Sample UB-04 Claim Form For Private Duty Nursing Ventilator-Dependent Member Services

1 IM BILLING PROVIDER
1 W. WILSON
ANYTOWN WI 55555-5555
(444) 444-4444

3a PAT. CNTL. # JED 1234
b. MED. REC. # 03 7654321
4 TYPE OF BILL 333
5 FED. TAX NO.
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 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		99504 TD, UG	110308	8	XXX XX		03
0550		99504 TD, UG	110408	8	XXX XX		04
0550		99504 TD, UG	110508	6	XXX XX		05

PAGE ____ OF ____ CREATION DATE TOTALS XXX XX

50 PAYER NAME
XYZ INSURANCE
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 SAME
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 V4611
67 67 67 67 67 67 67 67 67 67 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 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 123456789X
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.