The following item numbers and descriptions correspond to the UB-04 Claim Form.

**Note:** Items described as “Not Required by HPSM” may be completed for other payers, but are not recognized by the HPSM claims processing system.

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
<th>UB-04 Submission Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hospital Name, Address and Zip Code</td>
<td>Enter the facility name, address and zip code</td>
</tr>
<tr>
<td>2.</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>3. a</td>
<td>Patient Control Number</td>
<td>This is an optional field that will help you easily identify a recipient on RTDs and RAs.</td>
</tr>
<tr>
<td>3. b</td>
<td>Med Rec #</td>
<td>This is an optional field that will help you easily identify a recipient on RTDs and RAs.</td>
</tr>
<tr>
<td>4.</td>
<td>Type of Bill</td>
<td>Enter the appropriate Type of Bill code as specified in the UB-04 Manual Billing Procedures.</td>
</tr>
<tr>
<td>5.</td>
<td>Federal Tax ID Number</td>
<td>Enter the nine-digit federal tax ID number in this format; NN-NNNNNNNN</td>
</tr>
<tr>
<td>6.</td>
<td>Statement Covers Period (From-Through)</td>
<td>In six digit format MMDDYY (Month, Day, Year) enter the dates of service included in this billing</td>
</tr>
<tr>
<td>7.</td>
<td>Unlabeled</td>
<td>Not Required by HPSM</td>
</tr>
<tr>
<td>8. a</td>
<td>Patient name</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>8. b</td>
<td>Patient name</td>
<td>Enter the first and last name of the patient</td>
</tr>
<tr>
<td>9. a</td>
<td>Patient address</td>
<td>Enter the street address of the patient</td>
</tr>
<tr>
<td>9. b</td>
<td>Patient address</td>
<td>Enter the name of the city where the patient resides</td>
</tr>
<tr>
<td>9. c</td>
<td>Patient address</td>
<td>Enter the abbreviation of the name of the state in which the patient resides.</td>
</tr>
<tr>
<td>9. d</td>
<td>Patient address</td>
<td>Enter the zip code for which the patient resides</td>
</tr>
<tr>
<td>10.</td>
<td>Birthdate</td>
<td>Enter the patients date of birth in an 8 digit format (e.g., MMDDYYYY).</td>
</tr>
<tr>
<td>11.</td>
<td>Sex</td>
<td>Enter either an F or an M to identify the patients gender.</td>
</tr>
<tr>
<td>12.</td>
<td>Admission date</td>
<td>“Not Required by HPSM”</td>
</tr>
</tbody>
</table>

Updated 6/20/08
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>HR</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>14.</td>
<td>Type</td>
<td>Enter the numeric code indicating the necessity for admission to the hospital. Emergency = 1, Urgent = 2, Elective = 3, Newborn = 4, Trauma Center = 5, Information not available = 9.</td>
</tr>
<tr>
<td>15.</td>
<td>SRC</td>
<td>IF the patient was transferred from another facility, enter the number code indicating the source of transfer. Physician Referral = 1, Clinic Referral = 2, Managed Care Plan Referral = 3, Transfer from a Hospital (different facility) = 4, Transfer from a SNF = 5, Transfer from another Health Care Facility = 6, Emergency Room = 7, Court/Law Enforcement = 8, Information not available = 9, Transfer from a Critical Access Hospital (CAH) = A, Transfer from another Home Health Agency = B, Readmission to same Home Health Agency = C, Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer = D.</td>
</tr>
<tr>
<td>16.</td>
<td>DHR</td>
<td>Enter the discharge hour using the 24 hour format.</td>
</tr>
<tr>
<td>17.</td>
<td>STAT</td>
<td>Enter the appropriate 2 digit code representing the patients discharge status.</td>
</tr>
<tr>
<td>18.-28</td>
<td>Condition Codes</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>29.</td>
<td>ACDT</td>
<td>“Not Required by HPSM”.</td>
</tr>
<tr>
<td>30-34</td>
<td>Occurrence Codes and Dates</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence spans and Date</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>37 A-C</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>38</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>39-41A-D.</td>
<td>Value Codes and Amount</td>
<td>Patient’s Share-of-Cost code”23” or Medicare Deductible</td>
</tr>
<tr>
<td>42.</td>
<td>Revenue Code</td>
<td>Enter the appropriate accommodation or ancillary code. Ancillary codes are listed in Section 300-109.</td>
</tr>
<tr>
<td>43.</td>
<td>Description</td>
<td>Enter the description of the accommodation or ancillary code.</td>
</tr>
<tr>
<td>44.</td>
<td>HCPCS/Rate/HIPPS Code</td>
<td>Enter the appropriate HCPCS/CPT code.</td>
</tr>
<tr>
<td>45.</td>
<td>Service Date</td>
<td>Enter the 6 digit date of service (MMDDYY)</td>
</tr>
<tr>
<td>46.</td>
<td>Service Units</td>
<td>Enter the number of days of care by accommodation code.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point(.) or dollar sign ($).</td>
</tr>
<tr>
<td>48</td>
<td>Non-Covered Charges</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>49</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>50</td>
<td>A-C</td>
<td>Payer</td>
</tr>
<tr>
<td>51</td>
<td>A-C</td>
<td>Health Plan ID</td>
</tr>
<tr>
<td>52</td>
<td>A-C</td>
<td>Release of Information Certification</td>
</tr>
<tr>
<td>53</td>
<td>A-C</td>
<td>Assignment of Benefits Certification Indicator</td>
</tr>
<tr>
<td>54</td>
<td>A-C</td>
<td>Prior Payment</td>
</tr>
<tr>
<td>55</td>
<td>A-C</td>
<td>Estimated Amount Due</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Enter the facilities NPI.</td>
</tr>
<tr>
<td>57</td>
<td>Unlabeled</td>
<td>Enter the facilities Medi-Cal ID #.</td>
</tr>
<tr>
<td>58</td>
<td>A-C</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>59</td>
<td>A-C</td>
<td>Patient’s Relationship to Insured</td>
</tr>
<tr>
<td>60</td>
<td>A-C</td>
<td>Insured Unique ID</td>
</tr>
<tr>
<td>61</td>
<td>A-C</td>
<td>Insured Group Name</td>
</tr>
<tr>
<td>62</td>
<td>A-C</td>
<td>Insurance Group Number</td>
</tr>
<tr>
<td>63</td>
<td>A-C</td>
<td>Treatment Authorization Codes</td>
</tr>
<tr>
<td>64</td>
<td>A-C</td>
<td>Employment Status Code</td>
</tr>
<tr>
<td>65</td>
<td>A-C</td>
<td>Employer Name</td>
</tr>
<tr>
<td>66</td>
<td>DX</td>
<td>No entry can be made</td>
</tr>
<tr>
<td>67</td>
<td>A-Q</td>
<td>Diagnosis Codes</td>
</tr>
</tbody>
</table>

Updated 6/20/08
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>for the date of service. (Do Not enter decimal point.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>69.</td>
<td>ADMIT DX</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>70.</td>
<td>Patient Reason DX</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>71.</td>
<td>PPS Code</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>72.</td>
<td>ECI</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>73.</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>74 a - e.</td>
<td>Principal Procedure Code and Date/Other Procedure Codes and Dates</td>
<td>Enter the appropriate procedure code from the ICD-9-CM section 3 identifying the primary and subsequent medical or surgical procedure(s).</td>
</tr>
<tr>
<td>75.</td>
<td>Unlabeled</td>
<td>“Not Required by HPSM”</td>
</tr>
<tr>
<td>76.</td>
<td>Attending Physician ID</td>
<td>Enter the attending physicians NPI and Medi-Cal Number.</td>
</tr>
<tr>
<td>77.</td>
<td>Operating Physician ID</td>
<td>Enter the operating physician NPI and Medi-Cal provider number.</td>
</tr>
<tr>
<td>78.</td>
<td>Other Physician ID</td>
<td>Enter the Admitting physician NPI and Medi-Cal provider number.</td>
</tr>
<tr>
<td>80.</td>
<td>Remarks</td>
<td>Use this area for procedures that require additional information, e.g. enter Mother’s name when the baby is using Mother’s ID and the baby’s birthdate.</td>
</tr>
<tr>
<td>81a – d.</td>
<td>CC</td>
<td>“Not Required by HPSM”</td>
</tr>
</tbody>
</table>