PROVIDER Bulletin

November 21, 2018

This Provider Bulletin applies to the lines of business and provider types checked below:

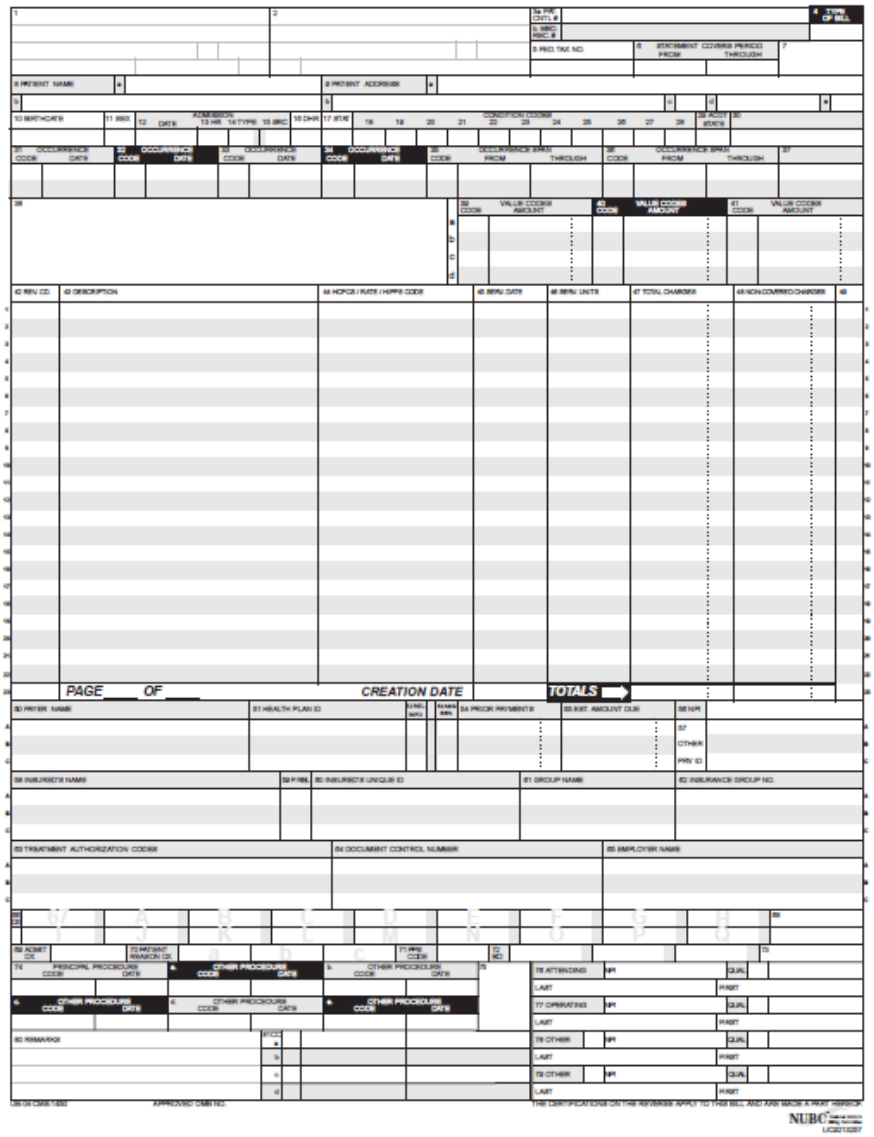
☒ **PHP (Medicare)** ☐ **Primary Care Physicians** ☐ **Specialists**

☒ **PHC (Medicaid)** ☒ **Ancillary** ☒ **Hospitals**

UB-04 claims submission guide

The Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form, for facility and ancillary paper billing. The UB-04 claim form accommodates the National Provider Identifier (NPI) and ICD-10 coding. Sample UB-04 forms for inpatient and outpatient claims is provided below.

If you have any questions regarding the UB-04 claim form, please call our Claims Customer Service at 855.318.4387.



Field location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax ID Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9a-e	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	Required, if applicable
13	Admission Hour	Required	Required, if applicable
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable

This Provider Bulletin is not intended to replace or conflict with any requirements outlined in your signed Agreement with AHF, PHP or PHC. If you have any questions or suggestions contact the Provider Relations Department at 954.522.3132 or email to remon.walker@phcplans.org

42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
NDC Code	Required, if applicable		Required, if applicable
44	HCPCS/Rates	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required

To expedite claims processing & payment, we encourage all providers to submit claims electronically to PHC/PHP via Change Healthcare, Payor ID: 95411

Paper Claims: Attn: Claims
PHP/PHC
P.O. Box 7490
LaVerne, CA 91750

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