

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 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. Line 1: Provider Name Line 2: Address; must be a street address Line 3: City, State, and ZIP Code + 4 digits 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. 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.). 1 st digit: a leading zero 2 nd digit: type of facility, e.g., 1=hospital, 2=SNF, 6=ICF. 3 rd digit: bill classification, e.g., 1=inpatient, 5=ICF, 8=hospital swing or administrative wait bed. 4 th 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. 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 The only valid code for an Ambulatory Surgical Care facility is 0831 .	Required The only valid codes for Home Health services are 032X , 033X , or 034X .	Required 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 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	<p>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.</p> <p>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.</p> <p>The Statement Covers Period must not cross the state or facility's fiscal year end.</p> <p>This period should include all covered and non-covered (days not authorized) days, however days of recipient ineligibility should not be included.</p> <p>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.</p>	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	Required
13.	Admission Hour	Code referring to the hour during which the patient was admitted for inpatient care.	IP: Required OP: Optional	Optional	Optional	Optional	Required	Required	Optional
14.	Priority (Type) of Visit	Code indicating the priority of this admission/visit. 1 = Emergency 2 = Urgent 3 = Elective 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. 1 = Physician Referral 2 = Clinic Referral 3 = HMO Referral 4 = Transfer from a Hospital 5 = Transfer from a SNF 6 = Transfer from another health care facility (ICF, AW or SB bed) 7 = Emergency Room 8 = Court/Law Enforcement A = Transfer from a Critical Access Hospital Newborn codes: 1 = Normal Delivery 2 = Premature Delivery 3 = Sick Baby 4 = Extramural Birth Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list.	IP: Required Note: Newborn claims must be billed separate from the mother and billed using the newborn's Medical Assistance ID Number. 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 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: 01 = Discharge to home or self care. 02 = Discharge or transfer to short term general hospital for inpatient care. 03 = Discharge or transfer to skilled nursing facility (SNF). 04 = Discharge or transfer to an Intermediate Care Facility (ICF). 05 = Discharge or transfer to another type of institution (e.g., designated cancer center or children's hospital). 06 = Discharge or transfer to home under care of organized home health service organization. 07 = Left against medical advice. 20 = Expired. 30 = Still a patient. Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list.	IP: Required OP: Optional	Optional	Optional	Required for <u>inpatient</u> 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: ML = Patient is in a Nursing home A1 = EPSDT-related claim A4 = Family Planning 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. Value code 80 = covered days. Enter # of covered days billed. Value code 81 = non-covered days. Enter # of non-covered days. 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. 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). "Statement Covers Period" (Days Spanned) = Covered + Non-covered Days (Total Days)	IP: Required OP: Optional	Optional	Optional	Required for <u>inpatient</u> hospice	Required	Required	Optional

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		<p>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, <i>including the "through" date</i>.) The sum of covered plus non-covered days must then equal 6.</p> <p>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.</p> <p>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.</p> <p>Value code 15 = Worker's compensation. Value code 37 = Pints of blood furnished Value code 38 = Blood deductible pints Value code 39 = Pints of blood replaced Value code 54 = Newborn birth weight in grams</p> <p>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.</p> <p>Note: this list is not all inclusive; refer to the NUBC UB-04 Manual for a complete list.</p>							
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 Use revenue code 0490 (Ambulatory Surgical Care).	Required	Required Enter the appropriate revenue code from those listed below for each category described in Field 43. 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) 0655 = Hospice/ Inpatient Respite Care (1 Unit=1 Day) 0656 = Hospice/ Inpatient Non-respite Care (1 Unit=1 Day) 0658 = Hospice Nursing Home Care (1 Unit=1 Day) 0001 = Total Charge			
43.	Revenue Description	<p>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.</p> <p>Outpatient claims: For revenue codes 025x and 063x, enter the following information exactly as specified:</p> <ul style="list-style-type: none"> ▪ Enter the NDC qualifier 'N4' in the first two (2) positions. ▪ Immediately following the N4 qualifier, enter the 11-digit National Drug Code number (no hyphens). ▪ 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: F2=International Unit GR=Gram ML=Milliliter UN=Unit ▪ 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. ▪ The Revenue Description field on the UB-04 is 24 characters in length. ▪ Example: <ul style="list-style-type: none"> ▪ N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7 	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. Outpatient claims: HCPCS codes are required for drugs billed using revenue code 025x or 063x. Enter the 5 character HCPCS code	IP: No entry 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. 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. 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. 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. 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 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) 1 Unit = 1 Day (Rev. Codes 0651, 0653, 0654, and 0659)	Required	Required	Required 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. 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. <ul style="list-style-type: none"> Line Item Charges: Required (Lines 1-22). Total (Summary) Charges: Required on Line 23 page using Revenue Code 0001. 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. 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. Line A: primary payor Line B: secondary payor 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. I: Informed Consent to release medical information for conditions or diagnoses regulated by federal statutes. 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. 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 through 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. 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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63.	Treatment Authorization Code	Number or other indicator that designates billed treatment has been authorized by payor. 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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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. 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). 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.

- Medicare is Primary
- Medicaid is Secondary

Example 1a
Inpatient Medicare
Deductible &
Coinurance

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2	3a PAT. CNTL # 0812345	4 TYPE OF BILL 0111
			b. MED. REC. #	
			5 FED. TAX NO.	
			032008	032208

8 PATIENT NAME a	9 PATIENT ADDRESS a
b DOE, JANE E.	

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28				29 ACDT STATE	30	
		03 20 08	08	1	7	17	01											

31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE
50	04 04 08						

39 VALUE CODES	40 VALUE CODES	41 VALUE CODES
80	2 A1	A2
	536.00	448.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD - SEMI-PRIVATE			2	209800		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001	PAGE 5 OF 1	CREATION DATE 04 05 08	TOTALS 7	471200	0
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50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
MEDICARE MEDICAID		Y Y		2240.00	0 984.00	1234567890 020024 HS99IP	

58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
DOE, JANE E. DOE, JANE E.		574500000A 0600611111		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 4801	68
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69 ADMIT DX 4801	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE 8701	DATE 032008	75 OTHER PROCEDURE CODE	DATE	76 ATTENDING NPI
77 OPERATING NPI	QUAL	78 OTHER NPI	QUAL	79 OTHER NPI

80 REMARKS	81CC a	b	c	d

RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER



Central Alaska Hospital
 REMITTANCE REPORT

Example 1b
Inpatient Medicare
Deductible &
Coinsurance

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 111

PROVIDER
 NUMBER: 020024
 NAME: CENTRAL ALASKA HOSPITAL
 ADDRESS: 1000 HOSPITAL DR.
 CITY/ST/ZIP: ANYTOWN, AK 99500-0000

PAYER
 C24
 MEDICARE PART A
 PO BOX 6720
 FARGO ND 58108-6720

**Note: Your EOMB may be
 formatted differently.**

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM THRU		PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
MEDICAL RECORD NUMBER	INTERNAL CONTROL NO	COST DAYS	COV DAYS	NONCOV DAYS	C O	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE-DUCTIBLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED	
DOE, JANE E. 00047960	0812345 12345678901234	0	574500000A 2	03/20/08	0	03/22/08	4712.00	0.00	0.00	536.00	448.00	0.00	2240.00
CAPITAL PMT:	0.00	HSP:	0.00			FSP: 0.00	DSH ADJ:	0.00	0.00	984.00	0.00	0.00	
HOLD HARM:	0.00	IME-ADJ:	0.00			EXCEPTIONS: 0.00						DRG CODE:	
COVERD CHARGES:	4712.00	CLAIM STATUS CODE:	0			TYPE OF BILL: 111							

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0120		03/20/08	209800	1014.67			
0270		03/20/08	25600	136.53			
0350		03/20/08	97600	520.53			
0450		03/20/08	106300	398.14			
0460		03/20/08	31900	170.13			

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims

Scenario: Inpatient Claim Form, with Medicare Deductible and Coinsurance

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional Medicaid crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional requirements for Institutional Medicare crossover claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in mm/dd/yy format.
2. Field 39a: <i>Value Codes/Amount</i>	Already filled with Covered days Value Code and Units
3. Field 40a: <i>Value Codes/Amount</i>	Enter Value Code "A1" and the Medicare deductible in the Amount field. Note: Medicare is the primary payer in field 50A, therefore, the value code for Medicare deductible is A1.
4. Field 41a: <i>Value Codes/Amount</i>	Enter Value Code "A2" in the Code field. Enter the Medicare coinsurance in the Amount field. Note: Medicare is the primary payer in field 50A, therefore, the value code for Medicare coinsurance is A2.
5. Field 50A: <i>Payer Name</i>	As Medicare is the primary payer, enter the word "Medicare". Line A: enter all information pertaining to Medicare.
6. Field 54:	
<ul style="list-style-type: none"> • Medicare is the primary payer; • Medicaid is the secondary payer; 	Line A: enter the Medicare Paid Amount. Line B: no entry needed.
7. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid; this is the sum of the Medicare coinsurance and deductible amount. Note: Medicaid is the secondary payer in field 50B, therefore, the estimated amount due from Medicaid is entered in field 55B.
8. The Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

1 CENTRAL ALASKA HOSPITAL
 1000 HOSPITAL DR.
 ANYTOWN, AK 99500-0000
 (907) 333-3333

- **Aetna is Primary**
- **Medicare is Secondary**
- **Medicaid is Tertiary**

Example 2a
Inpatient w/ Third-Party Insurance, Medicare & Medicaid

3a PAT. CNTL # 0812345
 b. MED. REC. #
 5 FED. TAX NO.
 4 TYPE OF BILL 0111
 032008 032208

8 PATIENT NAME a DOE, JANE E. 9 PATIENT ADDRESS a

10 BIRTHDATE 11 SEX 12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30
 03 20 08 08 1 7 17 01

31 OCCURRENCE CODE 32 OCCURRENCE DATE 33 OCCURRENCE CODE 34 OCCURRENCE DATE 35 OCCURRENCE CODE 36 OCCURRENCE DATE 37 OCCURRENCE DATE
 50 04 04 08

38 39 VALUE CODES AMOUNT 40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT
 80 2 B1 250.00 B2 150.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD - SEMI-PRIVATE			2	209800		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001 PAGE 5 OF 1 CREATION DATE 04 05 08 TOTALS 471200 0

50 PAYER NAME AETNA MEDICARE MEDICAID 51 HEALTH PLAN ID 52 REL INFO Y Y Y 53 ASG BEN. 54 PRIOR PAYMENTS 3627.94 599.98 55 EST. AMOUNT DUE 400.00 56 NPI 1234567890 57 OTHER 020024 58 PFV ID HS99IP

58 INSURED'S NAME DOE, JANE E. 59 P. REL. 60 INSURED'S UNIQUE ID 1234567890 574500000A 61 GROUP NAME 62 INSURANCE GROUP NO. 0600611111

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

66 DX 4801

69 ADMIT DX 4801 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73
 74 PRINCIPAL PROCEDURE CODE 8701 75 OTHER PROCEDURE CODE 032008 76 ATTENDING NPI QUAL LAST FIRST
 77 OPERATING NPI QUAL LAST FIRST
 78 OTHER NPI QUAL LAST FIRST
 79 OTHER NPI QUAL LAST FIRST

80 REMARKS 81CC a b c d

**Example 2b
Inpatient w/ Third-Party
Insurance, Medicare &
Medicaid**



P.O. BOX 999999
HARTFORD, CT 06115-0431
USA



EXPLANATION OF BENEFITS

Please Retain for Future Reference
Central Alaska Hospital/ PIN: 0001111111
Page 1 of 1

**Note: Your EOB may be
formatted differently.**

Patient Name: JANE E. DOE (self)

Claim ID: E123BZB6T24 Recd: 03/28/08 Member ID: 1234567890 Patient Account: 0812345

Member: Jane E. Doe
Group Name: Acme Inc.
Product: HealthPlanChoice
AETNA LIFE INSURANCE COMPANY

DIAG: 4801
Group Number: 123456-99-123
Network ID: 02101 AETNA NAP HOSPITAL + PPOM

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
3/20-22/08	21	120	2	2098.00			98.00	1		400.00	98.00	1600.00
3/20-22/08	21	270	12	256.00			47.88	2		41.62		166.50
3/20-22/08	21	350	1	976.00			1.94	2		194.81		779.25
3/20-22/08	21	450	2	1063.00			29.00	2		206.80		827.20
3/20-22/08	21	460	5	319.00			5.26	2		58.75		254.99
TOTALS				4,712.00			182.08			901.98	98.00	3627.94

ISSUED AMT: \$3627.94

Remarks:

- 1 - We have paid the maximum allowed by your plan of benefits for this service. The balance is the member's responsibility.
- 2 - The Provider has agreed to accept a discount for this charge. The member is not responsible for this amount.

For Questions Regarding This Claim:
P.O. Box 2250, Anytown, USA 12345-6789

CALL 1-800-777-7777 FOR ASSISTANCE

Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: \$999.98

Claim Payment: \$3627.94

RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER

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Central Alaska Hospital
 REMITTANCE REPORT

Example 2c
Inpatient w/ Third-Party
Insurance, Medicare &
Medicaid

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 111

Note: Your EOMB may be formatted differently.

NUMBER:	PROVIDER	PAYER
020024	020024	C24
NAME:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
ADDRESS:	1000 HOSPITAL DR.	PO BOX 6720
CITY/ST/ZIP:	ANYTOWN, AK 99500-0000	FARGO ND 58108-6720

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCPC AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
DOE, JANE E.	0812345	574500000A	03/20/08	03/22/08			999.98	0.00	250.00	150.00	0.00		599.98
00047960	12345678901234	0 2			0.00		0.00	0.00	400.00	0.00	0.00		
CAPITAL PMT:	0.00	HSP:	0.00		FSP: 0.00	DSH ADJ:		0.00					
HOLD HARM:	0.00	IME-ADJ:	0.00		EXCEPTIONS:	0.00							
COVERD CHARGES:	999.98	CLAIM STATUS CODE:	0		TYPE OF BILL:	111							

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0120		03/20/08 - 03/22/08	498.00	198.40			
0270		03/20/08 - 03/22/08	41.62	33.30			
0350		03/20/08 - 03/22/08	194.81	155.84			
0450		03/20/08 - 03/22/08	206.80	165.44			
0460		03/20/08 - 03/22/08	58.75	47.00			

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims

Scenario: Inpatient Claim Form, with Aetna Primary and Medicare Deductible and Coinsurance:

- Aetna is Primary
- Medicare is Secondary
- Medicaid is Tertiary

Providers should complete the UB-04 for institutional Medicaid crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional requirements for Institutional Medicare crossover claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Already filled with covered days Value Code and Amount. Enter the qualifier in the code field and the value in the amount field.
3. Field 40a: <i>Value Codes/Amount</i>	Enter Value Code "B1" and the Medicare deductible amount in the Amount field. Note: The value code used corresponds with the payer in field 50B.
4. Field 41a: <i>Value Codes/Amount</i>	Enter Value Code "B2" in the Code field. Medicare is in field 50B, thereby the Medicare coinsurance Value Code is B2. Enter the Medicare coinsurance in the Amount field.
5. Field 50: <i>Payer Name</i>	
<ul style="list-style-type: none"> • Aetna is the primary payer; 	Line A: enter all information pertaining to Aetna.
<ul style="list-style-type: none"> • Medicare is the secondary payer; 	Line B: enter all information pertaining to Medicare.
<ul style="list-style-type: none"> • Medicaid is the tertiary payer; 	Line C: enter all information pertaining to Medicaid.
6. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> • Aetna is the primary payer; 	Line A: enter the Aetna Paid Amount.
<ul style="list-style-type: none"> • Medicare is the secondary payer; 	Line B: enter the Medicare Paid Amount.
<ul style="list-style-type: none"> • Medicaid is the tertiary payer; 	Line C: no entry needed.
7. Field 55C: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid; this is the sum of the Medicare coinsurance and deductible amount. Note: Medicaid is the third payer in field 50C; therefore, the estimated amount due from Medicaid is entered in field 55C.
8. the Aetna EOB	A copy of the Aetna EOB must be attached to the claim.
9. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

- Medicare is Primary
- Blue Cross is Secondary
- Medicaid is Tertiary

Example 3a
Inpatient w/ Medicare
& Third-Party
Coinsurance Only

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2		3a PAT. CNTL # 0812345		4 TYPE OF BILL 0111	
b. MED. REC. #		5 FED. TAX NO.		032008		032208	

8 PATIENT NAME a				9 PATIENT ADDRESS a																																					
b DOE, JANE E.				c																																					
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACDT STATE		30	
03 20 08		08		1		7		17		01																															
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE FROM		37 OCCURRENCE THROUGH		38		39 VALUE CODES		40 VALUE CODES		41 CODE		42 VALUE CODES		43		44		45		46		47		48		49					
50		03 28 08														80		2		A2		942.40																			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD - SEMI-PRIVATE			2	209800		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001	PAC	OF 1	CREATION DATE	04 05 08	TOTALS	471200	0
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50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
MEDICARE				Y				3769.60		0		1234567890	
BLUE CROSS				Y				439.30		503.10		OTHER 020024	
MEDICAID				Y								PRV ID HS99IP	

58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
DOE, JANE E.				574500000A					
DOE, JANE E.				1234567890					
DOE, JANE E.				0600611111					

63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			

66 DX		67		68	
4801					

69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
4801									
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI	
8701		032008							
79 OTHER PROCEDURE CODE		80 REMARKS		81CC a		81CC b		81CC c	

80 REMARKS		81CC a		81CC b		81CC c		81CC d	

RUN DATE: 03/28/08
 RUN TIME: 1412
 RUN USER: DBCOOPER

7

Central Alaska Hospital
 REMITTANCE REPORT

Example 3b
Inpatient w/ Medicare
& Third-Party
Coinsurance Only

RA NUMBER: 000000001 RA DATE: 03/28/08 FILE NUMBER: 1223 CLAIM TYPE: 111

PROVIDER
 NUMBER: 020024
 NAME: CENTRAL ALASKA HOSPITAL
 ADDRESS: 1000 HOSPITAL DR.
 CITY/ST/ZIP: ANYTOWN, AK 99500-0000

PAYER
 C24
 MEDICARE PART A
 PO BOX 6720
 FARGO ND 58108-6720

**Note: Your EOMB may be
 formatted differently.**

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
MEDICAL RECORD NUMBER	INTERNAL CONTROL NO	COST DAYS	COV DAYS	NONCOV DAYS	C O	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE-DUCTIBLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED	
DOE, JANE E. 00047960	0812345 12345678901234	0 0	574500000A 2	03/20/08	03/22/08		4712.00 0.00	0.00 0.00	0.00 0.00	942.40 0.00	0.00 0.00		3769.60
CAPITAL PMT: HOLD HARM:	0.00 0.00	HSP: IME-ADJ:	0.00 0.00			FSP: 0.00 EXCEPTIONS: 0.00	DSH ADJ: 0.00					DRG CODE:	
COVERD CHARGES:	4712.00	CLAIM STATUS CODE:	0			TYPE OF BILL: 111							

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0120		03/20/08 - 03/22/08	2098.00	1678.40			
0270		03/20/08 - 03/22/08	256.00	204.80			
0350		03/20/08 - 03/22/08	976.00	780.80			
0450		03/20/08 - 03/22/08	1063.00	850.40			
0460		03/20/08 - 03/22/08	319.00	255.20			



P.O. Box 240489
Anchorage, AK 99524

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Note: Your EOB may be formatted differently.

*Example 3c
Inpatient w/ Medicare
& Third-Party
Coinsurance Only*

Page C-20
Date of Payment: MARCH 23, 2008
Check Number: 0987654321
Payment Reference #: 1234567890123456
Provider Number: 200098765432
Provider Tax ID Number: 123123123
NPI ID: 1212121212

CENTRAL HOSPITAL
PO BOX 1234
ANYTOWN, AK 99500

**MARCH 23, 2008
DETAILED EXPLANATION OF PAYMENT**

Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider of Service Product	SERVICE DATES	Rev Code	UNITS BILLED/ ALLOWED	APC/ APG/ DRG/ ROOM TYPE	BILLED CHARGES	INFORMATIONAL	PROVIDER	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY	PAYABLE AMOUNT	REASON REMARKS
						AMOUNT ALLOWED	ADJUSTMENT (A) DISALLOWED (D)		FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)		

AK HERITAGESELECT

DOE, JANE	032008 032208	0120	2 / 2		419.60	419.60	0.00	0.00	209.80 C	209.80	
1234567890	032008 032208	0270	12 / 12		51.20	51.20	0.00	0.00	25.60 C	25.60	
0812345	032008 032208	0350	1 / 1		195.20	195.20			97.60 C	97.60	
SEUSS, THEODOR G	032008 032208	0450	2 / 2		212.60	212.60			106.30 C	106.30	
312894723498	032008 032208	0460	5 / 5		63.80	63.80			63.80 D		
CENTRAL HOSPITAL											
HERITAGE PLUS 1	Claim Total	Paid To: P			\$942.40	\$942.40	\$0.00	\$0.00		\$439.30	

Our records indicate your current TAX ID as being 920009999

Reason Remarks Explanation

- E CONDITION ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED
- X THE COORDINATION OF BENEFITS INFORMATION RECEIVED IS INCOMPLETE. OTHER CARRIER PAYMENT INFORMATION IS NEEDED BEFORE CLAIM CAN BE PROCESSED.
- O BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
- P THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
- S A DISCOUNT WAS APPLIED TO THIS CLAIM.
- T THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET.
- B THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
- M AMOUNT WHICH REIMBURSEMENT TO PROVIDER IS LESS THAN THE AMOUNT OF BILLED CHARGES.

*Example 3d
Inpatient w/ Medicare
& Third-Party
Coinsurance Only*

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims

Scenario: Inpatient Claim Form, with Medicare as Primary and Third-Party as Secondary

- Medicare is Primary
- Blue Cross is Secondary
- Medicaid is Tertiary

Providers should complete the UB-04 for institutional Medicaid crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional requirements for Institutional Medicare crossover claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Already filled with covered days Value Code and Units
3. Field 40a:	Enter Value Code "A2", and the recipient's Medicare coinsurance amount. Note: Medicare is the primary payer in field 50A, therefore, the value code for Medicare coinsurance is A2.
4. Field 50: <i>Payer Name</i>	
• Medicare is the primary payer;	Line A: enter all information pertaining to Medicare.
• Blue Cross is the secondary payer;	Line B: enter all information pertaining to Blue Cross.
• Medicaid is the tertiary payer;	Line C: enter all information pertaining to Medicaid.
5. Field 54: <i>Prior Payments</i>	
• Medicare is the primary payer;	Line A: enter the Medicare Paid Amount.
• Blue Cross is the secondary payer;	Line B: enter the Blue Cross Paid Amount.
• Medicaid is the tertiary payer;	Line C: no entry needed.
6. Field 55C: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid. Note: The entry in row C corresponds to the position of Medicaid as the tertiary payer in Field 50C.
7. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.
8. the Blue Cross EOB	A copy of the Blue Cross EOB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

• Medicare Primary
• Medicaid Secondary

Example 4a
Outpatient
Medicare
Coinsurance Only

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333	2	3a PAT. CNTL # 0812345 b. MED. REC. # 5 FED. TAX NO.	4 TYPE OF BILL 0131
--	---	--	---------------------

8 PATIENT NAME a	9 PATIENT ADDRESS a																			
b DOE, JANE E.	c	d	e																	
10 BIRTHDATE 03 20 08	11 SEX 08	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
31 OCCURRENCE CODE 50	32 OCCURRENCE DATE 04 04 08	33 OCCURRENCE CODE 1	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH														
38	39 VALUE CODES A2	40 VALUE CODES AMOUNT 367.20	41 VALUE CODES	42 VALUE CODES 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
0258	N400026064871UN1234.567	J1480		1	14000		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001 PAGE 3 OF 1 CREATION DATE 04 05 08 TOTALS 275400

50 PAYER NAME A MEDICARE B MEDICAID	51 HEALTH PLAN ID	52 REL. INFO Y 53 ASG. BEN. Y	54 PRIOR PAYMENTS 1468.80	55 EST. AMOUNT DUE 0 367.20	56 NPI 1234567890 S 020024 OTHER HS99OP PRV ID
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58 INSURED'S NAME A DOE, JANE E. B DOE, JANE E.	59 P. REL.	60 INSURED'S UNIQUE ID 574500000A 0600611111	61 GROUP NAME	62 INSURANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 DX 78650	5990	79099	78720	4019	68
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69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI

80 REMARKS	81CC a	81CC b	81CC c	81CC d
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RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER



Central Alaska Hospital
 REMITTANCE REPORT

*Example 4b
 Outpatient
 Medicare
 Coinsurance Only*

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 131

NUMBER: 020024
 NAME: CENTRAL ALASKA HOSPITAL
 ADDRESS: 1000 HOSPITAL DR.
 CITY/ST/ZIP: ANYTOWN, AK 99500-0000

PAYER
 C24
 MEDICARE PART A
 PO BOX 6720
 FARGO ND 58108-6720

*Note: Your EOMB may be
 formatted differently.*

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM THRU		PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT				
MEDICAL RECORD NUMBER	INTERNAL CONTROL NO	COST DAYS	COV DAYS	NONCOV DAYS	C O	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE-DUCTIBLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED					
DOE, JANE E. 00047960	0812345 12345678901234	574500000A 0						03/20/08 03/20/08			2754.00 0.00	0.00 0.00	250.00 0.00	367.20 0.00	0.00 0.00	0.00 0.00	1468.80 0.00
CAPITAL PMT: HOLD HARM:	0.00 0.00	HSP: IME-ADJ:	0.00 0.00			FSP: 0.00 EXCEPTIONS: 0.00	DSH ADJ: 0.00										DRG CODE:
COVERD CHARGES:	2754.00	CLAIM STATUS CODE:	0			TYPE OF BILL: 131											

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0258		03/20/08	14000	74.67			
0270		03/20/08	25600	136.53			
0350		03/20/08	97600	520.53			
0450		03/20/08	106300	566.94			
0460		03/20/08	31900	170.13			

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims with J (drug) Code

Scenario: Outpatient Claim Form, with Medicare Coinsurance Only

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional Requirements for Institutional Medicare Crossover Claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Line a: enter Value Code "A2" and the recipient's Medicare coinsurance amount. Note: the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 50: <i>Payer Name</i>	Enter the word "Medicare".
<ul style="list-style-type: none"> • Medicare is the primary payer; • Medicaid is the secondary payer; 	Line A: enter all information pertaining to Medicare. Line B: enter all information pertaining to Medicaid.
4. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> • Medicare is the primary payer; • Medicaid is the secondary payer; 	Line A: enter the Medicare Paid Amount. Line B: no entry needed.
5. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid. Note: The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
6. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

- Medicare Primary
- Medicaid Secondary

Example 5a
Outpatient
Medicare Deductible
Only

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2	3a PAT. CNTL # 0812345	4 TYPE OF BILL 0131
			b. MED. REC. #	
			5 FED. TAX NO.	FROM 032008 THROUGH 032008

8 PATIENT NAME a	9 PATIENT ADDRESS a
b	c
b	d
b	e

10 BIRTHDATE 03 20 08	11 SEX 08	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28				29 ACDT STATE	30
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31 OCCURRENCE CODE 50	32 OCCURRENCE DATE 04 04 08	33 OCCURRENCE CODE 1	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE	39 OCCURRENCE CODE	40 OCCURRENCE DATE	41 OCCURRENCE CODE	42 OCCURRENCE DATE	43 OCCURRENCE CODE	44 OCCURRENCE DATE	45 OCCURRENCE CODE	46 OCCURRENCE DATE	47 OCCURRENCE CODE	48 OCCURRENCE DATE	49 OCCURRENCE CODE	50 OCCURRENCE DATE
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39 VALUE CODES A1	40 VALUE CODES 250.00	41 VALUE CODES	42 VALUE CODES	43 VALUE CODES	44 VALUE CODES	45 VALUE CODES	46 VALUE CODES	47 VALUE CODES	48 VALUE CODES	49 VALUE CODES
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42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0258	N400026064871UN1234.567	J1480		1	14000		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001	PAGE 3 OF 1	CREATION DATE	04 05 08	TO	275400	0
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53 PAYER NAME A MEDICARE B MEDICAID	51 HEALTH PLAN ID	52 REL. INFO Y	53 ASG. BEN. Y	54 PRIOR PAYMENTS 1500.00 0	55 AMOUNT DUE 250.00	56 NPI 1234567890 020024 HS99OP
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58 INSURED'S NAME A DOE, JANE E. B DOE, JANE E.	59 P. REL.	60 INSURED'S UNIQUE ID 574500000A 0600611111	61 GROUP NAME	62 PLAN GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 DX 78650	5990	79099	78720	4019	68
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69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI

80 REMARKS	81CC a b c d
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RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER



Central Alaska Hospital
 REMITTANCE REPORT

*Example 5b
 Outpatient
 Medicare Deductible
 Only*

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 131

NUMBER:	PROVIDER	PAYER
NAME:	020024	C24
ADDRESS:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
CITY/ST/ZIP:	1000 HOSPITAL DR.	PO BOX 6720
	ANYTOWN, AK 99500-0000	FARGO ND 58108-6720

*Note: Your EOMB may be
 formatted differently.*

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
DOE, JANE E. 00047960	0812345 12345678901234	COST 0	COV 0	NONCOV 0	C 0	PRIMARY PAYOR	DENIED CHARGES	OUTLIER AMOUNT	BLOOD DE- DUCTIBLE	PATIENT LIB MET	PRIMARY PAY AMT	INTEREST INCLUDED	1500.00
CAPITAL PMT: 0.00 HSP: 0.00 FSP: 0.00 DSH ADJ: 0.00 HOLD HARM: 0.00 IME-ADJ: 0.00 EXCEPTIONS: 0.00 COVERD CHARGES: 2754.00 CLAIM STATUS CODE: 0 TYPE OF BILL: 131													

DRG CODE:

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0258		03/20/08	14000	0.00			
0270		03/20/08	25600	0.00			
0350		03/20/08	97600	0.00			
0450		03/20/08	106300	0.00			
0460		03/20/08	31900	0.00			

Completing the UB-04 Claim Form for Institutional Medicare Crossover paper claims with J (drug) code

Scenario: Outpatient Claim Form, with Medicare Deductible Only

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional Requirements for Institutional Medicare Crossover Claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Enter Value Code "A1" and the recipient's Medicare deductible amount. Note: the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 50: <i>Payer Name</i>	Enter the word "Medicare".
<ul style="list-style-type: none"> • Medicare is the primary payer; 	Line A: enter all information pertaining to Medicare.
<ul style="list-style-type: none"> • Medicaid is the secondary payer; 	Line B: enter all information pertaining to Medicaid.
4. Field 54: <i>Prior Payments</i>	
<ul style="list-style-type: none"> • Medicare is the primary payer; 	Line A: enter the Medicare Paid Amount.
<ul style="list-style-type: none"> • Medicaid is the secondary payer; 	Line B: no entry needed.
5. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid. Note: The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
6. The Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

- Medicare Primary
- Medicaid Secondary

Example 6a
Outpatient
Medicare Deductible
and Coinsurance

1 CENTRAL ALASKA HOSPITAL 1000 HOSPITAL DR. ANYTOWN, AK 99500-0000 (907) 333-3333		2		3a PAT. CNTL # 0812345		4 TYPE OF BILL 0131	
				b. MED. REC. #		5 FED. TAX NO. FROM 032008 THROUGH 032008	

8 PATIENT NAME a		9 PATIENT ADDRESS a	
b DOE, JANE E.		b	

10 BIRTHDATE 03 20 08	11 SEX 08	12 DATE	13 HR 1	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22-25				26	27	28	29 ACDT STATE	30
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31 OCCURRENCE CODE 50	32 OCCURRENCE DATE 04 04 08	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH
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38	39 VALUE CODES A1	40 VALUE CODES A2	41 VALUE CODES	42 VALUE CODES
	AMOUNT 536.00	AMOUNT 260.00		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0258	N400026064871UN1234.567	J1480		1	14000		
0270	MED SURG SUPPLIES			12	25600		
0350	CT SCAN			1	97600		
0450	EMERG ROOM GENERAL			2	106300		
0460	PULMONARY FUNCTION GEN			5	31900		

0001	PAGE 4 OF 1	CREATION DATE 04 05 08	TOTALS 275400	0
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62 PAYER NAME MEDICARE MEDICAID	51 HEALTH PLAN ID	52 REL INFO Y	53 ASG BEN. Y	54 PRIOR PAYMENTS 1300.00	55 EST. AMOUNT DUE 0	56 NPI 1234567890	57 OTHER PRV ID 020024 HS990P
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58 INSURED'S NAME DOE, JANE E.	59 P. REL.	60 INSURED'S UNIQUE ID 574500000A	61 GR 5	62 SURANCE GROUP NO. 6
DOE, JANE E.		0600611111		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 DX 78650	5990	79099	78720	4019	68
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69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI
79 OTHER PROCEDURE CODE	80 OTHER PROCEDURE CODE	QUAL	QUAL	QUAL

80 REMARKS	81CC a	81CC b	81CC c	81CC d
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RUN DATE: 04/04/08
 RUN TIME: 1412
 RUN USER: DBCOOPER

7

Central Alaska Hospital
 REMITTANCE REPORT

Note: Your EOMB may be formatted differently.

RA NUMBER: 000000001 RA DATE: 04/04/08 FILE NUMBER: 1223 CLAIM TYPE: 131

**Example 6b
 Outpatient
 Medicare Deductible
 and Coinsurance**

NUMBER:	PROVIDER	PAYER
NAME:	020024	C24
ADDRESS:	CENTRAL ALASKA HOSPITAL	MEDICARE PART A
CITY/ST/ZIP:	1000 HOSPITAL DR.	PO BOX 6720
	ANYTOWN, AK 99500-0000	FARGO ND 58108-6720

PATIENT NAME	PATIENT ACCOUNT NUMBER	HEALTH INSURANCE NO	COVERAGE DATES FROM	THRU	PER DIEM	PP CD	SUBMITTED CHARGES	DRG/HCCP AMOUNT	DEDUCT-IBLE AMT	CO-INS AMOUNT	NON-COV CHARGES	CONTRACT ADJUST	PROVIDER PAYMENT
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DOE, JANE E. 00047960	0812345 12345678901234	COST 0	COV 0	NONCOV 0	C O	PRIMARY PAYOR	03/20/08	03/20/08	2754.000.00	536.00	260.00	0.00	1300.00
CAPITAL PMT:	0.00	HSP:	0.00	FSP:	0.00	DSH ADJ:	0.00	0.00	0.00	796.00	0.00	0.00	DRG CODE:
HOLD HARM:	0.00	IME-ADJ:	0.00	EXCEPTIONS:	0.00								
COVERD CHARGES:	2754.00	CLAIM STATUS CODE:	0	TYPE OF BILL:	131								

CLAIM LEVEL
 Reason Codes Reason Amts Reason Qty

SERVICE LEVEL

REV Code	Proc Code	Svc Dates	Submitted Amt	Paid Amount	Reason Cd	Reason Amt	Reason
0258		03/20/08	14000	74.67			
0270		03/20/08	25600	136.53			
0350		03/20/08	97600	520.53			
0450		03/20/08	106300	398.14			
0460		03/20/08	31900	170.13			

Completing the UB-04 Claim Form for Institutional Medicare Crossover Paper Claims with J (drug) Code

Scenario: Outpatient Claim Form, with Medicare Deductible and Coinsurance

- Medicare is Primary
- Medicaid is Secondary

Providers should complete the UB-04 for institutional Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover component of these claims are listed in *mm/dd/yy* format below.

Additional Requirements for Institutional Medicare Crossover Claims:

1. Field 31: <i>Occurrence Code/Date</i>	Enter the Occurrence Code "50" and the Medicare paid date in <i>mm/dd/yy</i> format.
2. Field 39a: <i>Value Codes/Amount</i>	Enter Value Code "A1" and the recipient's Medicare deductible amount. Note: the Value Code used corresponds with Field 50A, where Medicare is primary.
3. Field 40a:	Enter Value Code "A2" and the recipient's Medicare coinsurance amount. Note: the Value Code used corresponds with Field 50A, where Medicare is primary.
4. Field 50: <i>Payer Name</i>	Enter the word "Medicare".
• Medicare is the primary payer;	Line A: enter all information pertaining to Medicare.
• Medicaid is the secondary payer;	Line B: enter all information pertaining to Medicaid.
5. Field 54: <i>Prior Payments</i>	
• Medicare is the primary payer;	Line A: enter the Medicare Paid Amount.
• Medicaid is the secondary payer;	Line B: no entry needed.
6. Field 55B: <i>Est. Amount Due</i>	Enter the Estimated Amount Due from Medicaid Note: The entry in row B corresponds to position of Medicaid as the secondary payer in field 50B.
7. the Medicare EOMB	A copy of the Medicare EOMB must be attached to the claim.

For more information on completing the UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.