UB-04 Paper Claim Submission

Provider Training
Agenda

• Completing a UB-04 Paper Claim Form
• Claim Submission
• Claim Samples
• Medicare Part C Crossover Claim Form
• Third Party Liability (TPL)
• Medicare Crossovers
• Remittance Advice (RA)
• Adjustments and Voids
• Additional Resources
Florida Medicaid Online Resources

- Florida Medicaid Provider General Handbook
- Coverage and Limitations Handbooks
- Florida Medicaid Provider Reimbursement UB-04 Handbook

Agency for Health Care Administration (Agency):
http://ahca.myflorida.com/medicaid
Completing a UB-04 Paper Claim Form
UB-04 Paper Claim Form (top section)
UB-04 Paper Claim Form (bottom section)
Paper Claim Submission Checklist

In order for a claim to be paid, it must be a clean claim.

Checklist for a clean claim:

- Has the claim been accurately and fully completed according to Medicaid billing guidelines?
- Is the claim accompanied by all necessary documentation and on a version 01-12 claim form?
- Can the claim be processed and adjudicated by DXC without obtaining additional information from the provider?
UB-04 Completion Rules

Rules for completing a UB-04

- Enter all information using black or blue ink. Do not use highlighters.
- Be sure the information on the form is legible and aligned with the corresponding space.
- Only complete the fields that are required and applicable.
- If needed, use correction tape. Do not use whiteout fluid.
- Complete the form by referencing the service-specific coverage and limitations handbook and the UB-04 Reimbursement Handbook, as necessary.
Entering NPI on the UB-04

As of January 1, 2011, National Provider Identifier (NPI) entries in the billing and rendering provider sections of CMS-1500 paper claims are required.

If a taxonomy code is used to create a unique map from a provider’s NPI to a Florida Medicaid ID number, the applicable taxonomy code and qualifier must be entered on paper claims.

Referring Providers must be identified using the appropriate qualifier (DN) and the NPI and taxonomy or Florida Medicaid ID, accompanied by the appropriate qualifier code (ZZ if reporting an NPI taxonomy or 1D if reporting a Florida Medicaid provider ID). The NPI entered must be valid and known to Florida Medicaid.
# Locators 1 & 3a
## UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 1        | Line 1: Provider Name  
Line 2: Street Address or Post Office Box  
Line 3: City, State, and Zip Code (plus 4)  
Line 4: Telephone; Fax; Country Code (if other than USA) |
| 3a       | Enter patient’s unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable.  
This number will be included on the payment check or remittance. |
Locators 4 & 5
UB-04 Paper Claim Form

Enter the appropriate four-digit code for the type of bill.

See Chapter 1 of the UB-04 Reimbursement Handbook for a complete listing of Type of Bill codes.

Examples of Type of Bill Codes:
• 0111: Inpatient Admit through Discharge Date
• 0131: Outpatient Claim
• 0211: Skilled Nursing Facility Level One
• 0721: Freestanding Dialysis Center
• 0813: Hospice Original Claims

Enter the federal tax identification number in the format NN-NNNNNNNN.
# Locator 6
## UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Enter the start and end service dates for the month being billed in MMDDYY format. (Ex. August 21, 1997, enter as 082197.)</td>
</tr>
</tbody>
</table>

**Inpatient:** For admission and discharge on the same day, both the **From** and **Through** dates are the same.

**Inpatient Psychiatric Services:** See split billing instructions in Chapter 1 of the UB-04 Reimbursement Handbook.

**Outpatient:** Only the services received in a single day can be billed on an outpatient claim. The **From** and **Through** dates are the same.

**Hospice and Freestanding Dialysis Centers:** Do not show dates before the recipient’s Medicaid eligibility began. For services received on a single day, the **From** and **Through** dates must be the same.

**Long Term Care Facilities:** Enter the start and end service dates for the month being billed.
Locators 8 & 9
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a</td>
<td>Enter patient’s Medicaid identification number only if number is different from the insured’s ID on Form Locator 60.</td>
</tr>
<tr>
<td>8b</td>
<td>Enter the recipient’s last name, first name, and middle initial exactly as it appears on the Medicaid identification card or other Medicaid proof of eligibility.</td>
</tr>
<tr>
<td>9a</td>
<td>Street Address or Post Office Box</td>
</tr>
<tr>
<td>9b</td>
<td>City</td>
</tr>
<tr>
<td>9c</td>
<td>State</td>
</tr>
<tr>
<td>9d</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>
Locators 10 & 11
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Enter the patient's date of birth in MMDDYYYY format. (Ex. August 21, 1997, enter as 08211997.)</td>
</tr>
<tr>
<td>11</td>
<td>Enter the letter M if the patient is male, F if the patient is female, or U if unknown.</td>
</tr>
</tbody>
</table>
**Locators 12 & 13**  
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **12**   | **Inpatient:** Enter the patient’s date of admission in MMDDYY format. (Ex. August 21, 1997, enter as 082197.)  
**Outpatient:** Enter the date of service.  
**Freestanding Dialysis Centers:** No entry required.  
**Hospice:** Enter the patient’s date of admission in MMDDYY format. This date must be the same as the effective date of hospice election or change of election.  
**Long Term Care Facilities:** Enter the patient’s date of admission to the facility or to a new Level of Care in MMDDYY format. |
| **13**   | **Not required but desirable for Hospital Services:** Enter the two-digit code for the hour of admission from the table in Chapter 1 of the UB-04 Reimbursement Handbook. |
## Locator 14
### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 14      | **Inpatient:** Enter the code indicating the priority of this admission:  
• 1: Emergency  
• 2: Urgent  
• 3: Elective  
• 4: Newborn (See Form Locator 15)  
• 5: Trauma Center  
• 9: Information not available  

**Outpatient:** Enter code 1 for emergencies, code 2 for urgent cases, or code 5 for trauma center if the patient was seen in a trauma center or hospital. Otherwise, no entry is required. MediPass authorization is not required if the type of admission is a 1 or 5.  

**Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** No entry required. |
Locator 15
UB-04 Paper Claim Form

**Locator 15 Instructions**

**Inpatient, Hospice, and Freestanding Dialysis Centers:** Enter the code indicating the source of the referral. Newborn coding must be used when the type of admission code in Form Locator 14 is 4.

**Admission Source Codes (Excluding Newborn):**

1: Physician Referral
2: Clinic Referral
3: HMO Referral
4: Transfer from a Hospital
5: Transfer from a Skilled Nursing Facility
6: Transfer from Another Health Care Facility
7: Emergency Room
8: Court or Law Enforcement
9: Information Not Available
A: Transfer from a Critical Access Hospital

**Source Codes for Newborns:**

1 - Normal Delivery: A baby delivered without complications.
2 - Premature Delivery: A baby delivered with time or weight factors qualifying it for premature status.
3 - Sick Baby: A baby delivered with medical complications, other than those relating to premature status.
4 - Extramural Birth: A newborn born in a non-sterile environment.

**Outpatient and Long Term Care Facilities:** No entry required.
Locators 16 & 17
UB-04 Paper Claim Form

16 Inpatient: Enter the hour of discharge from the hospital, converted to 24-hour time as shown in the coding table in Chapter 1 of the UB-04 Reimbursement Handbook.

Outpatient: No entry required, but desirable.

Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities: No entry required.

17 Inpatient, Outpatient, Hospice, and Long Term Care Facilities: Enter the code indicating the patient status as of the discharge date (or last date billed in the case of interim billing) as reported in Form Locator 6.

Examples of Discharge Status Codes:
• 01: Discharged to home or self-care
• 20: Expired/Death
• 30: Still a patient

For a complete listing of Patient Status Codes, see Chapter 1 of the UB-04 Reimbursement Handbook.
### Locators 18-28
#### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28</td>
<td><strong>Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities:</strong> Identify any condition relating to this bill in alphanumeric sequence.</td>
</tr>
</tbody>
</table>

For a complete list of condition codes, see Chapter 1 of the UB-04 Reimbursement Handbook.

**The list includes:**
- Insurance Codes
- Accommodation Codes
- Skilled Nursing Facility Codes
- Renal Dialysis Codes
- Special Program Codes
- Peer Review Organization (PRO) Approval Indicator Series Codes
# Locator 29

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred. (Ex. FL, GA, etc.)</td>
</tr>
</tbody>
</table>
## Locators 31-36
### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-34</td>
<td><strong>Inpatient and Outpatient:</strong> Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. (Ex. August 21, 1997, enter as 082197.) For a complete list of Occurrence Codes, see Chapter 1 of the UB-04 Reimbursement Handbook.</td>
</tr>
<tr>
<td></td>
<td><strong>Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities:</strong> No entry required.</td>
</tr>
<tr>
<td>35-36</td>
<td>If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved, if not all of the stay was approved.</td>
</tr>
</tbody>
</table>
### Locators 39-41
**UB-04 Paper Claim Form**

**Locators Instructions**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 39-41    | **Inpatient and Outpatient**: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable:  
06: Medicare Part A or B Blood Deductible  
07: Medicare Cash Deductible  
37: Pints of Blood Furnished  
38: Blood Deductible Pints  
39: Pints of Blood Replaced  
80: Covered Days  
81: Non-Covered Days  
82: Co-insurance Days  
83: Lifetime Reserve  
**Hospice**: If the patient has a patient responsibility, enter value code 31 and the corresponding amount.  
**Long Term Care Facilities**: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the month, even when billing a partial month. Enter value code 80 for covered days and the number of days covered by the primary payer, as qualified by the payer. |
## Locator 42
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>42 REV. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Enter the appropriate four-digit revenue codes itemizing accommodations, services, and items furnished to the patient.</td>
</tr>
<tr>
<td></td>
<td>Revenue code <strong>0001</strong> must be entered as the final revenue code on the last page of the UB-04 claim in Line 23 of Form Locator 42 with the claim total charge amount in Form Locator 47.</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient:</strong> Select from Appendix A of the Florida Medicaid Hospital Coverage and Limitations Handbook.</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient:</strong> Select from Appendix B of the Florida Medicaid Hospital Coverage and Limitations Handbook.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice:</strong> See Chapter 3 in the Florida Medicaid Hospice Coverage and Limitations Handbook.</td>
</tr>
<tr>
<td></td>
<td><strong>Freestanding Dialysis Centers:</strong> See Chapter 3 of the Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook.</td>
</tr>
<tr>
<td></td>
<td><strong>Long Term Care Facilities:</strong> Enter the appropriate revenue code.</td>
</tr>
</tbody>
</table>
## Locator 43
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 43      | Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities: Enter a written description of the related revenue categories included on this bill.  

**Freestanding Dialysis Centers:** When billing for a drug, enter identifier N4, the eleven-digit National Drug Code (NDC), Unit Qualifier, and number of units from the package of the dispensed drug in Form Locator 43 for the specified detail line. For more information, please consult the UB-04 Medicaid Provider Reimbursement Handbook. The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims.

**Note:** On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page in the Page ____ of ____ area.
Locator 44
UB-04 Paper Claim Form

### Instructions

**Inpatient:** Required for inpatient newborn hearing screening services when billing revenue code 0471 in Form Locator 42. For details on inpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, and 0790, see the instructions for Form Locator 74.

**Outpatient:** Enter the five-digit CPT-4 lab code from the Outpatient Hospital Laboratory Fee Schedule when billing for laboratory revenue codes 0300-0314. Revenue codes 0360, 0361, 0451, 0471, 0722, 0750, and 0790 also require a HCPCS CPT procedure code in this Form Locator.

**Freestanding Dialysis Centers:** Claims for the administration of Erythropoietin (Epogen, EPO) require the entry of the five-digit injection HCPCS code. When billing for drugs and biologicals, the 11-digit National Drug Code (NDC) is required in Form Locator 43 along with the five-digit HCPCS code in Form Locator 44.

**Hospice:** When billing revenue center code 0657, enter the corresponding five-digit CPT-4 code that is in the Florida Medicaid Hospice Coverage and Limitations Handbook. No other codes are covered.

**Long Term Care Facilities:** No entry is required.
Locator 45
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Required on outpatient claims.</td>
</tr>
</tbody>
</table>

**Lines 1 – 22:** On each line, enter the date of service.

**Line 23:** On each page, enter the date the bill was created or prepared for submission in MMDDYY format. (Ex. August 21, 1997, enter as 082197.)
Submitting a UB-04 Paper Claim

Locator 46
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td><strong>Note:</strong> This form locator will accept up to seven characters. Leading zeros are not required.</td>
</tr>
</tbody>
</table>

**Inpatient:** Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day.

**Outpatient:** Enter the units of service for each revenue code.

**Hospice:** Enter the number of units of service for each type of service. Units are measured in days for codes 0651, 0655, and 0656; in hours for code 0652; and in procedures for 0657.

**Freestanding Dialysis Centers:** Enter the units of service for the revenue center code(s). For revenue center codes 0821 and 0831, units are measured in the number of dialysis treatments the patient received in the billing period.

**Long Term Care Facilities:** Enter the number of days associated with each revenue code. Medicaid reimburses for the date of admission, but not for the date of discharge. Include the date of admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the same day, count it as one day.
Locator 47 & 48
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 47      | **Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Long Term Care facilities should not deduct the patient responsibility.  
**Line 23:** Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. |
| 48      | **Inpatient and Long Term Care Facilities:** No entry required.  
**Outpatient, Freestanding Dialysis Centers, and Hospice:** Enter the total payment received or expected to be received from a primary insurance payer identified in Form Locator 50A. If the primary insurance payer pays a lump sum payment, enter a prorated amount on each line. If there is more than one additional private payer, lump all amounts together in Form Locator 48 and attach each company’s Explanation of Benefits or remittance. |
### Locators 50-51
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 A-C</td>
<td><strong>Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities</strong>: Enter Florida Medicaid for the Medicaid payer identification. Enter the name of the third party payer, if applicable.</td>
</tr>
<tr>
<td>51 A-C</td>
<td><strong>Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities</strong>: For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51 A, B, or C depending if the insurance is primary, secondary, or tertiary. If the number is unknown, leave blank.</td>
</tr>
</tbody>
</table>
## Locators 52 & 54

### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **52 A-C** | **Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** Indicate whether the patient or patient’s legal representative has signed a statement permitting the provider to release data to other organizations.  

**Code Structure:**  
- I: Informed consent to release medical information for conditions or diagnoses regulated by Federal statutes.  
- Y: Provider has a signed statement permitting release of medical billing data related to a claim. |
| **54 A-C** | **Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** Enter the amount that the provider has received toward payment of this bill prior to the billing date on this claim. Do **NOT** put the Medicaid amount due in this form locator.  

**Inpatient and Outpatient:** If no payment was received or if the service was denied, attach a copy of the Explanation of Benefits from the insurance carrier with the reason for the denial. |
### Locators 56 & 57

#### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 56       | Enter the unique NPI number assigned to the provider submitting the bill.  
*Note: If the taxonomy code is used to create a unique map from a provider’s NPI to a Florida Medicaid ID number, it is entered in Locator 81 with qualifier B3.* |
| 57 A-C   | Use for an identification number other than NPI. The provider may enter its nine-digit Medicaid provider number in Form Locator 57. |
### Locators 58 & 59
#### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 A-C</td>
<td><strong>Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:</strong> Enter the insured’s last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility.</td>
</tr>
</tbody>
</table>
| 59 A-C   | **Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** Enter the code indicating the relationship of the patient to the identified insured.  
**Line A:** Primary Payer, Required  
**Line B:** Secondary Payer, Situational  
**Line C:** Tertiary Payer, Situational  
**Code Examples:**  
- 01: Spouse  
- 18: Self  
- 19: Child  
- 21: Unknown |
Locator 60
UB-04 Paper Claim Form

Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities: Enter all of the insured’s unique identification numbers assigned by any payer organizations. The recipient's ten-digit Medicaid ID number must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C.

If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
## Locator 61
UB-04 Paper Claim Form

### Instructions

**Outpatient Therapies and Diagnostic Imaging Services:** For claims with outpatient therapy and diagnostic imaging revenue codes that require both a MediPass authorization and a prior authorization code, enter the ten digit prior authorization code (alpha numeric) in Form Locator 61.

**Inpatient and All Other Services:** This field **MUST** be left blank.

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td><strong>Outpatient Therapies and Diagnostic Imaging Services:</strong> For claims with outpatient therapy and diagnostic imaging revenue codes that require both a MediPass authorization and a prior authorization code, enter the ten digit prior authorization code (alpha numeric) in Form Locator 61. <strong>Inpatient and All Other Services:</strong> This field <strong>MUST</strong> be left blank.</td>
</tr>
</tbody>
</table>
### Locators 63 & 65

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **63 A-C** | **Inpatient MediPass**: MediPass authorization is not required for inpatient admission, except for children under 21 in the CMS Network. If the admission was an emergency, the MediPass authorization is not required.  
**Inpatient Admissions**: Most inpatient admissions require authorization from the Peer Review Organization (PRO).  
**Inpatient Psychiatric or Substance Abuse**: When the admitting and primary diagnosis codes fall into the range for psychiatric care, prior authorization from the psychiatric PRO is required. Enter the prior authorization number from the PRO in 63 A, B, or C depending on whether Medicaid is the primary, secondary or tertiary payer.  
**Outpatient**: Enter the MediPass primary care physician’s authorization number in 63 A, B, or C depending on whether Medicaid is the primary, secondary or tertiary payer.  
**Hospice, Freestanding Dialysis Center, and Long Term Care Facilities**: No entry required. |
| **65 A-C** | Enter the name of the employer who provides or might provide health care coverage for the patient. |
**Locators 66 & 67**  
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td><strong>Diagnosis &amp; Procedure Code Qualifier (DX):</strong> Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported. <strong>9:</strong> Ninth Revision or <strong>0:</strong> Tenth Revision: By federal mandate, <strong>ICD-10 MUST be used for all claims with dates of service on or after 10/01/2015.</strong> Any claim submitted with an ICD-9 code with a date of service on or after 10/01/2015 will receive an error message and will be denied. Claims must be submitted with <strong>EITHER</strong> ICD-9 or ICD-10 codes. Claims submitted with both ICD-9 and ICD-10 codes will be denied.</td>
</tr>
</tbody>
</table>
| 67       | **Inpatient and Hospice:** Enter the ICD code chiefly responsible for causing the hospitalization or need for hospice care. Be specific to the fourth and fifth digit.  
**Psychiatric Admissions:** Require the entry of a diagnosis in this Form Locator and in Form Locator 69.  
**Outpatient:** Enter the most specific ICD code describing the principal diagnosis.  
**Freestanding Dialysis Centers:** Enter the most specific ICD code describing the principal diagnosis for the condition causing the need for dialysis.  
**Long Term Care Facilities:** Enter the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long term care.  
For additional information concerning this form locator, please consult the UB-04 Medicaid Provider Reimbursement Handbook. |
## Locator 67
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 67 A-Q  | **Inpatient:** Enter the International Classification of Diseases (ICD) codes for additional conditions co-existing at admission or during the stay.  
**Outpatient and Freestanding Dialysis Centers:** Enter the ICD codes for additional conditions co-existing at the time of service.  
**Hospice and Long Term Care Facilities:** No entry required.  
**Special Circumstances When Diagnosis Codes are NOT Required on Outpatient Claims:** Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following:  
• The only revenue center codes on the claim are in the range 0300-0307  
• The only revenue center codes on the claim are any one or any combination of the following (with any type of admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460, 0610, 0611, 0612, 0730, 0731, and/or 0740 |
## Locators 69 & 70
### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 69      | **Inpatient:** Required for all inpatient claims and claims with Type of Bills (FL 4): 011X, 012X, 018X and 021X. The presence of an admitting diagnosis in the range of psychiatric or substance abuse indicates that the inpatient services needed authorization by the psychiatric Peer Review Organization (PRO).  

**Outpatient:** Required for outpatient claims. Report the presenting symptom (diagnosis) and the reason for the patient's visit on claims that contain emergency services.  

**Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities:** No entry required. |
| 70      | **Outpatient:** Enter the diagnosis codes describing the patient's reason for visit at the time of the outpatient registration. This is required for all unscheduled outpatient visits as defined when the following occurs: FL 4, Type of Bill 013X or 085X; FL 14, Type of Admission codes 1, 2, or 5; and FL 42, Revenue Codes 045X, 0516, 0526 or 0762 (Observation Room). |
Locator 74
UB-04 Paper Claim Form

Inpatient: Enter the code identifying the principal International Classification of Diseases (ICD) surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format. (Ex. August 21, 1997, enter as 082197.) False labor does not require a procedure code.

A first surgical procedure code is required in this form locator when one of the following revenue codes is reported: 0360, 0361, 0722, 0750, or 0790.

Outpatient: For details on outpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, or 0790, see the instructions for Form Locator 44.

Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities: No entry required.
Locators 74 a-e
UB-04 Paper Claim Form

Ub-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>74 a-e</td>
<td><strong>Inpatient</strong>: Enter the codes identifying all significant procedures, other than the principal procedure, performed during the billing period covered by this bill and the dates on which the procedures were performed.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities</strong>: No entry required.</td>
</tr>
</tbody>
</table>
### Locators 76 & 77
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Billers filling out the UB-04 form that includes an attending provider continue to use form locator 76 and its subfields. Billers do not have to enter a qualifier for an attending provider; however, billers must enter the appropriate NPI taxonomy. The attending provider's NPI must be valid and known to Florida Medicaid. <em>Note: A Medical license number is no longer acceptable in this form locator.</em></td>
</tr>
<tr>
<td>77</td>
<td>Operating Physician Name and Identifiers (OPERATING). Required when a surgical procedure code is listed on the claim. Entry of the NPI is optional for this field, but the Qualifier 0B (for state license number) and the state license number must be entered. <strong>Enter the license information in the following manner:</strong> ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending physician number.</td>
</tr>
</tbody>
</table>

**Form Locator Details**

<table>
<thead>
<tr>
<th>ATTENDING</th>
<th>NPI</th>
<th>QUAL</th>
<th>OPERATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST</td>
<td>PROVIDER</td>
<td>FIRST</td>
<td>IMA</td>
</tr>
</tbody>
</table>
Locator 79
UB-04 Paper Claim Form

Billers filling out the UB-04 form that includes a referring provider can now do so by filling out form locator 79 and its subfields. Billers must enter qualifier DN, followed by the taxonomy or Florida Medicaid provider ID, accompanied by the appropriate qualifier code (ZZ if reporting an NPI taxonomy or 1D if reporting the Florida Medicaid provider ID). The referring provider’s NPI must be valid and known to Florida Medicaid.
## Locator 80
### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 80      | **Line 1:** Financial Classification (FC) Code. Enter **FC** followed by the three-digit Financial Classification Code in line 1 of Form Locator 80. This code identifies the relationship of the payers indicated in Form Locators 50 A-C.  

A complete list of FC codes can be found in Chapter 1 of the UB-04 Reimbursement Handbook.  

To adjust or void a previously paid claim, enter the Internal Control Number (ICN) of that claim in line 2 and the FC code in line 1. Be sure the correct type of bill code is entered in Form Locator 4.  

**Line 2:** Enter the ICN to adjust or void.  

**Line 3:** Enter **Crossover** on Medicare crossover claims without Third-Party Liability (TPL) payment. Enter **Part C** for Medicare Part C claims. |
Locators 81 a-d
UB-04 Paper Claim Form

If a taxonomy code is used to create a unique map from the provider’s NPI to a Florida Medicaid ID number, enter the NPI, qualifier code B3, and the taxonomy code in Form Locator 56. Enter the taxonomy qualifier code B3 in the small field in the left-hand column and enter the taxonomy value in the middle column.

81 d **Long Term Care Facilities:** In the first field, enter Qualifier Code 02.

In the second field, enter the established Level of Care (LOC) code to indicate the type of care that the recipient has been determined to require:

1: Skilled
2: Intermediate I
3: Intermediate II
4: State Mental Health Hospital
5: ICF-DD Levels of care
6-9: ICF-DD Levels of Care
H: Aids Per Diem
U: Skilled Fragile Children under 21
X: Medicare Part A Coinsurance Payment

In the third field, enter the facility’s per diem. For Level of Care X, enter the total Medicare Part A payment amount divided by the number of days paid by Medicare plus the daily coinsurance amount.
Overview of NPI Completion Fields
Claim Certification

Because the UB-04 Paper Claim Form does not have the provider’s signature, the provider’s endorsed signature on the back of the remittance check issued by the Medicaid fiscal agent takes the place of a signature on a paper claim form.

The provider’s signature on the check acknowledges the submission of the claim and the receipt of the payment for the claim. It also certifies that the claim is in compliance with the conditions stated on the back of the paper claim form and with all federal and state laws.

Any provider who utilizes the electronic funds transfer system is certifying with each use of the system that the claim(s) for which the provider is being paid is in compliance with the provisions found on the back of the paper claim form and with all federal and state laws.
UB-04 Claim Submission
A **clean claim** for services rendered must be received by Florida Medicaid or its fiscal agent no later than 12 months from the Date of Service (DOS).

### Third Party Liability Claims (TPL)
Providers also have 6 months from the TPL Explanation of Benefits (EOB) date.

### Medicare Crossover Claims
The filing limit for crossover claims is the greater of either 36 months from the date of service or 12 months from Medicare’s adjudication date.

### Adjustments
Providers have 12 months from the payment date to make an adjustment. Claims may be submitted directly to DXC Technology.

### Voids
Claims can be submitted directly to DXC Technology with no time limit. Replacements for voids must be submitted to the area office within 6 months of the date of the void if over 12 months from the DOS.
Billing Delivery and Newborn Claims

Under DRG pricing, the infant and mother are billed on separate claims, and the appropriate DRG payment is issued. For every birth in which the mother and the baby are eligible for Medicaid, two claims are required.

Infant

The infant claim must include the child’s ten-digit Medicaid recipient ID number, all charges and services associated with the birth, and those provided only to the infant. The admission date and from date of service must correspond to the infant’s date of birth. If the infant was born elsewhere, the admission and from date of service should equal the date the infant was admitted. Services provided to the mother cannot be included in the infant claim.

Mother

The mother claim must include the mother’s ten-digit Medicaid recipient ID number, all charges and services associated with the delivery, and those provided only to the mother.
Where to Send UB-04 Claims

Send UB-04 Claims to:
DXC Technology
UB-04 Claims
P.O. Box 7082
Tallahassee, FL 32314-7082

Note: Paper claim submissions applicable to Out-of-State providers only.
Claim Samples
Inpatient UB-04 Paper Claim Form (top section)
Inpatient UB-04 Paper Claim Form (bottom section)
### Outpatient UB-04 Paper Claim Form (top section)

![Outpatient UB-04 Paper Claim Form](image-url)

#### ABC Hospital
123 Palm Street
Anywhere Florida 33333-1234
(850) 999-8888

**Claimant Name:**
Resident, Florida A

**Claimant Date of Birth:**
04291972  F  041116  2 7 01

#### Hospital Outpatient Sample
(Provider ID Mapped to Taxonomy)
Outpatient UB-04 Paper Claim Form (bottom section)
Hospice UB-04 Paper Claim Form (top section)
Hospice UB-04 Paper Claim Form
(bottom section)
Freestanding Dialysis UB-04 Paper Claim Form (top section)
Freestanding Dialysis UB-04 Paper Claim Form (bottom section)
Long Term Care Facility UB-04 Paper Claim Form (top section)
Long Term Care Facility UB-04 Paper Claim Form (bottom section)
Third Party Liability
Third Party Liability

Third Party Liability (TPL) is the obligation of any entity, other than Medicaid, to pay all or part of the cost of the recipient’s medical care.

- Providers must verify recipient eligibility prior to rendering services.
- Medicaid is the payer of last resort.
- If a recipient has other insurance coverage, the provider must bill the primary insurance prior to billing Medicaid.
Medicaid Reimbursement for TPL Claims

- If the amount of the Third Part Liability (TPL) payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service.
- If the amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment, minus any Medicaid copayment or coinsurance.
- All TPL paper claims must be submitted with the corresponding TPL Explanation of Benefits (EOB).
Inpatient TPL UB-04 Paper Claim Form
(top section)

```
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1021</td>
<td>Semi-Private Room</td>
<td>1,400.00</td>
</tr>
<tr>
<td>0170</td>
<td>Nursery</td>
<td>900.00</td>
</tr>
<tr>
<td>0250</td>
<td>Pharmacy</td>
<td>480.00</td>
</tr>
<tr>
<td>0300</td>
<td>Laboratory</td>
<td>300.00</td>
</tr>
<tr>
<td>0360</td>
<td>Operating Room Services</td>
<td>800.00</td>
</tr>
<tr>
<td>0370</td>
<td>Anesthesia</td>
<td>250.00</td>
</tr>
<tr>
<td>0450</td>
<td>Emergency Room</td>
<td>150.00</td>
</tr>
<tr>
<td>0720</td>
<td>Labor/Delivery Room</td>
<td>175.00</td>
</tr>
</tbody>
</table>
```

Hospital Inpatient Sample
## Inpatient TPL UB-04 Paper Claim Form (bottom section)

### Form Example

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient TPL UB-04 Paper Claim Form</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Florida Medicaid</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Florida Health Network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Resident, Florida A</strong></td>
<td>7412345922</td>
</tr>
<tr>
<td><strong>Resident, Florida A</strong></td>
<td>987654321</td>
</tr>
<tr>
<td><strong>TREATMENT AUTHORIZATION CODES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>81199000441</strong></td>
<td></td>
</tr>
<tr>
<td><strong>002</strong></td>
<td></td>
</tr>
<tr>
<td><strong>055.4</strong></td>
<td></td>
</tr>
<tr>
<td><strong>063.0</strong></td>
<td></td>
</tr>
<tr>
<td><strong>00</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TREATMENT DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>000020</strong></td>
<td>040116</td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>01000200</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>09076543210</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>9876543210</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OB ME9999999</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OB ME12345676</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE</strong></td>
<td></td>
</tr>
</tbody>
</table>

---

**Image:** A close-up of the UB-04 form with data filled in.
Outpatient TPL UB-04 Paper Claim Form (top section)
Outpatient TPL UB-04 Paper Claim Form (bottom section)
Medicare Crossovers
Medicare Crossover Reimbursement

A **crossover claim** is a Medicare claim that is forwarded or submitted to Medicaid for consideration of payment.

- If the service is covered by Medicare Part B, and not by Medicaid, Medicaid will reimburse 100% of the Medicare coinsurance and deductible.
- If the service is covered by Medicare Part B and by Medicaid, Medicaid pays the lesser of either the deductible/coinsurance amount or the Medicaid fee minus the Medicare paid amount.
Cross Reference Files

- Medicaid must have a record of your Medicare provider number.
- Notify the fiscal agent of any changes in your Medicare number or status.
- To check if your Cross Reference File is correct, you may either check your provider file in the secure section of the Web Portal or call DXC Technology Provider Enrollment at 1-800-289-7799, Option 4.
Medicare Denied Claims

• Medicaid may consider the claim for **Medicaid Only** payment if the procedure performed is normally covered by Medicaid.

• Complete the form as a **straight Medicaid** claim.

• Attach the Explanation of Medicare Benefits (EOMB) that reflects the denied service and a letter requesting that the claim be considered for Medicaid payment because Medicare will not cover the service.

• Send all documents to the Medicaid area office.
Inpatient Crossover UB-04 Paper Claim Form (top section)
Inpatient Crossover UB-04 Paper Claim Form (bottom section)
Outpatient Crossover UB-04 Paper Claim Form (top section)
Outpatient Crossover UB-04 Paper Claim Form (bottom section)
Outpatient Part C Crossover Claim (top section)

Remember to attach the Explanation of Medicare Benefits (EOMB) and Medicare Part C – Medicaid CMS-1500 Crossover Invoice.
Outpatient Part C Crossover Claim (bottom section)
Access the Medicare Part C Crossover Claim form by navigating to the **Florida Medicaid Forms** page on the Agency website at [http://ahca.myflorida.com/medicaid/review/forms.shtml](http://ahca.myflorida.com/medicaid/review/forms.shtml)

For **Medicare Part C claims**, prepare a Medicare Part C Crossover Claim Form.

- **Part A claims** – enter the word **CROSSOVER** in line 3 of form locator 80.

- **Part C claims** – enter the words **PART C** in line 3 of form locator 80.
Remittance Advice
Remittance Advice (RA) Options

Electronic Remittance Advice (ERA) Images

Providers can view an image of their RAs via the secure Web Portal under Reports.

X12 835

Providers download electronic files via the secure Web Portal under Trade Files.
## Sample Remittance Advice

### UB-04 Paper Claim

**Report:** CB000-0000

**UB-04 Paper Claim**

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Beneficiary Name</th>
<th>Date of Service</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>073106</td>
<td>Patient, William M</td>
<td>07/01/2019</td>
<td>$42,266.78</td>
</tr>
<tr>
<td>073104</td>
<td>Patient, Katie M</td>
<td>07/02/2019</td>
<td>$37,708.71</td>
</tr>
</tbody>
</table>

**Summary:**

- Total Payment: $80,075.49
- Total Payment Adjusted: $80,075.49
- Total Payment Adjusted (After Adjustment): $80,075.49

---

**Patient Information:**

- **Name:** Patient, William M
- **Address:** 12345 Street, City, State, Zip

---

**Claims Information:**

- **Claim ID:** 073106
- **Beneficiary Name:** Patient, William M
- **Date of Service:** 07/01/2019
- **Payment Amount:** $42,266.78

---

**Claim Details:**

- **Service Code:** 209
- **Amount:** $1,577.49
  - **Units:** 1.00
  - **Allowance:** $1,577.49
  - **CO-Pay:** $0.00
  - **Total:** $1,577.49

---

**Adjustment Details:**

- **Adjustment Code:** 209
- **Description:** Adjustment
- **Amount:** $0.00
- **Reason:** 9926

---

**Other Claims:**

- **Claim ID:** 073104
- **Beneficiary Name:** Patient, Katie M
- **Date of Service:** 07/02/2019
- **Payment Amount:** $37,708.71

---

**Adjustment Details:**

- **Adjustment Code:** 209
- **Description:** Adjustment
- **Amount:** $0.00
- **Reason:** 9926

---

**Total Payment Adjusted:**

- **Amount:** $80,075.49
- **Reason:** 9926

---

**Additional Information:**

- **Claim Notes:**
- **Provider Information:**
  - **Name:** H. E. Main Hospital
  - **Address:** 12345 Street, City, State, Zip
  - **Phone:** 555-1234

---

**Business Rules:**

- **Claim Validation:**
- **Payment Processing:**
- **Adjustment Criteria:**
The **Reports Section** allows the user to search for a specific Florida Medicaid-issued report by Report name and Date.

The default Download Format is PDF.

Reports can be pulled for up to three months.
Adjustments and Voids
Adjustment Information

- You can only adjust a paid claim.
- A provider has 12 months from the payment date to adjust.
- The adjustment claim must match the original claim with the exception of the corrections.
- The adjustment will replace the original claim.
- If you have a claim where a line item was paid and a line item was denied, simply resubmit the denied line.
- Send claim directly to DXC Technology.
Inpatient Adjustment UB-04 Paper Claim Form (top section)
Inpatient Adjustment UB-04 Paper Claim Form (bottom section)
Void Information

- You can only void a paid claim.
- There is no time limit to submit a void claim.
- A provider has 6 months from the date of the void to request an exception from the area office if the claim is over 12 months from the Date of Service (DOS).
- A void will result in a complete recoupment of the original payment made under the ICN that is being voided.
Outpatient Adjustment UB-04 Paper Claim Form (top section)
Outpatient Adjustment UB-04 Paper Claim Form (bottom section)
Where to send Adjustments and Voids

Send Adjustments and Voids to:
DXC Technology
Adjustments and Voids
P.O. Box 7082
Tallahassee, FL 32314-7082

Note: Paper claim submissions applicable to Out-of-State providers only.
Electronic Adjustments and Voids

First, find the claim that needs to be adjusted or voided by performing a Claim Search. Click on Claims, Claim Search, and open the claims that needs to be adjusted or voided.

To adjust a claim, open the claim, make any necessary changes, then click the adjust button.

To void a claim, click the void button at the bottom of the page.

Providers have 12 months from the Paid Date to adjust a claim.
For more detailed information on how to fill out an LTC UB-04 paper claim, you can access the applicable service-specific Coverage and Limitations Handbook on the Agency’s site at http://ahca.myflorida.com/medicaid/review/Promulgated.shtml. Choose Service-Specific Policies, and then click on the PDF, in the Reference Material Column, to the left of the Rule name that applies to the Handbook for which you are searching.
Web Based Training (WBT)

Web-Based Training (WBT) courses are offered on a variety of subjects and are free to all Florida Medicaid providers.

WBTs can be accessed 24 hours a day, seven days a week.

To access available WBTs, please visit the Medicaid Web Portal.
Summary

- Completing a UB-04 Paper Claim Form
- Claim Submission
- Claim Samples
- Third Party Liability (TPL)
- Medicare Crossovers
- Remittance Advice (RA)
- Adjustments and Voids
- Additional Resources
We’re Here to Help!

Automated Voice Response System (AVRS)
1-800-239-7560

Provider Services Main Telephone Line:
For billing questions, claim status:
1-800-289-7799

- Option 4: Provider Enrollment
- Option 5: Password Reset
- Option 7: Provider Services Contact Center & PFS Representatives

Magellan Medicaid Administration, Inc.
For pharmacy questions:
1-800-603-1714

Electronic Data Interchange – EDI
For 837 and electronic transmission questions:
1-866-586-0961

Thank you for attending training.