Sample of a Correctly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER
1 W. WILSON
ANYTOWN WI 55555
(444) 444-4444

2

3a PAT. CNTL # JED1234
b. MED. REC. # 03 765432

4 TYPE OF BILL XXX

5 FED. TAX NO. 1234567890

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME
a
b MEMBER, IM A

9 PATIENT ADDRESS
a 555 ORBITING DRIVE, WESTHILL, WI 52345
b c d e

10 BIRTHDATE 07151955
11 SEX F
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
550		XXXXX	MMDDYY	1	XXX XX		DD
580		XXXXX	MMDDYY	1	XXX XX		DD
	PAGE ____ OF ____	CREATION DATE		TOTALS	XXX XX		

50 PAYER NAME
A MEDICARE
B XYZ INSURANCE
C T19 MEDICAID

51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS XX XX
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID 87654321

58 INSURED'S NAME
A IM INSURED
B
C

59 P REL
60 INSURED'S UNIQUE ID 1234567890
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX XXXXX
67 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z
68

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

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

76 ATTENDING NPI QUAL 1D 12345678
LAST PROVIDER FIRST I.M.
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
M-7

81CC
a
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.