

## Direct and Timely Billing

As a Regence BlueShield and Regence Life and Health participating physician, other health care professional or facility, you have agreed to bill us directly for covered services provided to your Regence BlueShield or Regence Life and Health patients within the time period reflected in your contract (which in most cases is within one year of the date of service). Once coverage is verified, patients should not be asked for full payment at the time of service, although asking for copayments is appropriate. After services are rendered, the patient should only be billed for deductible, copayment and/or coinsurance amounts not collected and non-covered services.

## Use Your Identification Number

All electronically submitted claims must include the National Provider Identifier (NPI) along with the required tax identification number. Until further notice an electronically submitted claim may also include the appropriate Regence BlueShield provider identification number.

The NPI is not required for paper claim submissions, though we strongly recommend you apply for and use an NPI. Paper claim submissions can continue to be submitted using the Regence BlueShield provider identifier with or without an NPI. If you are unsure of your provider identification number, please contact your provider consultant.

## Demographic Change(s) Notification

To ensure our provider directories and records are up to date, you can use our online *Provider Information Update Form* to submit changes to us. The form is located on our *Provider Web Site* in the Provider Library, under Forms. You can also download, print and fax the completed form and any additional supporting information to our secure fax line at 1 (888) 289-1313. Please let us know when any of the following events occur:

- Billing address change
- NPI Assignment
- Office location change
- Primary Care Physician (PCP) status change
- Provider(s) joining or leaving clinic
- Provider specialty change
- Retirement/leaving the state
- Social Security number or federal tax ID number change
- Termination or addition of a practice

Mail or fax changes to:  
Regence BlueShield M/S 916  
P.O. Box 21267, M/S 916  
Seattle, WA 98111

Fax to 1 (888) 289-1313

## Federal Tax Identification (ID) Number Change

If your federal tax identification (ID) number changes, please submit the new number to us using a federal *W-9 Tax Identification Change* form. **We must have this form before we can make any changes to your tax ID number.**

For accurate claims processing, continue to use your old tax ID number on claims for dates of service before the effective date of the new tax ID number. Only dates of services on or after the effective date of the new tax ID number should be billed with the new number.

You may need an Employer Identification Number (EIN) depending on your practice classification. Please contact the Internal Revenue Service for applicability and/or further information.

## Filing Claims Electronically

Electronic billing through Availity®, LLC or Office Ally is available for all Regence BlueShield, Regence Life and Health and BlueCard® out-of-area claims via OneHealthPort™. Electronic claims submission offers the following advantages:

- Single submission point for all electronic claims
- Faster claims turnaround time
- Automated claims payment for clean claims
- Detailed online submission and error reports
- Online real-time editing
- No per-claim submission charge for Regence claims if you submit directly through Availity or Office Ally.

If you already submit claims electronically, the following reminders are for you:

- Always enter the patient's information exactly as it appears on their member card. This will help avoid misrouting and processing delays.
- Use your online reports to help research claims processing.
- All claims for out-of-area members with alpha prefixes can and should be billed electronically to expedite their processing.
- Only claims for Medicare adjustments should be billed on paper.

To find out more about submitting claims electronically through Availity, LLC contact their EDI Support Center by phone at 1(877) 334-8446. For information about submitting claims through Office Ally contact them via email at [info@officeally.com](mailto:info@officeally.com) or by phone at 1 (949) 464-9129.

### File rejection reports

If you need help with an electronic rejection report that is not from Availity or your clearinghouse, contact Regence EDI Support Center 1 (800) 713-1693 or email [EDIsupport@regence.com](mailto:EDIsupport@regence.com).

## Filing Claims Manually

Regence requires paper claims to be submitted on an original, standard *CMS 1500-08/05* claim form. Instructions for completing this form begin on page 11 and are followed by a sample of the form. Once received, paper claims are scanned and converted into electronic images that are viewed and processed online by our claims analysts. Please observe the following guidelines to ensure your claims are successfully imaged:

- Key or type all information onto your claims. Handwriting and stamps are not always dark or legible enough to be captured by our imaging equipment. Centers for Medicare & Medicaid Services (CMS) no longer accept signature stamps.
- Do not use highlighters on your claims. The imaging equipment ‘blacks out’ the portions of your claims that are highlighted, making the information unreadable.

## Where to Send Original Paper Claims

The mailing addresses for submitting paper claims are shown below.

All Claims (except FEP)	FEP Claims Only
Regence BlueShield P.O. Box 30271 Salt Lake City, UT 84130-0271	Federal Employee Program P.O. Box 31207 Salt Lake City, UT 84131-0207

## Resubmitting Claims

Claims are generally processed within 14 days after receipt. However, some claims requiring investigation can take longer. If you do not receive notification of a processing action on a claim within 60 days, please verify status by using the Provider Center. If no record of the claim is found, please resubmit to us.

A **corrected billing** is defined by us to be any claim that has a correction to an original claim (e.g., a procedure code, diagnosis, date of service, member name, or member date of birth). You do not need to submit supporting documentation for a corrected claim to us for processing. Please use a *Corrected Claim Cover Sheet* is located in the on our *Provider Web Site* in the Provider Library Section, under Forms when submitting a corrected billing. It is also available on the Washington Healthcare Forum Web site at [www.wahealthcareforum.org](http://www.wahealthcareforum.org).

A **rebilling** is defined by us to be the same as a new claim and has not been entered into our claims processing system. For example, a claim submitted electronically that did not make it past the front end edits. That claim should be resubmitted using the rebilling guidelines below.

## Corrected Claims

Claims with changes or corrections to charges, procedure codes, diagnostic codes or other information should be resubmitted as soon as possible. To help us identify and process these resubmissions more efficiently, label your corrected claims as follows.

Claim Type	Labeling the Corrected Claim
Electronic	Enter <b>CORRECTED CLAIM</b> in the narrative record (NSF Record HA0) of the first service detail line.
Paper	Indicate <b>CORRECTED CLAIM</b> in Block 24 of your <i>CMS-1500</i> form and complete the <i>Corrected Claim Cover Sheet</i> on our <i>Provider Web Site</i> in the Provider Library, under Forms. Mail to:  Regence BlueShield PO Box 21267 Seattle, WA 98111-3267

## Tracer Claims

Resubmitted claims are also known as tracer claims, rebills, second submissions or duplicate billings. Before submitting tracer claims, use all available resources to check the status of your claims, including the Provider Center, EDI claims submission reports and careful voucher review. Tracer claims:

- Should not be submitted earlier than 20 days from the original claims submission.
- May be processed separately from “live claims” (“live claims” have priority).
- Are monitored. Providers submitting large volumes of tracer claims will be contacted to discuss possible alternatives.
- Submitted on paper should be marked **TRACER CLAIM** or **REBILLING** in Block 24 of your CMS-1500 claim form and mailed to:

Regence BlueShield  
P.O. Box 21267, M/S 916  
Seattle, WA 98111

- Submitted electronically should include TRACER CLAIM or REBILLING in the narrative record (NSF Record HA0) of the first service detail line.

## Returned Claims

Claims will be denied and listed on your payment voucher with the applicable message code if necessary information is missing or if it is illegible, or if the claim form is filled out incorrectly. Check your claims carefully to make sure that all needed information is included.

## Accidental Injuries

If a member is involved in an accident, submit the claim in the usual manner and include the place, exact date, time and cause of injury.

All injury claims are investigated for the cause of the injury. To save time and expedite claims processing, please indicate the cause and date of the injury on the original submission of the claim.

If no injury is present, use an illness diagnosis code 001-799. If the member has a condition such as “back pain” with no specific date of injury, use an illness code instead of an injury code. Make sure to state on the claim that it is not an injury.

## Claims Review of Inpatient Re-admission in 48-hours

Regence BlueShield uses the following guidelines for inpatient re-admission during a 48-hour period.

1. The re-admission must be to the same hospital within 48 hours
2. Re-admissions for “essentially the same condition” are denied for payment including, but not limited to, claims with any one of the following:
  - The same AP-DRG
  - The same primary ICD-9 diagnosis code
  - The same complication code (995 to 999.9 ICD-9 diagnosis code) in a primary position on the second claim and in any position on the first claim

*Note:* The message code for readmission within 48 hours for essentially the same condition denials is W90: A READMISSION WITHIN 48 HOURS OF DISCHARGE FOR THE SAME CONDITION IS PAID AT A SINGLE AP- DRG RATE. However, the charges that result from the denied readmission are included in the outlier amount when calculating stop loss on the original admission.

3. When a hospital agrees to the new DRG weights, Regence BlueShield will no longer review for a readmission within 48 hours of discharge for related conditions.

## Other Party Liability and Subrogation

When a member receives care for injuries or medical conditions sustained during an accident, health plans need information about the injury in order to determine who is financially responsible, i.e., Labor & Industries (L & I), an automobile insurer, some other third party, etc. Some of this information may come from the provider and some of it must come from the member, based upon subrogation provisions within the member's contract.

When a person is injured in an accident, the member's health plan may not be financially responsible for covering the cost of the required care. This is called Other Party Liability (OPL), i.e., when financial responsibility for coverage shifts from a member's health plan to a third party. For example, if a person is injured in a car accident, the automobile insurance company may be financially responsible. If a person is injured at work, L & I may be financially responsible.

The provider of care can incorporate the member's injury information on the claim form. The member must submit a signed incident/injury report containing his/her information. If the member completes and signs the incident/injury report in the provider's office, the provider can submit it with the claim. Otherwise the member must submit the report. If the member does not submit their incident/injury report, the health plan may deny the providers claim. In this situation, the provider can bill the member directly to collect fees for services provided. The *Incident Report* form is available on our *Provider Web Site* in the Provider Library section, under Forms.

*Note:* Please do not submit an *Incident Report* unless one is requested by Regence BlueShield.

On all possible third-party accident claims, the member will be sent an *Incident Report* form. Boeing has a form called a *Medical Service Inquiry* (MSI). When either of these forms are completed by the member and returned, claims will be processed in one of the following ways:

- If benefits are payable under the terms of any automobile medical, automobile no-fault, homeowners, premises liability, personal injury protection or similar contract of insurance **or**,
- If the member does not provide complete information upon request, claims are denied accordingly.

When we are notified in writing that the above mentioned benefits do not exist, have expired, or have been exhausted, Regence BlueShield will then begin processing claims and resume the pursue process in attempt to recover payments made on behalf of the subscriber/member.

Subrogation is defined as the right to recover payments. There must be Other Party Liability in order to recover payments.

## Worker's Compensation

If the member has sustained an on-the-job injury or illness, submit the claim(s) to Labor & Industries, the appropriate insurance company, or state. Worker's compensation does not apply to the Federal Employee Program (FEP).

If a member is involved in a non-occupational accident, submit the claim Regence BlueShield in the usual manner, adding the additional injury information requested on the *CMS-1500* claim form.

## Other Party Liability Threshold

When coverage responsibility is unclear, health plans may pay the claim if the total charge is below the threshold level. This is called the Other Party Liability (OPL) threshold. Regence BlueShield has a \$500 threshold for most injury claims. Once a claim that totals the OPL threshold amount is received, the OPL investigation will begin. When an investigation is started, all related claims regardless of the dollar amount will be subject to the OPL investigation.

Additional information about this policy is available on the Washington HealthCare Forum Web site at [www.wahealthcareforum.org](http://www.wahealthcareforum.org). The Administrative Simplification Policies & Guidelines are located in the Accelerate Your Practice tab, under Projects & Solutions.

The following diagnosis codes, along with their dollar thresholds, are ones which Regence BlueShield considers investigative for injuries:

Diagnosis Code	OPL Threshold (if not less than \$500)	Diagnosis Code	OPL Threshold (if not less than \$500)
008-008.8	\$1,000	900 – 999.9	\$500
310.2	\$1,000	E800 – 819.9	\$500
310.4	\$1,000	E822 – 869.9	\$500
353 – 353.5	\$500	E880 – 888	\$500
353.6 – 353.9	\$500	E894 – 899	\$500
354 – 354.9	\$0	E901.1 - 902.1	\$500
550 – 550.93	\$0	E906 – 906.0	\$500
717 – 717.9	\$500	E910.3	\$500
718 – 718.99	\$500	E914 – 915	\$500
719 – 719.99	\$500	E918 – 919.9	\$500
721 – 721.91	\$1,000	E921 – 921.9	\$500
722 – 722.93	\$1,000	E923 – 923.9	\$500
723 – 723.9	\$1,000	E929 – 929.9	\$500
724 – 724.9	\$1,000	All other 'E' codes	\$500
800 – 898.82	\$500		

If one of the above diagnosis codes is used and the visit is NOT accident related, please use ACC-NKI or ACC- No Known Injury in the comment or remarks section of the claim form. If an E code is used, an accident description the information is still required. If the threshold equals \$0, all claims for the injury will be investigated.

## Coordination of Benefits (COB)

Coordination of Benefits (COB) enables your patients to receive benefits from all health insurance plans they are covered under, while ensuring that the total combined payment from all sources is not more than the total charge for the services provided.

When your patient has coverage under two or more insurance plans, the *primary plan* will pay benefits first, with **secondary** and **tertiary plans** considering any remaining unpaid, eligible balances. **When Regence BlueShield or Regence Life and Health is the secondary or tertiary plan, you should file the claim with the *primary plan* first.** When you have received an Explanation of Benefits (EOB) or payment voucher from the *primary plan*, please submit the claim and a copy of the EOB or voucher to Regence, **identifying all insurance coverage information on each claim.**

If you submit claims electronically, please complete all other insurance payment fields to ensure the claim is processed correctly. Additional information about submitting secondary claims electronically is available on the Washington Healthcare Forum Web site at [www.wahealthcareforum.org](http://www.wahealthcareforum.org).

Additional COB information is available in the Claims & Billing section of our *Provider Web Site*.

## Maintenance of Benefits (MOB)

Maintenance of Benefits (MOB) lets your patients receive benefits from all health insurance plans they are covered under, while maintaining the patient's responsibility for coinsurance and/or copayment amounts on these coverages and ensuring that the total combined payment from all sources is never more than the total charge for the services.

With MOB processing, secondary payers only allow benefits up to their own maximum allowable for the specific service(s). If the primary carrier's payment is equal to or more than what the secondary carrier's payment would have been as primary, no additional benefits will be remitted. This can result in members having out-of-pocket expenses, something not usually seen with COB processing.

## Other Party Liability for Blue Plans

Other Party Liability (OPL) is a department that recovers money when primary responsibility is not the insurer's because of the involvement of another group health plan or contractual exclusions. OPL includes worker's compensation, subrogation and no-fault auto insurance.

In cases where another Blue Plan is involved as a third party, submit OPL information with the Blue Plan claim to Regence BlueShield. Upon receipt, Regence BlueShield will electronically route the claim to the member's Blue Plan. The member's Blue Plan will then process the claim and approve any payment based on the member's benefits. Regence BlueShield will reimburse you accordingly and provide information on your payment voucher.

# Medicare Crossover Claims

If you accept Medicare assignment and render services to members from other Blue Plans, please note the following:

**Medicare is primary:** When Medicare is the primary payer for an out-of-area Blue Plan member (e.g., Medigap plans), follow these procedures:

- 1) Submit claims to your local Medicare contractor first. **Do not file with Medicare and the supplemental insurer simultaneously.** Be sure to include the:
  - Complete Health Insurance Claim Number (HICN),
  - The patient's complete member number, and
  - Patient's name as it appears on the card
  - Other carrier's name and address (OCNA) number. If you include this information, make sure it is the correct OCNA for the member's Blue Plan.
  
- 2) After you receive the *Explanation of Medical Benefits* (EOMB) or payment advice from Medicare, determine if the claim was automatically crossed over to the supplemental insurer:
  - **Crossed over:** If the indicator on the EOMB or payment advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. You do not need to file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you, if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.
  - **Not crossed over:** If the indicator on the EOMB or payment advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim as you do today to Regence BlueShield along with the payment advice. Regence BlueShield or the member's Blue Plan will pay you the Medicare supplemental benefits. If you did not accept Medicare assignment, the member will be paid and you will need to bill the member.

**Blue Plan is primary:** When a Blue Plan is the primary payer (e.g., Medicare Advantage), submit claims to Regence BlueShield. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Based on the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a physician, other health care professional or facility who accepts Medicare assignment and renders service to Medicare Advantage members from other Blue Plans, you will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than your charge amount. CMS regulations state that the Medicare allowable amount is considered payment in full.

*Note:* Medicare Advantage Private Fee for Service (PFFS) reimbursement is paid at the Home plan contracted rate or Medicare rate, depending on the member contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill.

# Health Management Administrators (HMA)

Many self-funded groups select a third-party administrator to provide claims and benefit administration and customer service for their employees.

Healthcare Management Administrators, Inc. (HMA) is a wholly owned subsidiary of The Regence Group. Founded in 1986, HMA provides high quality, customer focused third-party administrative services to self funded employers. HMA clients are all self-funded single employers located throughout Washington and Oregon. They are based in Bellevue, Washington and have offices in Yakima, Washington and in Portland, Oregon.

HMA uses the Regence BlueShield PPO network as the provider network for their HMA Preferred product. HMA Preferred is a PPO plan offered to selected employer groups that sponsor self-funded health plans. The plan allows participants to access physicians and other providers in the Regence BlueShield PPO and PAR networks.

## **HMA claims submission**

To expedite the processing of your Healthcare Management Administrators (HMA) claims, do not submit them within your Regence electronic claims file. Submit them directly to Availity® with Payer ID HMA01. The claim should include the three-digit prefix and the subscriber number listed on the member's card.

Mail paper claims to:  
Healthcare Management Administrators, Inc.  
P.O. Box 85008  
Bellevue, WA 98015

For claim status and benefit information, contact HMA Customer Service at 1 (425) 462-1600 or toll free 1 (800) 700-7153.

Reimbursement for the HMA Preferred plan is the same as Regence BlueShield Preferred and/or Participating plan networks. All administration of the "HMA Preferred" PPO plan is handled by Healthcare Management Administrators, Inc. In some cases, the name of the sponsoring employer may appear on the masthead of the member card instead of the Healthcare Management Administrators logo. The upper right corner of the card will show the "HMA Preferred" PPO plan logo.

Please accept the HMA PPO member card as you would any Regence BlueShield PPO member card, per your Regence BlueShield contract. All claims should include the three-digit prefix and the subscriber number shown on the member card.

## **Where to find information regarding claims submission**

General information on claims submission can be found in this section and in the Claims & Billing section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider). If we require additional documentation beyond the claim form in order to process a particular service, we will send you a request for the necessary information. A description of the additional documentation (e.g., operative reports or chart notes) may be found in on our *Provider Web Site* in the Claims & Billing section, under Supporting Documentation.

## **Where to find information regarding medical and reimbursement policy**

Reimbursement and medical policy can be found on our *Provider Web Site* in the Provider Library section, under Policies. We make every effort to notify you if we make a change to billing guidelines or administrative, medical or reimbursement policies. In most cases notification will be via *The Connection Online*<sup>SM</sup> newsletter.

# CMS 1500 Claim Form Instructions

To complete this form, follow the instructions below. **Each field on the form has a corresponding number. Claims submitted with missing or invalid required fields may be rejected and/or returned for correction and resubmission.**

Requirements	Field	Description
	1:	Type of Health Insurance Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
<b>Required</b>	<b>1A:</b>	<b>Insured's Identification Number</b> Enter the three-digit alpha prefix and identification number of the insured <i>exactly as shown on the member card</i> .
<b>Required</b>	<b>2:</b>	<b>Patient's Name</b> Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the member card. <i>Do not use nicknames</i> .
<b>Required</b>	<b>3:</b>	<b>Patient's Birth Date and Sex</b> Enter the eight-digit month, day, century, and year of the patient's birth (MMDDCCYY). Check the appropriate box to identify patient's gender.
<b>Required</b>	<b>4:</b>	<b>Insured's Name</b> Enter the last name, first name, and middle initial of the insured as shown on the member card. If the patient is the insured, enter the word "same".
<b>Required</b>	<b>5:</b>	<b>Patient's Address</b> Enter the patient's complete address.
<b>Required</b>	<b>6:</b>	<b>Patient's Relationship to Insured</b> Check self, spouse, child or other.
	7:	Insured's Address Complete if the patient <i>is not</i> the insured.
	8:	Patient Status Check the appropriate box.
<b>Recommended</b>	<b>9:</b>	<b>Other Insured's Name</b> Enter the name of the insured with other insurance company.
<b>Recommended</b>	<b>9A:</b>	<b>Other Insured's Policy or Group Number</b> Enter the policy and/or group number of the other insurance coverage.
<b>Recommended</b>	<b>9B:</b>	<b>Other Insured's Date of Birth</b> Enter the information available to you in eight-digit format (MMDDCCYY).
	9C:	Employer's Name or School Name Enter the complete name.
	9D:	Insurance Plan Name or Program Name Enter the name of the insurance plan.
<b>Required</b>	<b>10:</b>	<b>Is Patient's Condition Related to</b> Check the correct boxes in a., b. and c.

	10D:	Reserved for Local Use Leave blank.
<b>Required</b>	<b>11:</b>	<b>Insured's Policy or FECA Number</b> Enter the group number of the insured as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
<b>Recommended</b>	<b>11A:</b>	<b>Insured's Date of Birth</b> Use eight-digit date format if submitting.
	11B:	Employer's Name or School Name
	11C:	Insurance Plan Name or Program Name
	11D:	Additional Benefit Plans
	12:	Patient's or Authorized Person's Signature Have patient sign if your office requires it.
	13:	Insured's or Authorized Person's Signature May be left blank.
<b>Required for accidents or injuries</b>	14:	<b>Date of Current illness, Injury, Pregnancy</b> Enter the date of the current illness, injury or pregnancy.
<b>Recommended for all other</b>		
	15:	If Patient has had Same or Similar illness Enter the date the patient first consulted you for this condition.
	16:	Dates Patient Unable to Work in Current Occupation Leave blank.
	17:	Name of Referring Provider or Other Source List the name of the referring, ordering or supervising physician or other health care professional.
	17A:	Other ID # Enter the assigned Regence provider number if submitting a paper claim and the physician or other health care professional listed in field 17.
	17B:	NPI # Enter the assigned NPI of the physician or other health care professional listed in field 17 for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
<b>Recommended</b>	<b>18:</b>	<b>Hospitalization Dates Related to Current Services</b>
	19:	Reserved for Local Use Leave blank.
	20:	Outside Lab If your patient had lab work done, check the correct box <i>even if you are not billing for the lab work</i> . Do not list charges in this field.

<b>Required</b>	<b>21:</b>	<b>Diagnosis or Nature of illness or Injury</b> Identify the patient's condition(s) by entering up to four ICD-9-CM codes in order of relevance. <b>Codes must be carried out to the highest possible (4th or 5th) digit. Non-specific diagnoses, such as 780, may result in denials.</b>
	22:	Medicaid Resubmission Leave blank.
	23:	Prior Authorization Number Leave blank.
<b>Required</b>	<b>24A:</b>	<b>Date(s) of Service</b> Enter the date(s) of service. If only one service is provided, the date can be entered as a "from date" or a "to date".
<b>Required</b>	<b>24B:</b>	<b>Place of Services</b> Indicate where services were provided by entering the appropriate two-digit place of service code. Valid codes are as follows: 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance (land) 42 Ambulance (air or water) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Facility 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility
	24C:	Emergency Indicator (EMG) Leave blank.
<b>Required</b>	<b>24D:</b>	<b>Procedures, Services, or Supplies: CPT/HCPCS, Modifier</b> Enter a valid procedure code best describing each service or supply. Explain unusual services or situations with procedure code modifiers. If a CPT and a HCPCS code describe the same service, use the CPT code. <b>Claims with an invalid or missing procedure code may be denied or returned for correction and resubmission.</b>

<b>Required</b>	<b>24E:</b>	<b>Diagnosis Pointer</b> Enter one diagnosis code reference number per claim line (i.e., up to four ICD-9-CM codes) as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis.
<b>Required</b>	<b>24F:</b>	<b>Charges</b> Enter your charge for each listed service.
<b>Required</b>	<b>24G:</b>	<b>Days or Units</b> Enter the number of services billed on the line. For anesthesia services, report time and modifier units on separate lines.
	<b>24H:</b>	<b>EPSDT Family Plan</b> Leave blank.
<b>Required if applicable</b>	<b>24I:</b>	<b>ID Qualifier</b> If entering an individual Regence provider number in 24J, ID Qualifier Code '1B' is required.
<b>Required if applicable</b>	<b>24J:</b>	<b>Rendering Provider ID # (split field)</b> The individual performing/rendering the service. <b>The rendering provider ID # is required when different than the billing provider found in Field 33.</b> Please submit only one provider per claim.  <b>Unlabeled Field</b> – Enter your individual Regence provider number if submitting paper claim.  <b>NPI Field</b> – Enter your Type 1 individual NPI number for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
<b>Required</b>	<b>25:</b>	<b>Federal Tax ID Number</b> Enter the provider's tax identification number as given by the Internal Revenue Service.
<b>Recommended</b>	<b>26:</b>	<b>Patient's Account Number</b> If you use patient account numbers, enter the number for this patient.
<b>Required for Medicare only</b>	<b>27:</b>	<b>Accept Assignment</b> Please check applicable box.
<b>Required</b>	<b>28:</b>	<b>Total Charge</b> Enter the total of all charges submitted on this claim.
<b>Recommended</b>	<b>29:</b>	<b>Amount Paid</b> Enter the exact amount the patient and/or other insurance carrier has paid to you for these services. Entering the words 'patient paid' without indicating the exact amount may cause claims delays and inaccurate processing.
	<b>30:</b>	<b>Balance Due</b> Enter the difference between Field 28 and Field 29.
<b>Required</b>	<b>31:</b>	<b>Signature of Physician or Supplier</b> Sign and date the form. Stamped and preprinted signatures that include the degree are acceptable for all products except Regence MedAdvantage. Claims for this product must be signed or have a preprinted signature including degree.
<b>Required if applicable</b>	<b>32:</b>	<b>Service Facility Location Information</b> Enter name and address of the location where the services were rendered.
<b>Required if applicable</b>	<b>32A:</b>	<b>NPI #</b> Enter the service facility NPI number (Type 2) of the service facility location, if known.

<b>Required if applicable</b>	<b>32B:</b>	<b>Other ID</b> Enter the two digit ID qualifier '1B' and the service facility Regence provider number of the service facility location if submitting a paper claim.
<b>Required</b>	<b>33:</b>	<b>Billing Provider Information and Phone #</b> Enter the billing provider's name, address, zip code, and telephone number.
<b>Required for electronic claim submissions</b>	<b>33A:</b>	<b>NPI #</b> Enter the NPI number (Type 1 or 2) of the billing provider.  The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
<b>Required for paper claims submissions if not submitting an NPI</b>	<b>33B:</b>	<b>Other ID</b> Enter the two digit ID qualifier '1B' and the Regence provider number of the billing provider. <b>Other ID is required if submitting a paper claim and 33A does not include an NPI.</b>



# UB-04 Paper Claim Form Instructions

All hospitals participating with Regence are required to submit *UB-04* claims in electronic format except for Type of Bill XX7. Following are instructions for completing a paper *UB-04* claim.

Requirements	Form Locator	Description
Required	1:	<b>Provider Name and Address, and Telephone Number</b> Enter provider's name, address, ZIP code and phone number.
	2:	Pay-to Name, Address, and Secondary Identification Fields Leave blank.
Required	3:	<b>Patient Control Number</b> Enter patient's control number or patient account number.
Required	4:	<b>Type of Bill (TOB)</b> Enter type of bill code. <b>Valid type of bill codes:</b> Hospital – Inpatient            11X 12X 18X Hospital – Outpatient           13X 14X Skilled Nursing – Inpatient    21X 22X Skilled Nursing – Outpatient   23X Home Health                      32X 33X 34X Clinic                                71X 72X 73X 74X 75X 76X 79X Special Facility                  81X 82X 83X 85X  <b>Valid third digit codes:</b> Admit through discharge claim   1 Interim - First claim                2 Interim - Continuing claim        3 Interim - Last claim                 4 Late charges only claim            5 Replacement of prior claim       7 (submit on paper) Void/cancel prior claim            8 (submit on paper)
Required	5:	<b>Federal Tax Number</b> Enter your federal tax identification number.
Required	6:	<b>Statement Covers Period (From-Through)</b> Enter statement covers from and through date. Must be in CCYYMMDD format.
	7:	Untitled Not used
Required	8:	<b>Patient's Name</b> Enter patient's last name, first name and middle initial.

<b>Required</b>	<b>9:</b>	<b>Patient Address</b> Enter patient's full mailing address including street number, city, state and zip code.
<b>Required</b>	<b>10:</b>	<b>Patient Birth Date</b> Enter patient's date of birth. Must be in MMDDCCYY format.
<b>Required</b>	<b>11:</b>	<b>Patient Sex</b> Enter "M" (male) or "F" (female).
<b>Required</b>	<b>12:</b>	<b>Admission Date</b> Enter date patient is admitted for this stay. Must be in MMDDCCYY format.
<b>Required for inpatient claims</b>	<b>13:</b>	<b>Admission Hour</b> Enter the admission hour code.  <b>Valid Admission Hour Codes.</b> 00 = 12:00-12:59 midnight    12 = 12:00-12:59 noon 01 = 01:00-01:59                13 = 01:00-01:59 02 = 02:00-02:59                14 = 02:00-02:59 03 = 03:00-03:59                15 = 03:00-03:59 04 = 04:00-04:59                16 = 04:00-04:59 05 = 05:00-05:59                17 = 05:00-05:59 06 = 06:00-06:59                18 = 06:00-06:59 07 = 07:00-07:59                19 = 07:00-07:59 08 = 08:00-08:59                20 = 08:00-08:59 09 = 09:00-09:59                21 = 09:00-09:59 10 = 10:00-10:59                22 = 10:00-10:59 11 = 11:00-11:59                23 = 11:00-11:59 99 = Unknown
<b>Required for inpatient claims</b>	<b>14:</b>	<b>Type of Admission/Visit</b> Enter the type of admission code. This code indicates the priority of this admission.  <b>Valid type of admission codes:</b> 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not available
<b>Required</b>	<b>15:</b>	<b>Point of Origin for Admission or Visit</b> Enter the code indicating the source of the referral for this admission or visit.  <b>Valid source of admission codes:</b> 1 = Non-Health Care Facility 2 = Clinic 3 = Reserved for national assignment 4 = Transfer from a hospital (different facility) 5 = Transfer from a skilled nursing facility or Intermediate Care Facility 6 = Transfer from another health care facility 7 = Emergency Room 8 = Court/Law enforcement 9 = Information not available

		<p>B = Transfer from another home health agency  C = Readmission to same home health agency  D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer  E = Transfer from ambulatory surgery center</p>
<b>Required for inpatient claims</b>	<b>16:</b>	<p><b>Discharge Hour</b>  Enter the discharge hour code.</p> <p><b>Valid Discharge Hour Codes.</b>  00 = 12:00-12:59 midnight    12 = 12:00-12:59 noon  01 = 01:00-01:59                13 = 01:00-01:59  02 = 02:00-02:59                14 = 02:00-02:59  03 = 03:00-03:59                15 = 03:00-03:59  04 = 04:00-04:59                16 = 04:00-04:59  05 = 05:00-05:59                17 = 05:00-05:59  06 = 06:00-06:59                18 = 06:00-06:59  07 = 07:00-07:59                19 = 07:00-07:59  08 = 08:00-08:59                20 = 08:00-08:59  09 = 09:00-09:59                21 = 09:00-09:59  10 = 10:00-10:59                22 = 10:00-10:59  11 = 11:00-11:59                23 = 11:00-11:59  99 = Unknown</p>
<b>Required for inpatient claims</b>	<b>17:</b>	<p><b>Patient Status</b>  Required for outpatient claims if the patient status code is other than 01. Enter patient status code.</p> <p><b>Valid Patient Status Codes:</b>  01 = Discharged to home or self-care (routine discharge)  02 = Discharged/transferred to another acute short-term general hospital for inpatient care  03 = Discharged/transferred to a SNF  04 = Discharged/transferred to an ICF  05 = Discharged/transferred to another type of institution not defined elsewhere in this code list  06 = Discharged/transferred to home under care organized home health service organization  07 = Left against medical advice or discontinued care  08 = Reserved for National Assignment  09 = Admitted as an inpatient to this hospital  20 = Expired  30 = Still patient or expected to return for outpatient services</p> <p><b>The following are used only on hospice claims:</b>  40 = Expired at home  41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice  42 = Expired – place unknown  43 = Discharged/transferred to a federal health care facility  50 = Discharged/transferred to Hospice – home  51 = Discharged/transferred to Hospice – medical facility  61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed  62 = Discharges/transferred to <u>an</u> inpatient rehabilitation facility</p>

		<p>including distinct part units of a “hospital”</p> <p>63 = Discharge/transferred to long term care hospital</p> <p>64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</p> <p>66 = Discharged/transferred to a Critical Access Hospital</p>
<b>Recommended</b>	<b>18 – 28:</b>	<p>Condition Codes</p> <p>Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. We can only accept up to 10 condition codes.</p> <p>Valid Condition Codes</p> <p>02 = Condition is Employment Related</p> <p>03 = Patient Covered by Insurance Not Reflected</p> <p>04 = Information Only Bill</p> <p>05 = Lien Has Been</p> <p>06 = ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance</p> <p>07 = Treatment of Non-terminal Condition for Hospice Patient</p> <p>08 = Beneficiary Would Not Provide Information Concerning Other Insurance Coverage.</p> <p>09 = Neither Patient Nor Spouse is Employed</p> <p>10 = Patient and/or Spouse is Employed but no EGHP Coverage</p> <p>11 = Disabled Beneficiary But no Large Group Health Plan</p> <p>12-14 = Payer codes reserved for internal use only by third party payers.</p> <p>17 = Patient is Homeless</p> <p>18 = Maiden Name Retained</p> <p>19 = Child Retains Mother’s Name</p> <p>20 = Beneficiary Requested</p> <p>21 = Billing for Denial Notice</p> <p>26 = VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility</p> <p>27 = Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test (Sole Community Hospitals only).</p> <p>28 = Patient and/or Spouse’s EGHP is Secondary to Medicare</p> <p>29 = Disabled Beneficiary and/or Family Member’s LGHP is Secondary to Medicare</p> <p>30 = Qualifying Clinical Trials</p> <p>Student Status</p> <p>31 = Patient is a Student (Full-Time - Day)</p> <p>32 = Patient is a Student (Cooperative/Work Study Program)</p> <p>33 = Patient is a Student (Full-Time - Night)</p> <p>34 = Patient is a Student (Part-Time)</p> <p>Accommodation</p> <p>36 = General Care Patient in a Special Unit (Not used by hospitals under PPS)</p> <p>37 = Ward Accommodation at Patient’s Request (Not used by hospitals under PPS.)</p> <p>38 = Semi-private Room Not Available (Not used by hospitals under PPS)</p> <p>39 = Private Room Medically Necessary (Not used by hospitals</p>

	<p>under PPS</p> <p>40 = Same Day Transfer  41 = Partial Hospitalization  42 = Continuing Care Not Related to Inpatient Admission  43 = Continuing Care Not Provided Within Prescribed Post Discharge Window  44 = Inpatient Admission Changed to Outpatient</p> <p>46 = Non-Availability Statement on File  47 = Reserved for TRICARE  48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)  49 = Product replacement within product</p> <p>Skilled Nursing Facility Information  55 = SNF Bed Not Available  56 = Medical Appropriateness  57 = SNF Readmission</p> <p>58 = Terminated Managed Care Organization Enrollee  59 = Non-primary ESRD Facility  67 = Beneficiary Elects Not to Use Lifetime Reserve (LTR)  69 = IME/DGME/N&amp;A Payment Only</p> <p>Renal Dialysis Setting  71 = Full Care in Unit  72 = Self-Care in Unit  73 = Self-Care Training  74 = Home  75 = Home 100-percent  76 = Back-up In-Facility Dialysis  77 = Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full  78 = New Coverage Not Implemented by Managed Care Plan  79 = CORF Services Provided Off-Site  80 = Home Dialysis-Nursing Facility</p> <p>A9 = Second Opinion Surgery  AA = Abortion Performed due to Rape  AB = Abortion Performed due to Incest  AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality  AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself  AE = Abortion Performed due to Physical Health of Mother that is not Life Endangering  AF = Abortion Performed due to Emotional/psychological Health of the Mother  AG = Abortion Performed due to Social Economic Reasons  AH = Elective Abortion Self  AI = Sterilization Self-explanatory</p> <p>AJ = Payer Responsible for Copayment  AK = Air Ambulance</p>
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		<p>AL = Specialized Treatment/bed Unavailable  AM = Non-emergency Medically Necessary Stretcher Transport Required  AN = Preadmission Screening Not Required</p> <p>B1 = Beneficiary is Ineligible for Demonstration Program  B2 = Critical Access Hospital Ambulance Attestation  B3 = Pregnancy Indicator  B4 = Admission Unrelated to Discharge</p> <p>Quality Improvement Organization (QIO)  C1 = Approved as Billed  C3 = Partial Approval  C4 = Admission Denied  C5 = Post-payment Review Applicable  C6 = Preadmission/Pre-procedure  C7 = Extended Authorization</p> <p>D0 = Changes to Service Dates  D1 = Changes to Charges  D2 = Changes to Revenue Codes/HCPCS/HIPPS Rate Code  D3 = Second or Subsequent Interim PPS Bill  D4 = Changes In ICD-9-CM Diagnosis and/or Procedure Code  D5 = Cancel to Correct HICN or Provider ID  D6 = Cancel Only to Repay a Duplicate or OIG Overpayment  D7 = Change to Make Medicare the Secondary Payer  D8 = Change to Make Medicare the Primary Payer  D9 = Any Other Change  DR = Disaster related  E0 = Change in Patient Status  G0 = Distinct Medical Visit  H0 = Delayed Filing, Statement Of Intent Submitted</p>
<b>Required for automobile accidents</b>	29	<p><b>Accident State</b>  Two-digit state abbreviation of the state where the accident occurred.</p>
	30	<p>Untitled  Not used.</p>
<b>Recommended Required for all accidents</b>	31 – 41:	<p><b>Occurrence Codes and Dates</b>  Required when there is a condition code that applies to this claim. Form locators 31, 32, 33, and 34 – allow both an occurrence codes and a date. Dates must be in MMDDYY format. The Occurrence Span Code can contain an occurrence code where the “Through” date would not contain an entry.</p> <p><b>Valid Occurrence Codes</b>  <b>Accident Related Codes</b>  01 = Accident/Medical Coverage  02 = No-Fault Insurance Involved  03 = Accident/Tort Liability  04 = Accident/Employment Related  05 = Accident/No Medical or Liability Coverage  06 = Crime Victim</p> <p><b>Medical Condition Codes</b>  09 = Start of Infertility Treatment Cycle</p>

10 = Last Menstrual Period  
11 = Onset of Symptoms/Illness (Outpatient claims only.)  
12 = Date of Onset for a Chronically Dependent Individual (CDI)  
(HHA Claims Only)

**Insurance Related Codes**

16 = Date of Last Therapy  
17 = Date Outpatient Occupational Therapy Plan Established or Reviewed  
18 = Date of Retirement Patient/Beneficiary.  
19 = Date of Retirement Spouse  
20 = Guarantee of Payment Began (Part A hospital claims only  
21 = UR Notice Received (Part A SNF claims only.)  
22 = Date Active Care Ended  
23 = Date of Cancellation of Hospice Election Period  
24 = Date Insurance Denied  
25 = Date Benefits Terminated by Primary Payer  
26 = Date SNF Bed Available  
27 = Date of Hospice Certification or Re-Certification  
28 = Date CORF Plan Established or Last  
29 = Date OPT Plan Established or Last Reviewed  
30 = Date Outpatient Speech Pathology Plan Established or Last Reviewed  
31 = Date Beneficiary Notified of Intent to Bill (Accommodations)  
32 = Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)  
33 = First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP  
34 = Date of Election of Extended Care Services  
35 = Date Treatment Started for Physical Therapy  
36 = Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)  
37 = Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant  
38 = Date treatment started for Home IV Therapy  
39 = Date discharged on a continuous course of IV  
40 = Scheduled Date of Admission  
41 = Date of First Test for Pre-admission Testing  
42 = Date of Discharge (Hospice claims only)  
43 = Scheduled Date of Cancelled Surgery  
45 = Date Treatment Started for Speech Therapy  
46 = Date Treatment Started for Cardiac  
47 = Date Cost Outlier Status Begins

**Service Related Codes**

A1 = Birth Date-Insured A The birth-date of the insured in whose name the insurance is carried.  
A2 = Effective Date-Insured A Policy  
A3 = Benefits Exhausted  
A4 = Split Bill Date  
B1 = Birth Date-Insured B  
B2 = Effective Date-Insured B Policy  
B3 = Benefits Exhausted  
C1 = Birth Date-Insured C  
C2 = Effective Date-Insured C Policy  
C3 = Benefits Exhausted

		<p>70 = Qualifying Stay Dates (Part A claims for SNF level of care only)</p> <p>71 = Hospital Prior Stay Dates (Part A claims only)</p> <p>72 = First/Last Visit</p> <p>74 = Non-covered Level of Care</p> <p><b>Codes 76 and 77 apply to most non-covered care</b></p> <p>76 = Patient Liability The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary.</p> <p>77 = Provider Liability- Utilization Charged The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care)</p> <p>M2 = Dates of Inpatient Respite From/Through dates of a period of inpatient</p> <p>M3 = ICF Level of Care</p> <p>M4 = Residential Level of Care</p>
	37:	<p>Untitled</p> <p>Not used.</p>
	38:	<p>Responsible Party Name and Address</p>
<b>Required</b>	<b>39 – 41 a - d:</b>	<p><b>Value Codes and Amounts</b></p> <p>Enter value code. Amount is required when a value code is entered. If value code 45 is entered then amount needs to reflect an admission hour (see Form Locator 13).</p> <p><b>Valid Value Codes</b></p> <p>01 = Most common semi-private rate</p> <p>02 = Hospital has no semi-private rooms</p> <p>03 = Inpatient professional component charges which are combined billed</p> <p>04 = Inpatient professional component charges which are combined billed</p> <p>05 = Professional component included in charges and also billed separate to carrier</p> <p>06 = Medicare blood deductible</p> <p>08 = Medicare life time reserve amount in the first calendar year</p> <p>09 = Medicare coinsurance amount in the first calendar year</p> <p>10 = Lifetime reserve amount in the second calendar year</p> <p>11 = Coinsurance amount in the second calendar year</p> <p>12 = Working aged beneficiary/spouse with employer group health plan.</p> <p>13 = ESRD beneficiary in a Medicare coordination period with an employer group health plan</p> <p>14 = No fault, including auto/other</p> <p>15 = Worker's compensation</p> <p>16 = PHS or other federal agency</p> <p><b>Medicaid Specific Codes</b></p> <p>21 = Catastrophic</p> <p>22 = Surplus</p> <p>23 = Recurring monthly income</p> <p>24 = Medicaid rate code</p>

**Reserved Codes**

- 31 = Patient liability amount
- 32 = Multiple Patient Ambulance Transport
- 37 = Pints of blood furnished
- 38 = Blood deductible pints
- 39 = Pints of blood replaced
- 40 = New coverage not implemented by HMO (for inpatient service only)
- 41 = Black Lung
- 42 = VA
- 43 = Disabled beneficiary under age 65 with LGHP
- 44 = Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received, then a Medicare secondary payment is due
- 45 = Accident Hour
- 46 = Number of grace days
- 47 = Any liability insurance
- 48 = Hemoglobin reading
- 49 = Hematocrit reading
- 50 = Number of physical therapy visits from onset (at the billing provider through this billing period)
- 51 = Number of occupational therapy visits from onset of symptoms ( at the billing provider through this billing period)
- 52 = Number of speech therapy visits from onset of symptoms (at the billing provider)
- 53 = Number of cardiac rehabilitation visits (at the billing provider through this billing period)
- 54 = Newborn birth weight in grams

**Home Health Specific Codes**

- 56 = Skilled nursing - home visit hours (HHA only)
- 57 = Home health aide - home visit hours (HHA only)
- 58 = Arterial blood gas value
- 59 = Oxygen saturation value
- 60 = HHA branch MSA
- 61 = Place of residence where service is furnished (HHA and Hospice)
- 67 = Peritoneal dialysis
- 68 = Number of units of EPO drug administered and/or supplied
- 71 = Funding of ESRD Networks
- 72 = Flat Rate Surgery Charge
- 73 = Drug deductible
- 74 = Drug coinsurance
- 76 = Provider's Interim Rate
- 80 = Covered days
- 81 = Non-covered days
- 82 = Co-insurance days
- 83 = Lifetime Reserve days

**Deductible Coinsurance Codes**

- A1 = Deductible amount Payer A
- B1 = Deductible amount Payer B

		<p>C1 = Deductible amount Payer C  A2 = Coinsurance amount Payer A  B2 = Coinsurance amount Payer B  C2 = Coinsurance amount Payer C  A3 = Estimated responsibility Payer A  B3 = Estimated responsibility Payer B  C3 = Estimated responsibility Payer C  D3 = Estimated responsibility patient</p> <p>A4 = Covered self-administrable drugs – emergency  A5 = Covered self-administrable drugs – not self-administrable in form and situation furnished to patient  A6 = Covered Self-Administrable Drugs – Diagnostic Study and Other (For use with Revenue Code 0637)</p> <p>A7 = Co-payment Payer A  B7 = Copayment Payer B  C7 = Copayment Payer C  A8 = Patient Weight  A9 = Patient Height  G8 = Facility where inpatient hospice service is delivered</p>
<b>Required for each charge entered</b>	<b>42:</b>	<b>Revenue Code</b> See Revenue Code table listed after UB-04 instructions for a complete listing of available revenue codes. An accommodation revenue code (0100-0219) is required for all inpatient type of bill (TOB).
Optional	43:	<b>Revenue Description</b> A narrative description of the related revenue categories included on the claim. Abbreviations may be used.
<b>Required</b>	<b>44:</b>	<b>HCPCS/Rates/HIPPS Rate Codes</b> A CPT or HCPCS code is required for outpatient services or supplies.
<b>Required</b>	<b>45:</b>	<b>Service Date</b> Enter the date that the services were provided. Must be in MMDDCCYY format.
<b>Required</b>	<b>46:</b>	<b>Units of Service</b> Enter the number of units rendered for each service. Units can be hours, days/sessions, tests/services or items. See Revenue Code table listed after UB-04 instructions for additional requirements.
<b>Required for each revenue code entered</b>	<b>47:</b>	<b>Total Charges</b> Enter total charges Enter total charges pertaining to the related revenue code for the current billing period. Zeros are valid.
Optional	48:	<b>Non-Covered Charges</b> Enter non-covered charges.
	49:	Untitled Not used.
	51 a- c:	<b>Health Plan ID</b> See Form locators 56 and 57 for NPI and Regence Identifier fields.

<b>Required</b>	52 a – c:	<b>Release of Information Certification Indicator</b> A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. This is required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.
Optional	53 a – c:	Assignment of Benefits Certification Indicator
Optional	54 a – c:	Prior Payments-Payers and Patient Enter the amount of the prior payments from other insurance.
Optional	55 a – c:	Estimated Amount Due from patient
<b>Required for electronic claim submissions</b>	<b>56:</b>	<b>Billing Provider National Provider ID (NPI)</b> The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
<b>Required for paper claim submissions if NPI is not submitted in form locator 56</b>	<b>57:</b>	<b>Other Provider ID (primary, secondary, and/or tertiary)</b> Use this field to report your Regence provider identification number if submitting a paper claim without an NPI.  Until further notice a billing provider can electronically submit both an NPI and a Regence provider identification number.
<b>Required</b>	<b>58</b> a – c:	<b>Insured’s Name</b> Enter the insured’s last name, first name and middle initial as it appears on the member card.
<b>Required</b>	<b>59</b> a – c:	<b>Patient’s Relationship to Insured</b> Enter patient’s relationship to insured code. 01 = Spouse 18 = Self 19 = Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship
<b>Required</b>	<b>60</b> a – c:	<b>Insured’s Unique Identification (ID)</b> Enter insured’s identification number as shown on member card.
Optional	61 a – c:	Insured’s Group Name
<b>Required</b>	<b>62</b> a – c:	<b>Insurance Group Number</b> Enter the insured’s group number as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Optional	63:	Treatment Authorization Code
Optional	64:	Document Control Number (DCN)
Optional	65:	Employer Name

Optional	66:	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) The qualifier denotes the version of <i>International Classification of Diseases</i> (ICD) reported. The following qualifier code reflects the edition portion of the ICD 9 – Ninth Revision
Required	67:	<b>Principal Diagnosis Code and Present on Admission Indicator</b> Enter the ICD-9 diagnosis code for the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for this hospital admission. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. Do not include the decimal between the third and fourth digits. "V" codes are acceptable as principal diagnoses.  This field is eight positions long. The principal diagnosis is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
Required	67A – 67Q:	<b>Other Diagnoses Codes</b> Enter up to seventeen ICD-9 diagnosis codes for the other diagnoses. The codes must be the full ICD-9 diagnosis codes, including all five digits where applicable. Do not include the decimal between the third and fourth digits. Both "V" and "E" codes may be entered as other diagnoses, though E codes are preferably billed in form locator 72.  There are 17 Other Diagnosis fields. Each Other Diagnosis field is eight positions long. The diagnosis code is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.  Diagnosis codes must be carried to their highest degree of detail. Do not duplicate the principal diagnosis in this field.
	68:	Untitled Not used.
Required for inpatient type of bills	69:	<b>Admitting Diagnosis</b> Must be a valid ICD diagnosis code. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.
Required for outpatient if applicable	70 a – c:	<b>Patient's Reason for Visit</b> Required for all unscheduled outpatient visits for outpatient bills.
Optional	71:	Prospective Payment System (PPS) Code

Required if applicable	72:	<p><b>External Cause of Injury Code (E-Code)</b> Enter up to three E-Codes if an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. The codes must be the full ICD-9 E-code, including all five digits where applicable. Do not include the decimal between the fourth and fifth positions.</p> <p>There are 3 E-Code fields. Each E-Code field is eight positions long. The E-Code is entered in positions 1 - 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p>
	73:	Untitled Not used.
Required for inpatient type of bills if applicable	74:	<p><b>Principal Procedure Code and Date</b> Enter the principal procedure code and date. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.</p>
Required for inpatient type of bills if applicable	74A – 74E:	<p><b>Other Procedure Codes and Dates</b> Enter up to five other procedure codes and dates. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.</p>
	75:	Untitled Not used.
Required	76:	<p><b>Attending Provider Name and Identifiers (including NPI)</b> Enter the unique provider's NPI and the name of the attending physician for inpatient bills or the physician that requested the outpatient services.</p> <p>Definition of attending provider: The provider who is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.</p>
Optional	77:	Operating Provider Name and Identifiers (including NPI)
Optional	78 and 79:	Other Provider Name and Identifiers (including NPI)
Required under circumstances listed	80:	<p><b>Remarks</b></p> <ol style="list-style-type: none"> <li>If revenue code 0450, 0456 or 0459 are entered in Form Locator 42, remarks should clarify circumstances for emergency room visit, i.e. who, what, when, where, why, how and time of day. Use of E-Code and Occurrence codes are valid.</li> <li>If CPT codes are used in place of HCPCS codes with any of the following revenue codes entered in Form Locator 44, remarks should specify the type of drug, implant, or device: 0254 = Drugs incident to other diagnostic service 0255 = Drugs incident to radiology 0256 = Experimental drugs 0259 = Other pharmacy 0274 = Prosthetic device 0278 = Other implants 0279 = Other supplies/devices</li> </ol>

		<p>0623 = Surgical dressings  0624 = Investigational device  0636 = Drugs requiring detailed coding  0637 = Self-administrable drugs</p> <p>5. If CPT codes are used in place of HCPCS codes with any of the following revenue codes entered in Form Locator 44, remarks should specify the type of equipment and for rental equipment, the period of rental:</p> <p>0290 = General Classification  0291 = Rental  0292 = Purchase of new equipment  0293 = Purchase of used equipment  0294 = Supplies/drugs for DME effectiveness  0299 = Other equipment</p> <p>If occurrence codes 01-05 are entered in Form Locators 31-41 and/or diagnosis codes 800-959.9, E800-849, E880-E929, E969-E999 are entered in Form Locators 67A -67Q or E999 is entered in Form Locator 72, remarks should clarify accident information, i.e. who, what, when, where, why, how and time of day.</p>
<b>Recommended</b>	<b>81:</b>	<p><b>Code-Code Field</b>  Enter for the following:  A1 = NUBC Condition Codes (FL 18-28)  A2 = NUBC Occurrence Codes/Dates  A3 = NUBC Occurrence Span  A4 = NUBC Value Codes (FL 39-41)</p>

