The instructions below are a tool to assist providers with correctly submitting claims to Alaska Medical Assistance, and are not intended as a substitute for the National Uniform Billing Committee (NUBC) Official UB-04 Specifications Manual. To obtain a copy of the NUBC UB-04 manual, please visit www.nubc.org, or call (312) 422-3390.

# PROVIDER MASTER GUIDE FOR PAPER CLAIM FORM UB-04

| **Provider Type**<br><br>**To obtain a National Uniform Billing Committee Manual, call (312) 422-3390 or go to http://www.nubc.org.** | | | **Inpatient/ Outpatient Hospital** | **Ambulatory Surgery** | **Home Health Services** | **Hospice** | **Inpatient Mental Health** | **Long Term Care (LTC)** | **End Stage Renal Disease** |
|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 1. | Billing Provider Name, Address and Telephone Number | Provider submitting the bill (billing provider). Address **must** be a street address. P.O. Boxes or Lock Box addresses may be entered only in Field 2, Pay-To Address.<br>Line 1: Provider Name<br>Line 2: Address; must be a street address<br>Line 3: City, State, and ZIP Code + 4 digits<br>Line 4: Telephone, Fax, Country Code (outside U.S.) | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 2. | Pay-to Name and Address | This field is not used by Alaska Medical Assistance. Payments are directed to the Pay-To Address on the Alaska Medical Assistance provider file. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 3a. | Patient Control Number | Patient's unique alphanumeric number assigned by provider to retrieve individual's financial billing records.<br>Patient account number will be reported on the paper Remittance Advice (RA), up to a maximum of 11 characters. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 3b. | Medical/Health Record Number | Number assigned to patient's medical/health record by provider. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 4. | Type of Bill | A code indicating specific type of bill (e.g., hospital inpatient, outpatient, etc.).<br>1st digit: a leading zero<br>2nd digit: type of facility, e.g., 1=hospital, 2=SNF, 6=ICF.<br>3rd digit: bill classification, e.g., 1=inpatient, 5=ICF, 8=hospital swing or administrative wait bed.<br>4th digit: defines the frequency of the bill for the institutional claim, e.g., 1=admit thru discharge claim, 2=interim billing, first claim, 3=interim billing, continuing claim, 4=interim billing, last claim.<br>At this time, the fourth digit value "7" or "8" will not be processed as an adjustment/void. Until further notice, adjustments (voids/replacements) requested on paper must be submitted using form AK-05. (Refer to Section II of the billing manuals for instructions on completing this form). | **Required** | **Required**<br>The **only** valid code for an Ambulatory Surgical Care facility is 0**831**. | **Required**<br>The **only** valid codes for Home Health services are 0**32X**, 0**33X**, or 0**34X**. | **Required**<br>The first three digits for Hospice Care services are: 081x for hospice, non hospital based, and 082x for hospital-based hospice care. | **Required** | **Required** | **Required**<br>The **only** valid value for ESRD claims is 0721. |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 5. | Federal Tax Number | Number assigned provider by the federal government for tax reporting. Also known as Tax ID Number or Employer ID Number. Identify affiliated subsidiaries using federal tax "Sub-ID." | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 6. | Statement Covers Period | The beginning and ending service dates of the period included on this bill. The "From" date should not be confused with the "Admission Date" in Field 12.<br><br>Enter the "from" and "through" date that services were rendered in MM/DD/YY format for the period included on the claim. Both a "from" and "through" date are required, even if they are the same date.<br><br>The Statement Covers Period must not cross the state or facility's fiscal year end.<br><br>This period should include all covered and non-covered (days not authorized) days, however days of recipient ineligibility should **not** be included.<br><br>The date of discharge, transfer, or death must be listed as the "through" date when the patient's status (Field 17) indicates discharge, transfer, or death. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 7. | Reserved for Assignment by NUBC | | | | | | | | |
| 8a. | Patient Identifier | No entry required. The patient's 10-digit Medicaid, DKC, or CAMA identification number is entered in Field 60. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 8b. | Patient Name | Last name, first name and middle initial of the patient. Separate last and first names with comma or space. Leave no space between prefix and name. Do not record titles. Keep hyphen in hyphenated names. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 9. | Patient Address | Patient's **mailing** address. Enter the complete mailing address including street number and name or P.O. Box number or Rural Free Delivery (RFD), city name, state name, and ZIP code + 4 digits | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 9a. | Street Address | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 9b. | City | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 9c. | State | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 9d. | Zip Code | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 9e. | Country Code | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 10. | Patient Birth Date | | Optional | Optional | Optional | Optional | Optional | Optional | Optional |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 11. | Patient Sex | If used, enter "F" for female or "M" for male. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 12. | Admission/ Start of Care Date | The start date for this episode of care. For inpatient services, this is the date of admission. Enter the actual date of admission in MM/DD/YY format. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** Admission date to facility or new level of care (LOC). | **Required** |
| 13. | Admission Hour | Code referring to the hour during which the patient was admitted for inpatient care. | **IP: Required**<br><br>**OP:** Optional | Optional | Optional | Optional | **Required** | **Required** | Optional |
| 14. | Priority (Type) of Visit | Code indicating the priority of this admission/visit.<br>1 = Emergency<br>2 = Urgent<br>3 = Elective<br>4 = Newborn | **Required** | Optional | Optional | Optional | **Required** | **Required** | Optional |
| 15. | Source of Referral for Admission or Visit | Code indicating source of the referral for this admission or visit.<br><br>1 = Physician Referral<br>2 = Clinic Referral<br>3 = HMO Referral<br>4 = Transfer from a Hospital<br>5 = Transfer from a SNF<br>6 = Transfer from another health care facility (ICF, AW or SB bed)<br>7 = Emergency Room<br>8 = Court/Law Enforcement<br>A = Transfer from a Critical Access Hospital<br><br>**Newborn codes**:<br>1 = Normal Delivery<br>2 = Premature Delivery<br>3 = Sick Baby<br>4 = Extramural Birth<br>Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list. | **IP: Required**<br><br>Note: Newborn claims must be billed separate from the mother and billed using the newborn's Medical Assistance ID Number.<br><br>**OP:** Optional | Optional | Optional | Optional | **Required** | **Required** | Optional |

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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 16. | Discharge Hour | Code indicating the discharge hour of the patient from inpatient care. | **IP: Required** on discharge claims<br><br>**OP:** Optional | Optional | Optional | Optional | **Required** on discharge claims | **Required** | Optional |
| 17. | Patient Discharge Status | Code indicating disposition or discharge status of the patient on the last day of the billing period, as reported in Field 6, "Statement Covers Period." Patient Discharge Status codes include, but are not limited to:<br>01 = Discharge to home or self care.<br>02 = Discharge or transfer to short term general hospital for inpatient care.<br>03 = Discharge or transfer to skilled nursing facility (SNF).<br>04 = Discharge or transfer to an Intermediate Care Facility (ICF).<br>05 = Discharge or transfer to another type of institution (e.g., designated cancer center or children's hospital).<br>06 = Discharge or transfer to home under care of organized home health service organization.<br>07 = Left against medical advice.<br>20 = Expired.<br>30 = Still a patient.<br>Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list. | **IP: Required**<br><br>**OP:** Optional | Optional | Optional | **Required** for inpatient hospice | **Required** | **Required** | Optional |
| 18.-28. | Condition Codes | Code(s) used to identify all conditions/events relating to this bill that may affect processing, such as:<br>ML = Patient is in a Nursing home<br>A1 = EPSDT-related claim<br>A4 = Family Planning<br>Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 29. | Accident State | Two-digit state abbreviation where the accident occurred. ***Required*** when services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 30. | Reserved for Assignment by NUBC | | | | | | | | |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 31.-34. | Occurrence Codes and Dates | Code and associated date defining significant event relating to this bill that may affect payor processing. ***Required*** when there is an Occurrence Code that applies to this claim. Note: Occurrence Codes and Occurrence Span Codes are mutually exclusive. E.G., 01=Accident/Medical Coverage, 03=Accident/Tort Liability, 4=Accident/Employment Related. This list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 35.-36. | Occurrence Span Codes and Dates | A code and the related dates that identify an event that relates to the payment of the claim. ***Required*** when there is an Occurrence Span Code (values 70-99 and M0-ZZ) that applies to the claim. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 37. | Reserved for Assignment by NUBC | | | | | | | | |
| 38. | Responsible Party Name and Address | Name and address of party responsible for the bill. ***Required*** if a window envelope is used. If used, affix the recipient's Medical Assistance coupon here. If the automated file indicates that the recipient is not eligible, the coupon will be used to notify the appropriate staff of eligibility discrepancies. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 39.-41. | Value Codes and Amounts | Code structure to relate amounts or values to identify data elements necessary to process claims. ***Required*** when there is a Value Code that applies to this claim.<br><br>Value code 80 = covered days. Enter # of covered days billed.<br>Value code 81 = non-covered days. Enter # of non-covered days.<br><br>Enter the total number of payable days (units) of service included on this claim. For a patient continuing in the facility on the last day in the billing period, the "through" date is counted as a covered day. For a discharged, transferred or deceased patient, the "through" date is **not** counted. **Do not** count days beyond the authorization as covered days. **Do not** count unauthorized days beyond the 3rd day as covered days.<br><br>Note: The sum of covered days plus non-covered days equals total days. Total days must equal the number of days spanned in "Statement Covers Period" (Field 6).<br><br>"Statement Covers Period" (Days Spanned) = Covered + Non-covered Days (Total Days) | **IP: Required**<br><br>**OP:** Optional | Optional | Optional | **Required** for inpatient hospice | **Required** | **Required** | Optional |


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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| | | When checking entries to be sure total days equal the days spanned, it is important to consider the patient's status (Field 17) on the last day in the billing period. For a continuing patient, the "through" date is counted on both sides of the above equation. For a discharged, transferred or deceased patient, the "through" date is ***not counted***. Example: for a continuing patient, the days spanned for a claim "from" 07/01/07 "through" 07/06/07 = 6 days. (Count calendar days beginning with the "from" date*, including the "through" date.*) The sum of covered plus non-covered days must then equal 6.<br><br>For a discharged patient, the days spanned for a claim "from" 07/01/07 "through" 07/06/07 are 5 days. (Count the calendar days beginning with the "from" date, but ***do not count*** the "through" date.) The sum of covered plus non-covered days must then equal 5.<br><br>The sum of covered and non-covered days must also equal the accommodation units (units associated with accommodation revenue codes) reported in "Service Units" (Field 46).Value code 34 = LTC Patient liability, enter amount of patient liability for the month of service billed.<br><br>Value code 15 = Worker's compensation.<br>Value code 37 = Pints of blood furnished<br>Value code 38 = Blood deductible pints<br>Value code 39 = Pints of blood replaced<br>Value code 54 = Newborn birth weight in grams<br><br>Fields 39a through 42a must be completed before the b fields are completed; 39b through 42b must be completed before the c fields are completed, etc.<br><br>Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list. | | | | | | | |
| 42. | Revenue Code | Revenue codes that identify specific accommodations, ancillary services, unique billing calculations or arrangements. After all revenue codes are entered in this field, skip a line and enter "0001," referencing total charges. | **Required** | **Required**<br>Use revenue code 0490 (Ambulatory Surgical Care). | **Required** | **Required**<br>Enter the appropriate revenue code from those listed below for each category described in Field 43.<br><br>0651 = Hospice/ Routine Home Care (1 Unit=1 Day) | **Required** | **Required** | **Required** |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| | | | | | | 0652 = Hospice/ Continuous Home Care (1 Unit=1 Hour)<br>0655 = Hospice/ Inpatient Respite Care (1 Unit=1 Day)<br>0656 = Hospice/ Inpatient Non-respite Care (1 Unit=1 Day)<br>0658 = Hospice Nursing Home Care (1 Unit=1 Day)<br>0001 = Total Charge | | | |
| 43. | Revenue Description | The standard abbreviated description of the related revenue code categories included on this bill. After all descriptions are entered in field, skip a line and enter "Total Charge." Except as noted below, describe each revenue code included on the claim form, using the appropriate description or abbreviation.<br><br>**Outpatient claims:**<br>**For revenue codes 025x and 063x, enter the following information exactly as specified:**<br>▪ Enter the NDC qualifier 'N4' in the first two (2) positions.<br>▪ Immediately following the N4 qualifier, enter the 11-digit National Drug Code number (no hyphens).<br>▪ Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:<br>F2=International Unit<br>GR=Gram<br>ML=Milliliter<br>UN=Unit<br>▪ Immediately following the Unit of Measurement Qualifier, enter the unit quantity with a floating decimal for fractional units limited to three (3) digits to the right of the decimal. Enter the quantity from left to right; leave spaces to the end of the field.<br>▪ The Revenue Description field on the UB-04 is 24 characters in length.<br>▪ Example:<br>▪ **N412345678901UN1234.567** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 44. | HCPCS/ Accommodation Rates/ HIPPS Rate Codes | Healthcare Common Procedure Coding System (HCPCS) applicable to outpatient bills.<br><br>**Outpatient claims:** HCPCS codes are required for drugs billed using revenue code 025x or 063x. Enter the 5 character HCPCS code | **IP:** No entry<br><br>**OP: Required** for outpatient lab services or when billing for drugs using revenue codes 025X or 063X. | **Required** Enter the code that identifies the surgery performed. When billing for bilateral procedure, list the actual surgical procedure twice or enter '2' units in Field 46 of the claim form. | **Required** Enter the procedure code which corresponds with each revenue code entered in Field 42. | No entry | No entry | No entry | **Required** when billing for drugs using revenue codes 025X or 063X. |
| 45. | Service Date | Date the outpatient service was provided. This applies to lines 1-22; Line 23 refers to bill's creation. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 46. | Service Units | A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, renal dialysis treatments, etc.<br><br>**Inpatient claims**: Enter the number of room and board days during the billing period. Units must be used with revenue codes 0100-0219. The total number of days may include multiple levels of care. The total number of days must = the sum of covered and non-covered days reported in Value code fields 39-41.<br><br>**Outpatient claims**: Enter the total number of units for multiple services on the same day. Lab services require the number of units to be entered.<br><br>HCPCS code and NDC are required for drugs billed using revenue code 025x or 063x. Enter the corresponding service units for the HCPCS reported in field locator 44.<br><br>**LTC/Nursing Home claims with oxygen services**: With prior authorization, oxygen charges may be billed as a separate line item, one month at a time, using revenue code 0270. Enter the number of liters/bottles used. The metered amount of oxygen given to a patient and dates used must be listed on an | **Required** Note: for IP claims, 1 unit = 1 day<br><br>**Outpatient hospitals:** HCPCS code and NDC are required for drugs billed using rev code 025x or 063x. Enter the corresponding service units for the HCPCS reported in field locator 44. | **Required** | **Required** Note: 1 unit = 1 visit | **Required** Note: 1 unit = 1 hour (Rev. Code 0652)<br><br>1 Unit = 1 Day (Rev. Codes 0651, 0653, 0654, and 0659) | **Required** | **Required** | **Required**<br><br>HCPCS code and NDC are required for drugs billed using rev code 025x or 063x. Enter the corresponding service units for the HCPCS reported in field locator 44. |



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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| | | attachment to the claim form. See note below.<br><br>**Note:** To compute the amount of oxygen to be billed, multiply the cost per liter or bottle times the number of liters or bottles used. Cost for professional services and supplies are covered in the all-inclusive per diem rate and cannot be billed separately. | | | | | | | |
| 47. | Total Charges | Total charges for the primary payor for related revenue codes for the current billing period as entered in statement covers period that includes both covered and non-covered items.<br>• Line Item Charges*:* ***Required*** (Lines 1-22).<br>• Total (Summary) Charges: ***Required*** on Line 23 page using Revenue Code 0001.<br><br>Enter the total charges included on claim for all covered and non-covered revenue codes and number of units indicated. The last figure represents total charges and corresponds with Revenue Code 0001 in Field 42. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 48. | Noncovered Charges | To reflect the non-covered charges for the destination payor as is pertains to the related revenue code.<br><br>If used, enter any non-covered charges in this field. This includes charges incurred during non-covered days and any other identified non-covered charges. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 49. | Reserved for Assignment by NUBC | | | | | | | | |
| 50. | Payor Name | Name of health plan the provider might expect some payment from for the bill.<br>Line A: primary payor<br>Line B: secondary payor<br>Line C: tertiary payor | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 51. | Health Plan Identification Number | The number used by the health plan to identify itself. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 52. | Release of Information Certification Indicator | Code indicates whether provider has a signed statement (from patient or patient's legal representative) on file permitting provider to release data to another organization.<br>I: Informed Consent to release medical information for conditions or diagnoses regulated by federal statutes.<br>Y: Provider has signed statement permitting release of medical billing data related to a claim. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |

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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 53. | Assignment of Benefits Certification Indicator | Code indicates provider has a signed form authorizing the third-party payor to remit payment directly to the provider. | No entry | No entry | No entry | No entry | No entry | No entry | No entry |
| 54. | Prior Payments Payor | Amount provider has received (to date) from health plan toward payment of this bill. ***Required*** when the indicated payor has paid an amount to provider towards this bill. Attach a copy of each insurance company's Explanation of Benefits (EOB). Refer to your provider billing manual for instructions on Medicare crossover billing. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 55. | Estimated Amount Due – Payor | Amount estimated by provider due from indicated payor (estimated responsibility less prior payments). | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 56. | Billing Provider's National Provider Identifier | Enter the billing provider's NPI number. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 57. | Other Billing Provider Identifier | Enter the billing provider's Medicaid contract ID number (Medicaid provider ID number). | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 58. | Insured's Name | Name of the individual under whose name the insurance benefit is carried. Separate last and first names with comma or space. Leave no space between prefix and name. Do not record titles. Record hyphenated names. Leave space between last name and suffix, ("Adams Jr., Glen"). Note field A=primary payor, B=secondary payor, C=tertiary payor. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 59. | Patient's Relationship to Insured | Code indicating relationship of the patient to the identified insured. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 60. | Recipient's Unique Identifier | Unique number assigned by the health plan to the insured.<br>Enter the patient's 10-digit Medical Assistance ID number as it appears on the eligibility coupon/label. | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** | **Required** |
| 61. | Recipient's Group Name | The plan name thorough which coverage is provided to the insured**.** | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 62. | Recipient's Group Number | Enter the insured's group number when the identification card shows a group number.<br>**Required** when other insurance/payors/health plans are known to potentially be involved in paying this claim and when the other insurance identification card shows a group number. | **Required** If applicable | **Required** If applicable | **Required** If applicable | **Required** If applicable | **Required** If applicable | **Required** If applicable | **Required** If applicable |


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|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 63. | Treatment Authorization Code | Number or other indicator that designates billed treatment has been authorized by payor.<br><br>Enter the 8-digit prior authorization number. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 64. | Document Control Number (DCN) | The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. | No entry | No entry | No entry | No entry | No entry | No entry | No entry |
| 65. | Employer Name (of the Insured) | Name of employer who provides health care coverage for insured individual identified in Field 58. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 66. | ICD-9-CM Qualifier | Enter a "9" in this field to indicate the version of the International Classification of Diseases reported. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 67. | Principal Diagnosis Code | Enter the ICD-9-CM codes describing the principal diagnosis (i.e., condition established after study to be chiefly responsible for causing patient's admission). | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 67a.-q. | Other Diagnosis Codes | ICD-9-CM diagnosis codes corresponding to all conditions that coexist at the time of admission, subsequently develop, or affect treatment received and/or length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay. | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable | **Required** if applicable |
| 68. | Reserved for Assignment by NUBC | | | | | | | | |
| 69. | Admitting Diagnosis Codes | ICD-9-CM diagnosis code describing the patient's diagnosis at the time of admission. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 70a.-c. | Patient's Reason for Visit | ICD-9-CM diagnosis codes describing the patient's reason for visit at the time of outpatient registration. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 71. | PPS Code. | This field is not used by Alaska Medical Assistance. | | | | | | | |
| 72a.-c. | External Cause of Injury (ECI) Code | ICD-9-CM diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 73. | Reserved for Assignment by NUBC | | | | | | | | |
| 74. | Principal Procedure Code and Date | ICD-9-CM procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by bill and corresponding date. Required on inpatient claims when a procedure is performed. | **IP: Required** | No entry | No entry | No entry | **Required** if applicable | **Required** if applicable | No entry |



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| **Provider Type**<br><br>**To obtain a National Uniform Billing Committee Manual, call (312) 422-3390 or go to http://www.nubc.org.** | | | **Inpatient/ Outpatient Hospital** | **Ambulatory Surgery** | **Home Health Services** | **Hospice** | **Inpatient Mental Health** | **Long Term Care (LTC)** | **End Stage Renal Disease** |
|---|---|---|---|---|---|---|---|---|---|
| **Field** | **Field ID** | **Instructions** | | | | | | | |
| 74a.-e. | Other Procedure Codes and Dates | ICD-9-CM procedure codes identifying all significant procedures other than principal procedure and dates (identified by code) on which procedures were performed. Report those most important for the episode of care and specifically any therapeutic procedures closely related to principal diagnosis. | **IP: Required** if applicable | No entry | No entry | No entry | **Required** if applicable | **Required** if applicable | No entry |
| 75. | Reserved for Assignment by NUBC | | | | | | | | |
| 76. | Attending Provider Name and Identifiers | Attending Provider is individual who has overall responsibility for patient's medical care and treatment in this claim.<br><br>Enter the number and name of the licensed physician who certified the medical necessity of services rendered and who has primary responsibility for the patient's care and treatment. Line 1: NPI number (10 bytes), Medicaid Provider ID Qualifier (2 bytes): 1D, Medicaid provider ID number (7 bytes). Line 2: Last name (16 bytes), First name (12 bytes). | Optional | Optional | Optional | Optional | Optional | Optional | **Required** |
| 77. | Operating Physician Name and Identifiers | Name and identification number of individual with primary responsibility for performing the surgical procedure(s).<br>Enter the number and name of the licensed physician who performed the surgery. Line 1: NPI number (10 bytes), Medicaid Provider ID Qualifier (2 bytes): 1D, Medicaid provider ID number (7 bytes). Line 2: Last name (16 bytes), First name (12 bytes). | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 78.-79. | Referring Provider Name and Identifiers | Enter the number and name of the licensed physician who referred the patient. Line 1: NPI number (10 bytes), Medicaid Provider ID Qualifier (2 bytes): 1D, Medicaid provider ID number (7 bytes). Line 2: Last name (16 bytes), First name (12 bytes). | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 80. | Remarks Field | Area to capture additional information necessary to adjudicate the claim. | Optional | Optional | Optional | Optional | Optional | Optional | Optional |
| 81a. | Code – Code Field | Report additional codes related to a Form Field (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. If providing taxonomy, in the small box to the left report qualifier code B3, and then the taxonomy code in the larger box to the immediate right (the middle column). | Optional | Optional | Optional | Optional | Optional | Optional | Optional |

Note: Providers will need to include their Medicaid Contract ID/Medicaid Provider ID on all paper claim forms until they have been approved for submission of NPI number only.