

# Hospital Outpatient “Crossover” UB-04

Claim form billing instructions for the  
Department of Human Services

# Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

# MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

# Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

# About the crossover

- If the recipient has Medicare Part B, you must bill Medicare first.
- Medicare will automatically send your claim to DMAP, this is called a “crossover”.
- Do not submit claims to DMAP until they have been billed to and adjudicated by Medicare.

# Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use commercially available versions of the UB-04.

# A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible.
- If possible, submit no more than twenty-two lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

# Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - Standard Register Company, Forms Division (800-755-6405)

# Services billed on the UB-04

## **Institutional Providers**

- Free Standing Kidney Dialysis
- Home Health
- Hospice
- Hospital

# Services billed on the UB-04

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: [DMAP.providerservices@state.or.us](mailto:DMAP.providerservices@state.or.us)

# Introducing the UB-04



# UB-04

- Not sure if you are using the correct form?

The bottom left corner will look like this.

UB-04 CMS-1450





# Box 1 - Optional

1	<b>Hospital</b>			
	<b>PO Box ###</b>			
	<b>Anytown, OR 97###</b>			

## Billing Provider Information

- Enter the name and address of the Hospital that is requesting to be paid for the services rendered.

# Box 3a - Optional

3a PAT.  
CNTL #

**X123400**

## Patient Account Number

- Enter your recipient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

# Box 4 - Required



## Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
  - 131 - Outpatient
  - 141 - Outpatient referenced diagnostic services
  - 721 - Independent End Stage Renal Dialysis Facilities
  - 831 - Hospital Based Ambulatory Surgery

# Box 6 - Required

6	STATEMENT COVERS PERIOD
	FROM                      THROUGH
	<b>120108</b> <b>120708</b>

## Statement Covers Period

- Enter the beginning and ending dates of services covered by this claim.
- This box must list numeric dates of service.
- The from date is the date of admission.
- The through date is the date of discharge, transfer or expiration.

# Box 7 - Optional

7

**XOVR**

## Crossover

- If the recipient has Medicare Part B, and the service is covered by Medicare, enter “XOVR”.
- Do not enter XOVR if the recipient has Medicare Part A only.

# Box 8b - Required

8 PATIENT NAME	a
b	<b>Patient, Your</b>

## Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use the recipient's last name first.
- Do not use nicknames.

# Box 12 - Required

12	DATE
<b>120108</b>	

## Admission Date

- Enter the actual date of admission.
- This date must match the “from” date of service as indicated in box 6.

# Box 13 - Required

13 HR
<b>10</b>

## Admission Hour

- Enter the hour of admission in military time.
- Example:
  - 01 - 1:00 a.m.
  - 10 - 10:00 a.m.
  - 14 - 2:00 p.m.
  - 23 - 11:00 p.m.

# Box 14 - Required

14 TYPE

2

## Admission Type

- Enter the type of admission.
- Example:
  - 1 - Emergent
  - 2 - Urgent
  - 3 - Elective
  - 4 - Newborn

# Box 16 - Required

16 DHA

**15**

## Discharge Hour

- Enter the discharge hour in military time.
- Example:

01 - 1:00 a.m.

10 - 10:00 a.m.

14 - 2:00 p.m.

23 - 11:00 p.m.

# Box 31 - Optional

31 CODE	OCCURRENCE DATE

## Accident Occurrence

- If this claim is a result of an accident, enter one of the following codes and the date of the occurrence.

01 - Auto accident

04 - Employment related accident

- Pursue all prior resources first.
- DMAP is the payer of last resort.

# Box 39 - Optional

39 CODE	VALUE CODES AMOUNT
<b>A1</b>	<b>250 00</b>
	.
	.
	.

## Value Codes

- Enter value code “A1” to identify Medicare Part B deductible.
- Enter Medicare Part B deductible dollar amount.

# Box 40 - Optional

40 CODE	VALUE CODES AMOUNT
<b>A2</b>	<b>95 00</b>

## Value Codes

- Enter value code “A2” to identify Medicare Part B coinsurance.
- Enter Medicare Part B coinsurance dollar amount.

# Middle section

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
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PAGE ____ OF ____		CREATION DATE		TOTALS			23

Red = Required

# Box 42 - Required

42 REV. CD.	
1	250
2	
3	258
4	260
5	260
6	260
7	260
8	270
9	301
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23	0001

## Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- When using the same revenue center code, you must:
  - List a different CPT or HCPCS code for each service (see box 44) or use a different date of service (see box 45).
- Refer to your Hospital supplemental for a complete list of revenue center codes.









# Total - Required

**TOTALS**  **1,760 00**

## Total Charges

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- Each claim form is a separate document, and is to be totaled as such.

# Bottom section

50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASS. GEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
										57 OTHER PRV ID	
58 INSURED'S NAME			59 P. REL.	59 INSURED'S UNIQUE ID			61 GROUP NAME		62 INSURANCE GROUP NO.		
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			
66 DX	67										68
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 EQI		73			
CODE		DATE		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI QUAL	
										LAST FIRST	
OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		76 OPERATING NPI QUAL		LAST FIRST	
										78 OTHER NPI QUAL	
										LAST FIRST	
80 REMARKS			81CC a				79 OTHER NPI QUAL		LAST FIRST		
			b								
			c								
			d								

Red = Required

Yellow = Optional

# Box 50 - Optional

50 PAYER NAME	
A	<b>Primary payer</b>
B	<b>Secondary payer</b>
C	<b>Tertiary payer</b>

## Payer Name

- Enter the names of up to three payer organizations in order.

Example:

If Medicaid is primary, enter on line A.

If Medicaid is secondary, enter on line B.

If Medicaid is tertiary payer, enter on line C.

# Box 54 - Optional

54 PRIOR PAYMENTS
<b>531 65</b>

## Prior Payments

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

# Box 56 - Required

56 NPI

#####

## National Provider Identifier (NPI)

- Enter the ten-digit NPI of the Hospital billing for services rendered.

# Box 57 - Required

57	
OTHER	#####
PRV ID	

## Provider Number

- Enter the six (6) or nine (9)-digit DHS issued provider number of the Hospital billing for services rendered.
- Beginning 12/09/2008, newly enrolled providers will have a 9-digit provider number.
- Do not list other payer provider numbers.
- Correspond the placement number as outlined in box 50 instructions.

# Box 60 - Required

60 INSURED'S UNIQUE ID
<b>XX###X#X</b>

## Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

# Box 63 - Optional

63 TREATMENT AUTHORIZATION CODES	
A	
B	<b># # # # # # # # # #</b>
C	

## Treatment Authorization

- If the service you provided requires prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.
- Correspond the placement as outlined in box 50 instructions.

# Box 66 - Required

66 DX	7993
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## Diagnosis Code

- Enter the recipient's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for causing this hospitalization.
- You may enter up to five codes if necessary by listing them in box 67 - 67D.
- The diagnosis codes must be carried out to its highest degree of specificity.
- Do not use the decimal point.

# Box 74 - Optional

74	PRINCIPAL PROCEDURE CODE	DATE

## Principal Procedure

- This box is required if a procedure was performed.
- Enter the ICD-9-CM procedure code which best identifies the procedure completed.
- The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

# Box 78 - Optional

78 OTHER	NPI #####	QUAL	#####
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## Referring Provider ID

- This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).
- Enter the ten-digit NPI of the referring PCM or PCO.
- Enter the six (6)-or nine (9)-digit DHS provider number of the referring PCM or PCO.
- If the recipient is not referred by the PCM or PCO, leave this box blank. Rendering provider numbers or six-nines are no longer required.

# Box 80 - Optional

80 REMARKS
<b>UD</b>

## Third Party Resource

- If the recipient has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.
- TPR codes can be found in your provider rulebook supplemental, or on the following slides.

# Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes continued on next slide

# Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAFA) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

# Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

# Multiple carrier TPR codes

SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes continued on next slide

# Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

C  
O  
M  
P  
L  
E  
T  
E  
D

1 Hospital PO Box ### Anytown, OR 97###		2		3a PAT CNTL # X123400		4 TYPE OF BILL 131	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 120108 120708		7 THROUGH XOVR			
8 PATIENT NAME a Patient, Your				9 PATIENT ADDRESS b			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a A1		250 00		A2		95 00	
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	
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2 258						120708 3 141 00	
3 260				Q0081		120108 1 193 00	
4 260				Q0081		120208 1 193 00	
5 260				Q0081		120308 1 193 00	
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# Resources

# Where to mail your claim

- Mail your UB-04 claim form to:

DMAP

PO Box 14956

Salem, OR 97309-4957

# Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your UB-04 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: [DMAP.providerservices@state.or.us](mailto:DMAP.providerservices@state.or.us)

Thank You!