

UB-04 claims submission guide

The UB-04 claim form, also known as the CMS-1450 form, is approved by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee for facility and ancillary paper billing. Sample UB-04 forms for inpatient and outpatient claims can be found on pages 4 and 5.

If you have any questions regarding the UB-04 claim form, please call your Network Coordinator or Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE).

UB-04 data field requirements

Field location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax ID Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9a-e	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	Required, if applicable
13	Admission Hour	Required	Required, if applicable
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
	NDC Code	Required, if applicable	Required, if applicable
44	HPCS/Rates	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (by Revenue Code)	Required	Required

Field location UB-04	Description	Inpatient	Outpatient
48	Non-Covered Charges	Required, if applicable	Required, if applicable
49	Future Use	N/A	N/A
50	Payer Name	Required	Required
51	Health Plan ID	Situational	Situational
52	Release of Information Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required, if applicable	Required, if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured's Group Name	Situational	Situational
62	Insured's Group Number	Situational	Situational
63	Treatment Authorization Codes	Required, if applicable	Required, if applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required	Required
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required, if applicable
70	Patient's Reason for Visit Code	N/A	Situational
71	PPS Code	Situational	Situational
72	External Cause of Injury Code	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required, if applicable	N/A
75	Future Use	N/A	N/A
76	Attending Provider Name/NPI	Required	Required
77	Operating Physician Name/NPI	Situational	Situational
78-79	Other Provider Name/NPI	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code Field/Qualifiers		
	0-A0	N/A	N/A
	A1-A4	Situational	Situational
	A5-AB	N/A	N/A
	AC - Attachment Control number	Situational	Situational
	AD-B0	N/A	N/A
	B1-B2	Situational	Situational
	B3 Taxonomy Code Qualifier	Required	Required

Readability requirements

To ensure that all claims are processed against the same requirements, paper claims are converted to an electronic format. However, system limitations can cause data elements to be misinterpreted during the conversion process.

Follow these guidelines to ensure your claims are successfully converted:

Do	Don't
<ul style="list-style-type: none"> • Use red drop on UB-04 paper forms only. • Replacement/corrected claims require a Type of Bill with a Frequency Code "7" (field 4) and claim number in the Document Control Number (field 64). • Enter all required data. • All patient details are required (ID number with prefix, last name, first name, and date of birth). • Separate the subscriber/patient last name and first name with a comma. • Ensure the use of proper coding (ICD-10 HIPAA codes, dates of service, and correcting a prior claim). • Use standard fonts and sizes. 	<ul style="list-style-type: none"> • Do not include handwriting anywhere on the claim form. • Do not use stamped data in any field (NPI, provider names, signatures, corrections, etc.). • Do not print claim data out of the designated field; it may not be captured. • Do not print from an older DOT matrix printer; it may not be captured.

Inpatient

1 Any Hospital 123 Any Street Philadelphia PA 19103		2 Any Hospital 456 Any Street Philadelphia PA 19103		3a PAT. CNTL. # 1234 b. MED. REC. # 98765		4 TYPE OF BILL 0111	
8 PATIENT NAME a Doe, John		9 PATIENT ADDRESS a 1234 Main Street		5 FE. D. TAX NO. 221234567		6 STATEMENT FROM 11 03 06 7 COVERS PERIOD THROUGH 11 04 06 RESERVED	
10 BIRTH DATE 03 20 1971		11 SEX M		12 DATE 11 03 06		13 HR 08	
14 TYPE 3		15 SRC 3		16 DHR 12		17 STAT 01	
18 CONDITION CODES		19		20		21	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE FROM		37 OCCURRENCE FROM		38 OCCURRENCE FROM	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
A1 952.00		Value Codes and amounts required when necessary to process claim					
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SE RV. DATE		46 SE RV. UNITS	
0129 Semi-Private		200.00				2	
0250 Pharmacy						1	
0360 OR Services							
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		FUTURE USE	
400.00		0.00		0.00		0.00	
500.00		0.00		0.00		0.00	
PAGE 1 OF 1		CREATION DATE		TOTALS		550.00 0.00	
50 PAYER NAME Independence Blue Cross Secondary Payer Tertiary Payer		51 HEALTH PLAN ID Report HIPAA National Health Plan Identifier when mandatory		52 REL. INFO Y Y		53 ASG. BEN. Y Y	
54 PRIOR PAYMENTS Required when indicated payer has paid amount to Provider		55 EST. AMOUNT DUE Amount estimated to be due		56 NPI 222222222		57 OTHER PR V ID 1234567890 Secondary Tertiary	
58 INSURED'S NAME Doe, John Secondary Tertiary		59 P. REL. 18		60 INSURED'S UNIQUE ID ABC1234567800		61 GROUP NAME Watch Repair, Inc.	
62 INSURANCE GROUP NO. 1234		63 TREATMENT AUTHORIZATION CODES 02468 Secondary Tertiary		64 DOCUMENT CONTR OL NUMBER 491234		65 EMPLOYER NAME Watch Repair, Inc.	
66 DX 67		68 Reserved		69 ADMIT DX 4280		70 PATIENT REASON DX DRG	
71 PPS CODE 3749		72 EC. 1		73 May be used to report external cause of injury Reserved		74 ATTENDING NPI 222222222	
75 LAST Smith		76 FIRST David		77 OPERATING NPI		78 OTHER NPI	
79 LAST		79 FIRST		79 QUAL		79 LAST	
80 REMARKS May be used to report additional information.		81CC a B3 282N00000X		81CC b Secondary		81CC c Tertiary	

Red = Required
Black = Situational/Required, if applicable/Optional

Use the appropriate ICD indicator and code set

Outpatient

1 Any Hospital 123 Any Street Philadelphia PA 19103		2 Any Hospital 456 Any Street Philadelphia PA 19103		3a PAT. CNTL # 1234 b. MED. REC. # 98765	4 TYPE OF BILL 0131
5 FE D. TAX NO. 221234567			6 STATEMENT FROM 11 03 06	COVERS PERIOD THROUGH 11 04 06	7 RESERVED

8 PATIENT NAME a Patient ID if different from Sub		9 PATIENT ADDRESS a 1234 Main Street	
b Doe, John		b Philadelphia	
10 BIRTH DATE 03 20 1971		11 SEX M	12 DATE 11 03 06
13 HR 08	14 TYPE 3	15 SRC 3	16 DHR
17 STAT 01		18 CONDITION CODES 22-28	
29 AC DT STATE PA		30 Country code if other than USA RESERVED	
31 OCCURRENCE DATE		32 OCCURRENCE DATE	33 OCCURRENCE DATE
34 OCCURRENCE DATE		35 OCCURRENCE FROM THROUGH	
36 OCCURRENCE DATE		37 OCCURRENCE FROM THROUGH	

38 Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing

39 CODE A1	VALUE CODES AMOUNT 952.00	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
b Value Codes and amounts required when necessary to process claim					
c					
d					

John Doe
1234 Main Street
Philadelphia, PA 19111

42 REV. CD.	43 DESCRIPTION	44 HCPCS /RATE /HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0310	Laboratory N400093723106	88173	11 03 06	1	100.00	0.00	Future Use
2 0402	Ultrasound	76942	11 04 06	1	100.00	0.00	
3 0360	OR Services	3749	11 04 06	1	100.00	0.00	
4							
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23 PAGE 1 OF 1		CREATION DATE		TOTALS		300.00	0.00

Red = Required
Black = Situational/Required, if applicable/Optional

50 PAYER NAME A Independence Blue Cross		51 HEALTH PLAN ID Report HIPAA National Health Plan Identifier when mandatory		52 REL INFO Y	53 ASS. BEN. Y	54 PRIOR PAYMENTS Required when indicated payer has paid amount to Provider	55 EST. AMOUNT DUE Amount estimated to be due	56 NPI 222222222	57 OTHER PRV ID 1234567890
B Secondary Payer									
C Tertiary Payer									
58 INSURED'S NAME A Doe, John		59 P. REL 18	60 INSURED'S UNIQUE ID ABC1234567800		61 GROUP NAME Watch Repair, Inc.		62 INSURANCE GROUP NO. 1234		
B Secondary									
C Tertiary									

Use the appropriate ICD indicator and code set

63 TREATMENT AUTHORIZATION CODES A 02468		64 DOCUMENT CONTR OL NUMBER 491234		65 EMPLOYER NAME Watch Repair, Inc.	
B Secondary					
C Tertiary					
66 DX 67		68 Reserved			
69 ADMIT DX 4280		70 PATIENT REASON DX May be used to report reason for visit		71 PPS CODE DRG	
72 EC I		73 May be used to report external cause of injury		73 Reserved	
74 PRINCIPAL PROCEDURE DATE		a. OTHER PROCEDURE DATE		b. OTHER PROCEDURE DATE	
c. OTHER PROCEDURE DATE		d. OTHER PROCEDURE DATE		e. OTHER PROCEDURE DATE	
76 ATTENDING NPI 222222222		QUAL		77 OPER ATING NPI	
LAST Smith		FIRST David			
78 OTHER NPI		QUAL		79 OTHER NPI	
LAST		FIRST			
80 REMARKS		81CC a B3 282N00000X			
b Secondary					
c Tertiary					
d					