Quick Reference:
Temporary Instructions for Submitting Part B claims Under Administrator Ruling CMS-1455-R

On March 13, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Ruling CMS-1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a Part A claim for an inpatient admission as not reasonable and necessary.

A copy of the ruling can be found at the following link:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf

CMS Ruling 1455-R Fact Sheet can be found at the following link:
http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4558

CMS has issued instructions to contractors to address the automation of claims processing which will be implemented in the July 2013 quarterly system release.

Until this process is implemented, providers shall follow these Temporary Instructions for the Part B Type of Bill (TOB) 12x.

For electronic submissions, providers are instructed to place the appropriate (pre-authorized) code into Loop 2300 REF02 (REF01 = G1). Please note, the loop and segment are included for billing purposes, but only SPN65 needs to be present in the field:

REF*G1*SPN65~

(The above code shall not include any spaces, and should appear as SPN65)

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format:

NTE*ADD*12345678901234-99999999-CMS1455R~

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the

provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

For DDE or Paper Claims, Providers are instructed to use fields: 5/MAP1715 (for DDE) or first line of the Treatment Authorization field #63 (for paper) and the following format:

SPN65 (the code shall not include any spaces, and should appear as SPN65)

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be added to the Remarks Field (form locator #80) on the claim in the format:

12345678901234-99999999-CMS1455R

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

Providers shall follow these Temporary Instructions for the Part B Type of Bill (TOB) 13x.

For electronic submissions, providers are instructed to place the appropriate remarks:

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format:

NTE*ADD*12345678901234-99999999-CMS1455R~

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

For DDE or Paper Claims, Providers are instructed to place the appropriate remarks:

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be added to the Remarks Field (form locator #80) on the claim in the format:

12345678901234-99999999-CMS1455R

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

Please Note:

- The hospital may submit a Part B inpatient claim (12x) for the Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient except where those services specifically require an outpatient status such as outpatient visits, emergency department visits, observation services, that are, by definition, provided to hospital outpatients and not inpatients. Consistent with existing Medicare policy, where no Part A payment is made because the inpatient admission is denied as not reasonable and necessary, hospitals may bill separately for outpatient services (13x) provided in the three-day payment window prior to the inpatient admission as the outpatient services that they were, including observation and other services that are furnished in accordance with Medicare's requirements. See Section 10.12, Chapter 4 of the Medicare Claims Processing Manual (Pub. 100-04). Because services provided during the three-day payment window are outpatient services, they cannot be included on the Part B inpatient claim. Instead, hospitals should bill for these services on a Part B outpatient claim in accordance with this policy.

- For the Part B 12x claim, the hospital will be initially be paid at 90% of the net amount that would be payable (after subtracting deductibles and co-insurance) if the provider had originally submitted the claim as outpatient services based on the OPPS Pricer amount or lab fee amount. (For Maryland Waiver providers, the 90% will be based on the outpatient

payment that would have been available if the claim were originally paid as an outpatient claim for payment.) Payments are claim, not line, level. When CR 8185 is implemented in July, contractors will mass adjust all TOB 12x rebilling claims that were processed under this temporary methodology for full Medicare payment.

Claim Examples

Since the billing concepts are new to most providers, we have provided sample claims for the most common scenarios of billing Part B claims under CMS Ruling 1455R. This concept can be applied to any of the scenarios that require split billing.

131 BILLING EXAMPLE #1

SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW

4 TYPE OF BILL: 0131

6. STATEMENT COVERS PERIOD: FROM 03312012 THROUGH 04012012

8 PATIENT NAME: MEDICARE SMITH

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS/RATES/HPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

SUBSEQUENT RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY. THE PROVIDER APPEALED THIS DECISION. DURING THE REVIEW PROCESS CMS 1455R BECAME EFFECTIVE. THE PROVIDER RECEIVED A 1ST LEVEL APPEAL DECISION DATED 03-15-2013 AND THE PROVIDER DECIDED NOT TO APPEAL TO THE 2ND LEVEL.

THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE APPEAL DECISION TO FILE PART B CLAIMS UNDER RULING CMS-1455-R.

PAGE 1 OF 1 | CREATION DATE | TOTALS

50 PAYER NAME: MEDICARE | 52 REL INFO: Y | 53 ASG BEN: Y | 56 NPI: 9876543210

58 INSURED'S NAME: SMITH, MEDICARE | 59 P. REL: 18 | 60 INSURED'S UNIQUE ID: 987654321A

80 REMARKS: 12345678901234-03152013-CMS1455R (DCN) (LAST ADJUCATION (ATTESTATION) DATE)

UB-04 CMS-1450 | APPROVED OMB NO. 0938-0997 | NUBC ™ National Uniform Billing Committee LIC3810506 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF

121 BILLING EXAMPLE #1

1	2	3a PAT. CNTL # / b. MED. REC #	4 TYPE OF BILL: 0121
		5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM: 04012012 THROUGH: 04022012
8 PATIENT NAME: a MEDICARE SMITH		9 PATIENT ADDRESS	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 D HR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29. ACDT STATE	30.

31 CODE	31 OCCURENCE DATE	32 CODE	32 OCCURENCE DATE	33 CODE	33 OCCURENCE DATE	34 CODE	34 OCCURENCE DATE	35. CODE	35. CCURRENCE SPAN FROM	THROUGH	36. CODE	36. CCURRENCE SPAN FROM	THROUGH	37

38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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13								13
14								14
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16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE__1__ OF __1__ CREATION DATE			TOTALS			23

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THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE APPEAL DECISION TO FILE PART B CLAIMS UNDER RULING CMS-1455-R.

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	MEDICARE		Y	Y			57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SMITH, MEDICARE	18	987654321A		A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	SPN65		A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT	a	b	c	71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING		QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	
							78 OTHER	NPI	QUAL	
							LAST		FIRST	
							78 OTHER	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC			
12345678901234-03152013-CMS1455R	a			
(DCN) (LAST ADJUCATION (ATTESTATION) DATE)	b			
	c			
	d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF

131 BILLING EXAMPLE #2

1	2 SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW	3a PAT. CNTL # / b. MED. REC #	4 TYPE OF BILL: 0131
		5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM: 03312012 THROUGH: 04012012
8 PATIENT NAME: a MEDICARE SMITH	9 PATIENT ADDRESS		

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

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35. CCURRENCE SPAN CODE	FROM	THROUGH	36. CCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE__1__ OF __1__ CREATION DATE			TOTALS			23

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY AND THE MEDICARE ADMINISTRATIVE CONTRACTOR ISSUED A DENIAL ON A REMITTANCE ADVICE DATED FEBRUARY 15, 2013. CMS 1455-R BECAME EFFECTIVE ON MARCH 13, 2013. THE RULING APPLIES TO THE DENIAL. THE PROVIDER MAY EITHER (1) APPEAL THE DENIAL WITHIN 120 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE, OR (2) THE PROVIDER MAY SUBMIT ITS PART B CLAIM(S) WITHIN 180 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE. THE DATE OF RECEIPT IS PRESUMED TO BE 5 DAYS AFTER THE DATE PRINTED ON THE REMITTANCE ADVICE. THE PROVIDER MAY NOT BOTH APPEAL THE DENIAL AND SUBMIT PART B CLAIMS.

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	MEDICARE		Y	Y			57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SMITH, MEDICARE	18	987654321A		A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT	a	b	c	71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING		QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC				78 OTHER	NPI	QUAL	
12345678901234-02152013-CMS1455R (DCN) (LAST ADJUCATION (ATTESTATION) DATE)	a				LAST		FIRST	
	b				78 OTHER	NPI	QUAL	
	c				LAST		FIRST	
	d							

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THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF

121 BILLING EXAMPLE #2

4 TYPE OF BILL: 0121			
6. STATEMENT COVERS PERIOD FROM: 04012012	THROUGH: 04022012		
8 PATIENT NAME: MEDICARE SMITH			

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY AND THE MEDICARE ADMINISTRATIVE CONTRACTOR ISSUED A DENIAL ON A REMITTANCE ADVICE DATED FEBRUARY 15, 2013. CMS 1455-R BECAME EFFECTIVE ON MARCH 13, 2013. THE RULING APPLIES TO THE DENIAL. THE PROVIDER MAY EITHER (1) APPEAL THE DENIAL WITHIN 120 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE, OR (2) THE PROVIDER MAY SUBMIT ITS PART B CLAIM(S) WITHIN 180 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE. THE DATE OF RECEIPT IS PRESUMED TO BE 5 DAYS AFTER THE DATE PRINTED ON THE REMITTANCE ADVICE. THE PROVIDER MAY NOT BOTH APPEAL THE DENIAL AND SUBMIT PART B CLAIMS.

PAGE 1 OF 1 — CREATION DATE — TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A MEDICARE		Y	Y			57	
B						OTHER	
C						PRV ID	

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A SMITH, MEDICARE	18	987654321A			
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A SPN65		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT	a	b	c	71 PPS CODE		72 ECI			73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	75	76 ATTENDING	QUAL
				LAST	FIRST
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE		77 OPERATING NPI	QUAL
				LAST	FIRST

80 REMARKS	81CC		78 OTHER NPI	QUAL
12345678901234-02152013-CMS1455R	a		LAST	FIRST
(DCN) (LAST ADJUCATION (ATTESTATION) DATE)	b		78 OTHER NPI	QUAL
	c		LAST	FIRST
	d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF

131 BILLING EXAMPLE #3

1	2 SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW	3a PAT. CNTL # / b. MED. REC #	4 TYPE OF BILL: 0131
		5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM: 03312012 THROUG: 04012012
8 PATIENT NAME: a MEDICARE SMITH	9 PATIENT ADDRESS		

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

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35. CCURRENCE SPAN CODE	FROM	THROUGH	36. CCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE__1__ OF __1__ CREATION DATE			TOTALS			23

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

SUBSEQUENT RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY. THE PROVIDER APPEALED THIS DECISION. DURING THE APPEALS PROCESS CMS-1455-R BECAME EFFECTIVE. THE PROVIDER REQUESTED A WITHDRAWAL OF THEIR APPEAL AND THE CONTRACTOR ISSUED A DISMISSAL NOTICE DATED 04-15-2013.

THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE DISMISSAL NOTICE TO SUBMIT THE PART B CLAIMS. THE DATE OF RECEIPT OF THE DISMISSAL NOTICE IS PRESUMED TO BE 5 DAYS FROM THE DATE ON THE NOTICE.

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	MEDICARE		Y	Y			57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SMITH, MEDICARE	18	987654321A		A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT	a	b	c	71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING		QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	
							78 OTHER	NPI	QUAL	
							LAST		FIRST	
							78 OTHER	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC			
12345678901234-04152013-CMS1455R	a			
(DCN) (LAST ADJUCATION (ATTESTATION) DATE)	b			
	c			
	d			

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121 BILLING EXAMPLE #3

1	2	3a PAT. CNTL #	4 TYPE OF BILL: 0121
		b. MED. REC #	
		5. FED.TAX NO.	6. STATEMENT COVERS PERIOD: FROM 04012012 THROUG 04022012

8 PATIENT NAME: a MEDICARE SMITH	b	9 PATIENT ADDRESS: a	b
c	d	e	

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

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35. CCURRENCE SPAN CODE	FROM	THROUGH	36. CCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
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14							14
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16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE__1__ OF __1__		CREATION DATE	TOTALS			23

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	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210	
A	MEDICARE		Y	Y			57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	SMITH, MEDICARE	18	987654321A			A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A	SPN65			A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT	a	b	c	71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING		QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	
80 REMARKS		81CC a					78 OTHER	NPI	QUAL	
12345678901234-04152013-CMS1455R		b					LAST		FIRST	
(DCN) (LAST ADJUCATION (ATTESTATION) DATE)		c					78 OTHER	NPI	QUAL	
		d					LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF