APPENDIX B:Tips for Completing the UB-92/HCFA 1450 Claim Form

Field Number	Field Description	Data Type	Instructions
1	Provider name, address and telephone number	Required	Enter the name of the facility submitting the bill and the complete billing address, telephone number, Organization and Vendor ID numbers.
2	Unlabeled field	Not required	Not applicable.
3	Patient control number	Optional	Enter the unique number assigned by the facility for the client.
4	Type of bill	Required	Enter a valid 3-digit Type of Bill code, that provides specific information about the services rendered. Refer to the UB92 Reference Codes following this document.
5	Federal tax number	Required	Enter the nine-digit Employer Identification Number (EIN) for the Provider indicated in box 1 assigned by the Internal Revenue Service (IRS).
6	Statement covers period "From" and "Through"	Required	Enter the beginning and ending date of services for the period reflected on the claim in MMDDYY format. The date of discharge is not a covered day for an inpatient stay.
7	Covered days	Not required	Enter the number of inpatient days covered for the billing period noted in Field 6.
8	Non-covered days	Not required	Enter the number of inpatient days not covered by the primary payer.
9	Coinsurance days	Not required	Enter the number of the inpatient Medicare days occurring after the 60th day and before the 91st day in a single episode.
10	Lifetime reserve days	Not required	Enter the number of lifetime reserve days used during the billing period noted on the claim.
11	Unlabeled field	Not required	Not applicable.
12	Patient's name (last, first name, middle initial)	Required	Enter the Client Name (Last, First Name, and Middle Initial).

13	Patient's address	Required	Enter the complete mailing address of the Client. Include the street number and name, post office box or rural route number and apartment number if applicable, city, state and zip code.
14	Birth date	Required	Enter the Client's Date of Birth in MMDDYY format.
15	Sex	Required	Enter the code for the gender status of the client. Refer to the UB92 Reference Codes following this document.
16	Marital status	Not required	Enter the marital status of the Client on the date of the admission. Refer to the UB92 Reference Codes following this document.
17	Admission date	Required	Enter the original date the Client was admitted for care in MMDDYY format.
18	Admission hour	Conditional	If this is an inpatient claim, enter the admission hour in Military Standard Time (e.g., 00:00 to 24:00), if applicable.
19	Admission type	Conditional	If this is an inpatient claim, enter the code for the admission type if applicable. Refer to the UB92 Reference Codes following this document.
20	Admission source	Conditional	If this is an inpatient claim, enter the appropriate Admission Source Code. Refer to the UB92 Reference Codes following this document.
21	Discharge hour	Conditional	If this is an inpatient claim, enter the hour at which the Client was discharged from inpatient care if applicable.
22	Patient status	Not required	Enter the appropriate code indicating the Client's disposition as of the ending date of service for the period of care. Refer to the UB92 Reference Codes following this document.
23	Medical record number	Optional	Enter the number assigned by the Provider to the Client's medical or health record.
24-30	Condition codes	Not required	Enter a valid condition code if applicable.
31	Unlabeled field	Not required	Not applicable.
32	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.

33	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
34	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
35	Occurrence code and date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
36	Occurrence span code and "From/Through" date	Not required	Enter a valid Occurrence code and date if applicable. Enter the date in MMDDYY format.
37	Unlabeled field	Not required	Not applicable.
38	Responsible party name and address	Not required	Enter the name and address of the party responsible for payment of the bill.
39	Value codes/amount	Not required	Enter a valid Value code and amount.
40	Value codes/amount	Not required	Enter a valid Value code and amount.
41	Value codes/amount	Not required	Enter a valid Value code and amount.
42	Revenue code	Required	Enter the applicable revenue codes for the services rendered. There are 23 lines available and should include the total line for revenue code 0001.
43	Description	Not required	Enter the corresponding description of the revenue code(s) indicated in Field 43 lines 1-23.
44	HCPCS/Rates	Required	Enter a valid HCPC or CPT procedure code for the ancillary services for outpatient or the accommodation rate for inpatient claims.
45	Service date	Required	Enter the date the service was rendered in MMDDYY format.
46	Service units	Required	Enter the service units for each service billed.
47	Total charges	Required	Enter the amount equal to the per unit charge to the related revenue codes billed for the statement from and through dates. This amount includes both the covered and non-covered charges.

48	Non-covered charges	Not Required	Enter the total non-covered charges for the Primary Payer, if applicable, for each service billed.
49	Unlabeled field	Not required	Not applicable.
50	Payer	Required	Enter the name(s) of the Primary, Secondary and Tertiary Payers as applicable. Provider should list multiple Payers in priority sequence according to the priority the provider expects to receive payment from these Payers.
51	Provider number	Required	Enter your plan assigned provider number.
52	Release of information certification indicator	Required	Enter the appropriate code denoting whether the Provider has on file a signed statement from the beneficiary to release information. Indicate a “Y” for yes, an “R” for restricted or modified release or an “N” for no release.
53	Assignment of benefits	Required	Enter the applicable code to indicate whether the Provider has a signed form authorizing the third party insurer to pay the Provider directly for the services rendered.
54	Prior payments	Conditional	Enter any prior payment amount the Facility has received toward payment of this bill for the Payer indicated in Field 50 lines a,b,c.
54P	Due From Patient	Not required	Enter the amount due from the client.
55	Estimated amount due	Not required	Enter the estimated amount due from the Payer indicated in Field 50 lines a,b,c.
56	Unlabeled field	Not required	Not applicable.
57	Unlabeled field	Not required	Not applicable.
58	Insured's name) last, first name, middle initial	Required	Enter the Insured’s Name (Last, First Name, Middle Initial).
59	Patient's relationship to insured	Required	Enter the applicable code that indicates the relationship of the client to the insured noted in Field 58. Refer to the UB92 Reference Codes following this document.

60	Certificate Number - Social Security Number - Health Insurance Identification Number	Required	Enter the Insured's EMS ID in Box 60a and the ID number assigned by secondary or tertiary insurance as applicable.
61	Group name	Not required	Enter the group or plan name of the Primary, Secondary and Tertiary Payer through which the coverage is provided to the insured if applicable.
62	Insurance group number	Not required	Enter the plan or group number for the Primary, Secondary and Tertiary Payer if applicable.
63	Treatment authorization codes	Not required	Enter the authorization number assigned by ABH.
64	ESC (Employment Status Codes)	Not required	Enter the applicable code that defines the employment status code of the insured indicated in Field 50. Refer to the UB92 Reference Codes following this document.
65	Employer name	Not required	Enter the name of the Primary Employer that provides the coverage for the insured indicated in Field 58.
66	Employer location	Not required	Enter the specific location of the Primary Insured individual identified in Field 58.
67	Principal diagnosis code	Required	Enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) that describes the principal diagnosis for the services rendered. Please exclude the decimal point.
68-75	Other diagnosis code	Conditional	If there are additional diagnoses, enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) for any other conditions that exist for the services rendered. Please exclude the decimal point.
76	Admitting diagnosis code	Required	Enter a valid ICD-9 or DSM diagnosis code (including the fourth and fifth digits if applicable) that describes the diagnosis at the time of the admission. Please exclude the decimal point.
77	E-code	Not required	Enter a valid ICD-9 diagnosis code (including the fourth and fifth digits if applicable) for the external cause of injury, poisoning or adverse effect. Please exclude the decimal point.
78	Unlabeled field	Not required	Not applicable.

79	Procedure method used	Not required	Enter the corresponding code that denotes the medical coding system used to complete the claim form.
80	Principal procedure code/date	Not required	Enter a valid ICD-9 code and date for the principal procedure performed during the period covered by the bill.
81	Other procedure code/date	Not required	Enter additional ICD-9 codes and dates to identify significant procedures performed during the period covered by the bill.
82	Attending physician identification number	Required	Enter the name and/or the assigned number of the licensed Physician who has primary responsibility for the Client's care.
83	Other physician identification number	Not Required	Enter the name and/or the assigned number of the licensed Physician, other than the attending physician, who treated the Client.
84	Remarks	Not required	Not applicable.
85	Provider representative	Required	Enter the signature of an authorized representative noting the Physician's certification is in effect. A stamp or facsimile of the Provider's representative signature is acceptable.
85	Date	Required	Enter the date the bill is submitted to the Payer organization in MMDDYY format.

APPENDIX C: UB-92/HCFA 1450 Reference Material

Patient Status (Field 22)

Definition	Code
Discharged to home or self-care (routine discharge)	01
Discharged/transferred to another short-term general hospital	02
Discharged/transferred to a skilled nursing facility	03
Discharged/transferred to an intermediate care facility	04
Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution	05
Discharged/transferred to home under care of organized home health service organization	06
Left against medical advice or discontinued care	07
Discharged/transferred to home under care of organized home health service organization	09
Admitted as an inpatient to this hospital	09
Expired (or did not recover-Christian Science patient)	20
Still a patient or expected to return for outpatient services	30
Reserved for National Assignment	31-39
Expired at home (for hospice care only)	40
Expired in a medical facility such as a hospital, SNF, ICF or free-standing hospice (for hospice care only)	41
Expired, place unknown (for hospice care only)	42
Discharged/Transferred to a Federal Hospital	43
Discharged to hospice, home	50
Discharged to hospice, Medical Facility	21

Release of Information Indicator Codes (Field 52)

Definition	Code
Yes	Y
Restricted or modified release	R
No release	N

Member's Relationship to the Insured Codes (Field 59)

(Date of Service is before October 16, 2003)

Definition	Code
Patient is the insured	01
Spouse	02
Natural child/insured has financial responsibility	03
Natural child/insured does not have financial responsibility	04
Stepchild	05
Foster child	06
Ward of the court	07
Employee	08
Unknown	09
Handicapped dependent	10
Organ donor	11
Cadaver donor	12
Grandchild	13
Niece/nephew	14
Injured plaintiff	15
Sponsored dependent	16
Minor dependent of a minor dependent	17
Parent	18
Grandparent	19
Life partner	20

Member's Relationship to the Insured Codes (Field 59)

(Date of Service is after October 16, 2003)

Definition	Code
Spouse	01
Grandfather or Grandmother	04
Grandson or Granddaughter	05
Niece/nephew	07
Foster Child	10
Ward	15
Stepson or Stepdaughter	17
Self	18
Child	19
Employee	20
Unknown	21
Handicapped Dependent	22
Sponsored Dependent	23
Dependent of a Minor Dependent	24
Significant Other	29
Mother	32
Father	33
Emancipated Minor	36
Organ Donor	39
Cadaver Donor	40
Injured Plaintiff	41
Child where insured has no financial responsibility	43
Life Partner	53
Other Relationship	G8

Valid Employment Status Codes (Field 64)

Definition	Code
Employed full-time	1
Employed part-time	2
Not employed	3
Self-employed	4
Retired	5
On active military duty	6
Unknown	9

APPENDIX D: UB-92 - Facility Codes

Psychiatric Services

Service	DMHAS LOC	UB-92 Revenue Code
Acute Psychiatric Inpatient	MH IV-2	124
Acute Inpatient Services Pilot II.0 Dual Diagnosis	Pilot II.0	121,124,126
Observation / Flex Bed	MH II.7	760, 762
Intensive Crisis Stabilization	MH II.9	769
Partial Hospitalization	MH II.5	913
Intensive Outpatient MH	MH II.1	912
Emergency Room	MH I.I	450

Substance Abuse Services

Service	DMHAS LOC	UB-92 Revenue Code
Inpatient Detox – Medically Managed	SA IV.2-D	126
Observation / Flex Bed	SA II.7	760, 762
Partial Hospitalization	SA II.5	913
Intensive Outpatient SA	SA II.1	912
Ambulatory Detox w/ On-Site Monitoring	SA II.D	191
Ambulatory Detox	SA I.D	190
Emergency Room	SA I.1	450

Professional Ambulatory Codes
Standard OP-BEH Auth

CPT Code	Description
90804	Individual Therapy - (20-30 min.)
90805	Individual Therapy w/ Med Management (20-30 min.)
90806	Individual Therapy (45-50 min.)
90807	Individual Therapy w/ Med Management (45-50 min.)
90846	Family Therapy without patient
90847	Family Therapy with patient
90853	Group Therapy
90862	Psychopharmacology Management
90875	Individual Psychophysiological Therapy w/Biofeedback (20-30 min.)
90876	Individual Psychophysiological Therapy w/Biofeedback (45-50 min.)
90880	Medical Hypnotherapy
99241	Office or Other Outpatient Consultation (15 min.)
99242	Office or Other Outpatient Consultation (30 min.)

99243	Office or Other Outpatient Consultation (40 min.)
99244	Office or Other Outpatient Consultation (60 min.)
99245	Office or Other Outpatient Consultation (80 min.)
99251	Inpatient Consultation (20 min.)
99252	Inpatient Consultation (40 min)
99253	Inpatient Consultation (55 min.)
99254	Inpatient Consultation (80 min.)
99255	Inpatient Consultation (110 min.)
99261	Follow-up Inpatient Consultation (10 min.)
99262	Follow-up Inpatient Consultation (20 min.)
99263	Follow-up Inpatient Consultation (30 min.)
99271	Confirmatory Consultation, Focused
99272	Confirmatory Consultation, Expanded
99273	Confirmatory Consultation, Detailed
99274	Confirmatory Consultation, Comprehensive, Moderate Complexity
99275	Confirmatory Consultation, Comprehensive, High Complexity

Professional Ambulatory Codes Requiring Special Authorization

CPT Code	Description
90801	Initial Psychiatric Interview Examination
90870	Electroconvulsive Therapy, Single Seizure
90871	Electroconvulsive Therapy, Multiple Seizures
90899	Unlisted Psychiatric Service or Procedure
96100	Psychological Testing
96115	Neurobehavioral Status Exam
96117	Neuropsychological Testing Battery