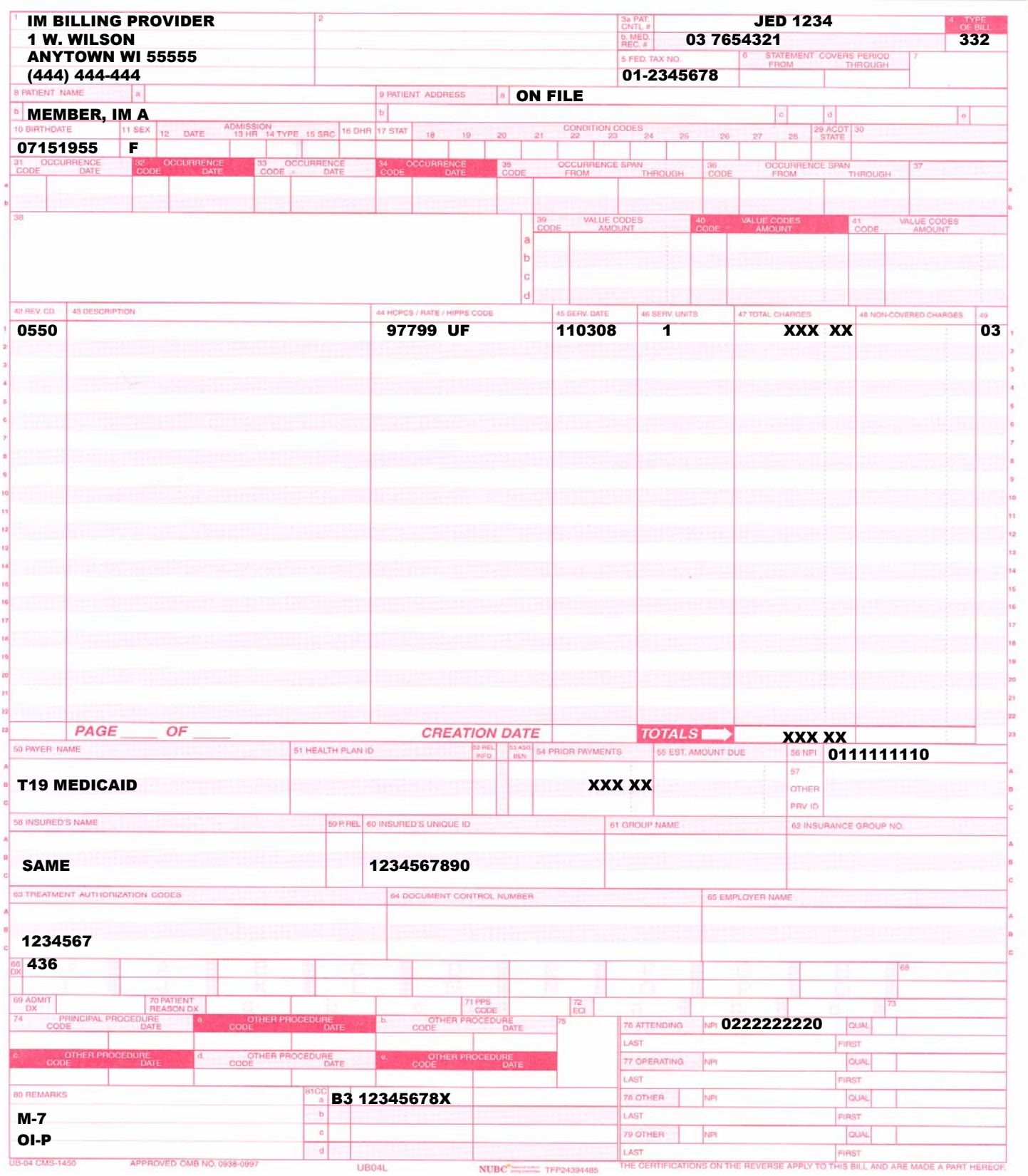
# Sample UB-04 Claim Form For Home Health Therapy Services



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

3a PAT. CNTL # JED 1234
b. MED. REC. # 03 7654321
4 TYPE OF BILL 332
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME
b MEMBER, IM A
9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE 07151955
11 SEX F
12 ADMISSION DATE 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

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0550 | | 97799 UF | 110308 | 1 | XXX XX | | 03 |
| | PAGE ___ OF ___ | CREATION DATE | | TOTALS | XXX XX | | |

50 PAYER NAME
a T19 MEDICAID
51 HEALTH PLAN ID
52 REL INFO
53 ASG. BEN.
54 PRIOR PAYMENTS XXX XX
55 EST. AMOUNT DUE
56 NPI 0111111110
57 OTHER PRV ID

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

63 TREATMENT AUTHORIZATION CODES
a 1234567
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX
a 436
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
e. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 0222222220 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
M-7
OI-P
81CC
a B3 12345678X
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.