physical City	Loop 2010AA	N401	Required
4	Line 3	Physical State	Loop 2010AA	N402	Required
5	Line 3	Physical Zip Code	Loop 2010AA	N403	Required
6	Line 4	Provider Tel #	Loop 2010AA	PER03	365-TE Required
7	Line 4	Provider Fax #	Loop 2010AA	PER04	365-FX Required
8	Line 4	Provider Country	Loop 2010AA	N404	Required
9	Line 1	Pay To Name	Loop 2010AB	NM103	Required
10	Line 2	Pay To Street	Loop 2010AB	N301	Required
11	Line 3	Pay To City	Loop 2010AB	N401	Required
12	Line 3	Pay To State	Loop 2010AB	N402	Required
13	Line 3	Pay To Zip Code	Loop 2010AB	N403	Required
14	Line 4	Pay To Provider ID	Loop 2010AB	REF01	2U,FY,NF Required

PAGE ____ **OF** ____ **CREATION DATE** ____/____/____ **TOTALS** →

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 DX 67 A B C D E F G H 68

69 ADMIT DX 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73

74 PRINCIPAL PROCEDURE CODE a OTHER PROCEDURE CODE b OTHER PROCEDURE CODE c OTHER PROCEDURE CODE d OTHER PROCEDURE CODE e OTHER PROCEDURE CODE 75

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS 81CC a b c d

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

- (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
- (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
- (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
- (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

REFERENCE ONLY

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS