



Creating solutions, One person at a time

PBH UB04 Billing Instructions

PBH requires certain services be billed on a UB04 billing form. Please see instructions below:

Box 1- Billing Provider: This information is automatically populated from the billing system.

Box 2 – Pay to Provider: This information is automatically populated from the billing system.

Box 3a- Patient Control Number: This field is reserved for the number assigned by the provider to facilitate retrieval, tracking, and filing of patient’s account (receivables).

Box 3b – Medical Record Number: This field is reserved for the number assigned by the provider to the patient’s medical record.

Box 4- Type of Bill: The Type of Bill code is comprised of three parts; a leading “0”, the Facility Type code and the Bill Frequency Type code. This field should be four digits when completed. The first two digits following the zero indicate the type of facility. The final digit indicates the type of bill. Below are all acceptable codes.

0111 – Hospital Inpatient – Admit though Discharge
0112 – Hospital Inpatient – First Claim
0113 – Hospital Inpatient – Continuing Claim
0114 – Hospital Inpatient – Last Claim
0117 – Hospital Inpatient – Replacement Claim
0118 – Hospital Inpatient – Void Claim

0131 – Hospital Outpatient – Admit through Discharge
0137 – Hospital Outpatient – Replacement Claim
0138 – Hospital Outpatient – Void Claim

0651 – Intermediate Care – Admit through Discharge
0652 – Intermediate Care – First Claim
0653 – Intermediate Care – Continuing Claim
0654 – Intermediate Care – Last Claim
0657 – Intermediate Care – Replacement Claim
0658 – Intermediate Care – Void Claim

0891 – Residential - Admit through Discharge
0892 – Residential – First Claim
0893 – Residential – Continuing Claim
0894 – Residential – Last Claim
0897 – Residential – Replacement Claim
0898 – Residential – Void Claim

Box 5- Federal Tax ID Number: This is automatically populated from the billing system.

Box 6- Statement Period From and Through Dates: Enter the eight digit beginning service date in the “From” box and the eight digit ending service date in the “Through” box. Dates are to be entered in the “mm/dd/yyyy” format.

Example: Enter the date of service January 31, 2011 as 01/31/2011.

Box 8b- Patient Name: Recipient’s full name as shown on the MID card (last name, first name, middle initial). This information is automatically populated from the billing system.

Box 10- Patient Date of Birth: This information is automatically populated from the billing system.

Box 11- Patient Sex: Valid characters are M or F. This information is automatically populated from the billing system.

Box 12- Admission Date: Enter the eight digit date of admission. Dates are to be entered in the “mm/dd/yyyy” format.

Box 14 – Type (Priority) of Visit: This field requires the one digit type code indicating the urgency/priority of the admission. ****Inpatient hospitalization only**

Box 15 – Source of Referral for Admission: Indicate the source using the one digit code that represents the source of referral for admission. ****Inpatient hospitalization only**

Box 16 – Discharge Hour (DHR) This field requires two digit codes indicating the discharge hour. ****Inpatient hospitalization only**

Box 17 – Patient Discharge Status: This field indicates the discharge status of the patient when service ended. This field is a two digit code.

Box 38- Insured Name and Address: This information is automatically populated from the billing system.

****Box 39-41; a-d – Value Codes and Amounts:** Use these form locators to indicate codes and amounts essential to the proper adjudication of the submitted

claim. Each form locator contains a three digit field in which to key the indicator code, and a larger free text field in which to designate an applicable amount.

Patient Responsibility - Key "31" in the code box of this field to identify the value code as a Patient Liability. Key the amount of PML due in the Amt. box.

Covered Days – Key "80" in the code box and the number of covered days in the amount.

Non-covered days - Key "81" for the code and the number of non-covered days as the amount.

Box 42- Revenue Code: For general hospitals, please use the appropriate revenue code(s) beginning with a leading zero followed by the three digit service code(s). The revenue code will have four digits when filled in correctly. *Ex. 0100*

Box 43- Description: This field will populate based on the revenue code entered in box 42 once the claim is saved.

Box 44- HCPCS/Rate/HIPPS Code: This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.

For all other types of facilities:

When billing therapeutic leave for the following residential services:

- H0019
- S5145
- H2020

Use the HCPCS code indicated on the authorization letter for therapeutic leave

***For services 04/01/05 and forward:*

- Enter revenue code 100 for ICF billing
- Enter revenue code 911 for Psychiatric Residential Treatment Facility (PRTF)
- Enter HCPCS code H0019 when revenue code 902 is used for residential billing
- Enter revenue code 183 for therapeutic leave for ICF only. Note: No auths are required for t/l for ICF therefore there will not be a "Y" code authorized.
- Enter codes YA254-YA259 as authorized for therapeutic leave authorized for residential providers.

Box 45- Service Date: Indicates the date the outpatient service was provided and the date the bill was created using the following format (mm/dd/yyyy).

*****Note: If billing span includes Therapeutic Leave charges, please follow the example given below:***

If billing for the month of January with two days of therapeutic leave (1/15-1/16); ***your billing will need to be submitted using three separate claims***. One claim for Residential charges (1/1-1/14); one claim for the Therapeutic Leave charges (1/15-1/16); and a final claim covering the remainder of the month's Residential charges (1/17-1/31).

Otherwise, enter the individual eight digit service date for each line item billed. Dates are to be entered in the "mm/dd/yyyy" format.

Box 46- Service Units: Enter the number of units, days or visit, where appropriate.

Box 47- Total Charges: For general hospitals enter the charges for the total number of charges billed for each service indicated. Otherwise enter the rate for the charge being billed.

***Note: If using **span billing** enter the **total amount** for the number of days being billed.*

****If necessary, add additional billing lines by typing in the number of lines you will need into the box that prompts for this. Make sure that all services are represented on their own line.****

Box 50- Primary Payer: This is a required field. Select the health plan that has primary responsibility for the costs incurred during service date from the drop down menu.

Box 50 (additional lines)- Secondary Payer: If the insured has a secondary payer such as Medicare or a managed care payer such as Aetna or Blue Cross of NC, enter the name of the plan in this box.

Box 51 (and additional lines if applicable) - Health Plan ID number: enter the number(s) from the claim used by the health plan(s) to identify itself.

Box 52- Release of Information: *****This box will automatically populate if/when a payer is selected in box 50 - each payer line will have a separate Release of Information marker box***

***Note: Check line B boxes 52 and 53 to indicate signature on file if there are secondary payers.*

Box 53- Assignment of Benefits: *****This box will automatically populate if/when a payer is selected in box 50 - each payer line will have a separate Assignment of Benefits marker box***

***Note: Check line B boxes 52 and 53 to indicate signature on file if there are secondary payers.*

Box 54- Prior Payments-Secondary Payer: Enter any prior payment amounts the facility has received toward payment of their bill for the payer indicated in box 50.

Box 55- Estimated Amount Due: Enter the estimated amount due from each indicated payer in box 50.

Box 56 – NPI: This field will be automatically populated based on the provider/clinician/physician selected from the NPI dropdown on the previous page (client search page in client gateway).

Box 58 - Insured Name: Enter the Name of the policyholder for the health plan indicated as Primary Payer in box 50

***Note: All information on “line A” applies to the primary policy holder.*

Box 58 (additional lines) - Insured Name: Enter the name of the policyholder for the secondary insurance if applicable.

***Note: All information on “line B” and other additional lines applies to other insurance on file.*

Box 59- Patient Relationship: Identify the relationship of the patient to the primary insurance policyholder using the following two digit codes:

Title:

- 01- Spouse
- 18- Self
- 19- Child
- 20- Employee
- 21- Unknown
- 53- Life Partner
- G8- Other Relationship

***Note – This is the relationship of the patient to the policy holder, so if the patient’s parents are the policy holders, the subsequent relationship would be “19-Child”.*

Box 59 (additional lines) - Patient Relationship: This box identifies the relationship of the patient to the secondary insurance policyholder if applicable. Enter the two digit code from the list above.

Box 60- Insured ID Number: Enter the number assigned by the primary health plan to identify the specific policy of the insured.

Box 60 (additional lines) - Insured ID Number: Enter the insured identification number (or policy number) for the secondary insurance if applicable.

Box 63- Treatment Authorization Codes: Enter the appropriate authorization number for services provided. (Optional)

Box 64A – Document Control Number: If the bill type indicates a replacement or void claim, enter the PBH claim number of the original submitted claim in this field. You will find the claim number on your Remittance Advice.

Box 67- Principal Diagnosis Code: Enter the primary diagnosis code in this box marked with an asterisk (*).

Boxes 67 (additional fields) - Secondary diagnosis code(s): Enter secondary diagnosis code(s) as applicable.

Box 69 – Adm. Diagnosis Code (inpatient hospital only): Enter the diagnosis code describing the patient’s diagnosis at the time of admission.

Box 81CCa – Taxonomy Code: Enter the taxonomy code in box 81CCa of the UB04. The value “B3” will be hard coded into the first field. This identifies the value to be entered as the Provider’s Taxonomy Code. Enter the Taxonomy code in the box to the right of where “B3” is located.

Once you have completed all required fields, click “Save”. Once you click “Save”, if you have made any syntax errors you will be notified at the top of the page in RED. You will NOT be able to save your claim unless all errors are addressed and corrected.

If you have not received syntax error messages, you can now save your claim and review prior to submission. If changes must be made, click “Edit” to return. If all information is correct, click “Submit” to enter the claim into the PBH billing system for processing. You may wish to print your submitted claim for your records.



UB04 Cheat-Sheet

Many fields on the UB04 are automatically populated. Below are the “un-populated fields” you will be required to enter to submit a completed UB04 form:

Box Number	Description	Info Required
Box 3a (optional)	Patient Control Number	Provider assigned patient acct #
Box 3b (optional)	Medical Record Number	Provider assigned medical records #
Box 4	Type of Bill	0111 – Hospital Inpatient – Admit though Discharge 0112 – Hospital Inpatient – First Claim 0113 – Hospital Inpatient – Continuing Claim 0114 – Hospital Inpatient – Last Claim 0117 – Hospital Inpatient – Replacement Claim 0118 – Hospital Inpatient – Void Claim 0131 – Hospital Outpatient – Admit through Discharge 0137 – Hospital Outpatient – Replacement Claim 0138 – Hospital Outpatient – Void Claim 0651 – Intermediate Care – Admit through Discharge 0652 – Intermediate Care – First Claim 0653 – Intermediate Care – Continuing Claim 0654 – Intermediate Care – Last Claim 0657 – Intermediate Care – Replacement Claim 0658 – Intermediate Care – Void Claim 0891 – Residential - Admit through Discharge 0892 – Residential – First Claim 0893 – Residential – Continuing Claim 0894 – Residential – Last Claim 0897 – Residential – Replacement Claim 0898 – Residential – Void Claim
Box 6	Statement period	Begin and end dates for service period being billed; must be in 8 digit format (mm/dd/yyyy)
Box 12	Admission Date	Eight digit start of service date.
Box 14 (inpatient hospital only)	Type of Visit	One digit priority/urgency of visit code

Box 15 (inpatient hospital only)	Source of referral	One digit code to indicate the source of the referral for visit
Box 16	Discharge Hour	Two digit code indicating the discharge hour of the patient from inpatient care.
Box 17	Patient Discharge Status	Two digit code to indicate the discharge status of the patient when service ended
Box 39 - 41; a-d	Value Codes & Amounts	To designate Patient Responsibility; Enter the value "31" in the <i>code</i> box and the amount of the PML in the <i>Amt.</i> box. To designate Covered Days; Enter the value "80" in the <i>code</i> box and the number of covered days in the <i>Amt.</i> box. To designate Non-Covered Days; Enter the value "81" in the <i>code</i> box and the number of non-covered days in the <i>Amt.</i> box.
Box 42	Revenue Code	Revenue codes must begin with a leading "0". Enter the three digit revenue code for the service provided.
Box 43	Description	This field will auto-populate based on the value entered in box 42 once the claim is saved.
Box 44	HCPCS Code/Rate/HIPPS Code	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.
Box 45	Service Date	<i>Indicates the date the outpatient service was provided and the date the bill was created using the following format (mm/dd/yyyy).</i>
Box 46	Service Units	Enter the number of units billed for each service provided.
Box 47	Total Charges	Enter the total amount of charges incurred for each individual service during the indicated service period.
Box 50	Payer Name	Select the primary payer responsible for charges incurred during the service period from the drop down menu.
Box 50	Payer Name (secondary)	Select additional secondary payer(s) from the drop down menu
Box 51	Health Plan ID	Enter the number(s) used by the health plan(s) to identify itself.
Box 52	Release of Information	<i>This box will be checked automatically when a payer is selected; however it can be deselected if necessary. Mark this box for each payer that it applies to.</i>
Box 53	Assignment of Benefits	<i>This box will be checked automatically when a payer is selected; however it can be deselected. Mark this box for each payer that it applies to.</i>
Box 54	Prior Payments -	Enter any prior payment amounts the facility has

	secondary	received toward payment of their bill for the payer indicated in box 50.
Box 55	Estimated Amount Due	Enter the estimated amount due from each payer indicated. If payment has been received, leave this field blank.
Box 56	NPI	Check to ensure that the appropriate NPI number has been populated to this field.
Box 58	Insured's Name	Enter the name of the policy holder of the primary insurance plan. If applicable, enter the name of the policy holder of any secondary insurance in the additional lines below.
Box 59	Patient Relationship	Enter the code representative of the relationship of the patient to the policy holder of primary and if applicable any secondary insurance. 01- Spouse 18- Self 19- Child 20- Employee 21- Unknown 53- Life Partner G8- Other Relationship
Box 60	Insured's ID number	Enter the unique policy number assigned by the health plan indicated to the insured. Do this for each payer identified.
Box 63	Treatment Authorization Codes (optional)	Enter the 10 digit (will have a leading "0") code(s) assigned to the prior authorization(s) received for services billed when applicable.
Box 64A	Document Control Number	If the bill type indicates a replacement or void claim, enter the PBH claim number of the original submitted claim in this field. You will find the claim number on your Remittance Advice.
Box 67	Principle Diagnosis code(s)	Enter the principle diagnosis in the field marked with an asterisk (*). Enter all secondary diagnosis codes in the additional fields provided.
Box 69	Admission Diagnosis code (inpatient hospitalization only)	Enter the code describing the patient's diagnosis at the time of admission.
Box 81CCa	Taxonomy code	The descriptor "B3" will be hard coded by the billing system to identify this field as the Provider's Taxonomy code. Beside it, enter the Taxonomy Code