INSTRUCTIONS FOR COMPLETING THE UB-92 CLAIM FORM

All entries on a UB-92 are made in a field called the Form Locator (FL). All Form Locators (FL) are assigned a number. For example, Form Locator 67 is referred to as FL67 and in this instance, FL67 is the Diagnosis Code.

The UB-92 will NOT be furnished by the State or CSC. Providers are required to obtain the UB-92 from whatever source they can procure it from. If you need assistance in securing a supply source for the UB-92 claim form, you may contact the resource listed below:

Steve Chesley
Senior Account Representative
Moore Wallace - An RR Donnelley Company
120 Industrial Park Road
Albany, NY 12206

Office: 518-435-2105
Toll Free: 800-488-8351
Fax: 518-489-7080
Email: stephen.chesley@rrd.com
Web Site: http://www.rrd.com

Any other supplier may be used as long as the UB-92 supplied is CMS approved. You may also obtain the paper UB-92 (Form UB-92 HCFA1450) from the Standard Register Company, Forms Division. Their phone number may be found in your local yellow pages.

Only ORIGINAL UB-92's can be submitted. Copies of any kind will be rejected and returned.

The UB-92 is used by two types of Institutional Providers, those Institutional Providers who submitted on the MMIS Form A, and all providers who submitted on the MMIS Form B. In this document, instructions will be split between Group A providers and Group B providers. Group B providers include Nursing Homes, Hospice, ICF, Child Care, RTF's, Assisted Living Program, Day Treatment and Day Care (all providers currently on Form B). See FL 4 for a complete list of provider types designated as A and B.

Providers are required to refer to their current MMIS billing manual, and when available, the new MMIS Provider manual, in order to know specifically when and under what circumstances an entry is required.

This document DOES NOT REPLACE the MMIS Manual.

Any Form Locator that is "skipped" is an entry that is not used by any provider submitting on the UB-92. If a form locator contains instructions, that means the field is used but may not pertain to a particular billing type. Refer to your manual for complete billing instructions as to whether a particular entry is required for your billing type.

Note: for those providers who used to report a Medicare Approved Amount, this entry is no longer required. You now only report the Medicare paid amount and the Medicare Deductible and/or Coinsurance due.

FORM LOCATOR INSTRUCTIONS

FL 1 – Name/Address

Enter the name and address of the billing provider. **Note**: Claim payment and the remittance advice are sent to the name and address on the State Master file for the Provider ID entered in FL51.

FL 3 – Patient Control Number

Enter the patient control number or office account number in this field, up to 20 characters in length.

FL 4 – Type of Bill

The Bill Type is a three digit entry. The first digit is the type of facility, the second digit is the Bill classification and the third is used by Medicaid to indicate an Adjustment or Void. See the list below for the proper Bill Type or refer to UB-92 manual.

The following is a list of the valid Type of Bill entries. The third digit may be any digit you choose from the UB-92 manual, EXCEPT 7 or 8. The third digit of 7 or 8 is used only to Adjust (7) or Void (8) a claim.

Group B Providers:

Nursing Home: **21** through **28**
Hospices: **81** through **82**
ICF: **61** through **68**
Child Care: **89**
RTF: **86**
ALP: **21** through **28**
Day Treatment: **21** through **28**

Group A Providers:

Home Health, Personal Care Services, Limited Licensure, Home Care, HHA Professional Services, Long Term Home Health: Bill Type **32** through 34

Traumatic Brain Injury, Case Management, Personal Emergency Response, Managed Care: Bill Type **89**

OMH Rehabilitative Services and OMRDD Waiver services: Bill Type **74-75**

School Supportive Health/Pre School supportive Health/Early Intervention: Bill Type **13, 14, 71** through **79**.

FL 6 – Statement Covers Period

For Group B providers this is the time period you are billing for, the From and Thru date of service. If the From and Thru date are the same date, the From date can be reported as the Thru date. **Note**: Date format is MMDDYY or MMDDYYY. Both are acceptable.

For Group A providers this is the date of service you are billing for. A single date of service can be entered as the From date and/or that same date can be repeated as the thru date. Or the Thru date may be left blank. Group A providers are allowed to bill for multiple dates of service. The rate code MUST be the same for all the dates in the date range entered. The individual dates of service must also be entered in FL45.

FL 7 – Covered Days

Not used by Group A providers.

Group B providers enter the number of Medicaid Covered days.

FL 8 - Non Covered Days

Not used by Group A providers.

Group B providers should enter the number of Medicaid non-covered days that appears in the billing period.

FL 9 – Coinsurance Days

Not used by Group A providers.

Group B providers should enter the number of Medicare Coinsurance days that appear in the statement covers period.

FL 12 – Name

Enter the name of the Medicaid Client (Recipient).

FL 14 – Birth date

Enter the FULL birth date of the client in the MMDDYYYY format such as 04151951 for April 15, 1951.

FL 15 – Sex

Enter the sex of the client as M for male or F for female.

FL 19 – Type

Group A providers: Enter the number 1 to indicate that the service rendered was an Emergency. If the service was not an Emergency leave blank.

Not used by Group B providers.

FL 22 – Stat

Enter the patient status code as it pertains to the status of the patient as of the date of service for Group A providers.

Group B providers should enter the status of the patient as it pertains to the end date of service.

Please see the following tables for valid patient status codes.

Group B Providers:

UB-92 Code	Description	Former Group B		UB-92 Code	Description	Former Group B
1	Discharged to home or self care (routine discharge)	1		40	Expired at Home	8
2	Discharged /transferred to another short term general hospital for inpatient care	2		41	Expired in a medical facility (e.g. hospital, SNF, ICF, or freestanding hospice)	8
3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare certification	3		42	Expired - place unknown	8
4	Discharged/transferred to Intermediate Care Facility (ICF).	4		50	Hospice – home	1
5	Discharged/transfer to another type of institution for inpatient care	5		51	Hospice - medical facility	3
6	Discharged/transfer to home under care of organized home health service organization	6		61	Discharged/transferred within this institution to hospital-based Medicare approved swing bed	3
7	Left against medical advice or discontinued care	9		62	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF)	5
9	Admitted as an inpatient to this hospital	18		63	Discharged/transferred to a Medicare certified Long Term Care Hospital (LTCH)	5
20	Expired	8		64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare	3
30	Still a Patient	11				

Status Codes not in the UB-92 table above are on the next page.

If one of the codes below is used, a Status Code from the table above must still be entered in FL22.

13 - Hospital Leave will be revenue code 0185 in FL 42.
14 - Therapeutic Leave will be revenue code 0183 in FL 42.

Child Care only
16 – AWOL will be revenue code 0189 in FL 42.
17 – Trial Discharge will be revenue code 0180 in FL 42.

Group A status codes:

UB-92 Code	Description	Former Group A Code
2	Discharged /transferred to another short term general hospital for inpatient care	2
9	Admitted as an inpatient to this hospital	2
20	Expired	1
40	Expired at Home	1
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or freestanding hospice)	1
42	Expired - place unknown	1

FL 24 thru 30 – Condition Codes

Group A providers may use the following Condition codes; refer to you Billing manual to determine if the entry is required.

A1 = EPDST/CHAP
A4 = Family Planning
A5 = Possible Disability

Not used by Group B Providers

FL 32 thru 35 Occurrence Code

Group A providers may enter the following Occurrence Codes. Refer to you billing manual to determine if the entry is required.

01 = Auto Accident
02 = Auto Accident – No Fault
03 = Accident
04 = Accident Employment Related (Workman's Comp)
05 = Other Accident
06 = Crime Victim

Not used by Group B Providers.

FL 37 - Used only for Adjusting or Voiding a PAID claim.

The entry in this field is used to adjust or void a previously paid claim. The CRN of the paid claim is entered on the line (A, B or C) that corresponds to the entry in FL 50 for Medicaid. Whatever line you entered Medicaid on in FL50 is the line you enter the TCN (Transmission Control Number, 16 digits which replaces the CRN – Claim Record Number, 15 digits) on for FL 37. If the CRN (TCN) is entered on line B or C, the lines above the entry must contain the word "NONE" If the claim is paid through the eMedNY system the CRN will be the TCN on the remittance. **Note**: CRNs for claims submitted before Phase II may be used to adjust or void claims. Enter the 15-digit CRN in the FL37 leaving a blank at the end.

FL 39 – Value Codes/Value Amounts

All providers are required to make entries in this area. The Value Code entry is a 2-digit code that defines what is entered in the Value Amount field. See the list below for valid Value Codes. **Note:** Not all value Codes are used by all providers. However, all providers are required to use the value code for rate code and locator code at a minimum. All entries in the value amount are made to the left of the decimal unless entering an actual dollar amount. A dollar amount is entered relative to the decimal with dollars to the left and cents to the right.

Value Code	Value Amount
24 = Rate code	Enter the rate code to be billed
61 = Locator Code	Enter the 3-digit Locator code, which is your current locator code with a zero in front.

Value codes and amounts are also used to report Medicare and Other Insurance information. The entries are based on the line where you entered Medicare or Other Insurance in FL 50. If the Other Payer entry in FL 50 was on line A, use the A codes below. If an Other Payer entry was also made on line B in FL 50 then use the B codes below.

Group A providers may make the following entries:

Value code	Value Amount
A1 or B1 = Medicare Deductible	Enter the Medicare deductible Amount due
A2 or B2 = Medicare Coinsurance	Enter the Medicare Coinsurance Amount due
A3 or B3= Medicare or Other Insurance Paid amount	Enter the amount paid by Medicare or the Other Insurance
A7 or B7 = Medicare Co-Pay	Enter the Medicare Co-pay amount
31=Patient Participation amount	Enter the amount due from the patient as a Spend-down

Group B providers can make the following entries:

Value Code	Value Amount
23 = Nami Amount	Enter the Nami amount due, the entry should be made in relation to the decimal as a dollar amount
A3 or B3 = Other insurance	Enter the amount paid by the Other Insurance

FL 42/45/46/47 – Revenue Code/Units/Amount Charged

All providers: The only revenue codes allowed on a NYS Medicaid form are those listed below. NO other revenue codes or notations should be entered in that area of the form.

FL 42 - Revenue code, Revenue Code 0001= Amount charged, enter the amount charged in FL 47 on the same line as revenue code 0001 appears. The total amount for the document.

NOTE: In addition, the amount charged MUST also be entered on any line where a Revenue Code has been entered.

For Group A providers only

FL 42 - Revenue Code, 0240 = Units, if billing for a number of Units (such as PCA, Home Health or Case Management etc) enter the number of Units in FL 46 on the same line as revenue code 0240. The amount charged for this line must be entered in FL 47.

FL 45 – Enter the specific date of service for this line.

For Group B providers, revenue codes are also used to replace certain Patient Status Codes as discussed in FL 22. See below. If one of the revenue codes below is used, the amount charged must also be entered on this line as well as with revenue code 0001.

Status Code:

13 - Hospital Leave = Revenue Code 0185
14 - Therapeutic leave = Revenue Code 0183

Child care only

16 – AWOL = Revenue Code 0189
17 – Trial Discharge = Revenue Code 0180.

Note: If billing for one of the leave situations 13 or 14 above, the number of days must be entered in FL 46 as well as in FL 7. The days are reported in both Form Locators.

FL44 – Early Intervention and School Supportive Health providers should enter a HCPCS procedure code on the first line along with the revenue code used on the first line.

FL 50 – Payer

There are 3 lines A, B and C in which payers can be entered. Medicaid is always the last payer. If Medicaid is the only payer, the word Medicaid should be entered on line A. If one other payer is involved in the claim, that other payer should be entered on line A and Medicaid on line B. If two other payers are primary to Medicaid then Medicaid will be on line C with the other payers on lines A and B.

FL 51 – Provider Number

The MMIS Provider ID MUST be entered on the same line that the word Medicaid appears in FL 50. If other payers are entered on lines A or B, then an entry must also be made in FL 51 for those payers. If the ID number is not known for the other payer, then enter the word NONE.

FL 60 – Cert – SSN – HIC – ID No.

Enter the Recipient ID number of the Medicaid patient. The number must be entered on the same line (A, B or C) as the word Medicaid in FL 50. If other payers have been entered on Lines A or B, then a number for those other payers must also be entered in FL 60 on lines A or B. If the ID number of the other payer for this patient is not known, then enter the word NONE.

FL 63 – Treatment Authorization Codes

If the claim requires Prior Approval enter the PA number on that line (A, B or C) that corresponds to the Medicaid entry in FL50. If entering the PA number on line B or C the preceding line(s) must have the word NONE. In Phase II, the PA number will be 11 digits, but you may enter the 8-digit PA number if it is still in use. DO NOT ADD ZEROS TO THE FRONT OR END OF THE 8 DIGIT PA NUMBER.

FL 67 – Principle Diagnosis Code

Enter the principle diagnosis code, if required, in this field. Please refer to your MMIS Provider manual to determine if a diagnosis is required.

FL 80 – Principal Procedure (ICD 9)

This field is NOT used by ANY provider. School Supportive Health and Early Intervention providers now use a HCPCS Procedure Code which is entered in FL 44 on the first line along with the revenue code used on the first line.

FL 82 – Attending Physician ID

This is the Service Provider entry. If the billing requires a Service Provider, enter the service Provider ID in this field. If entering a license number, enter the 3-digit profession code followed by the license number with zeros entered in front of the license number to make the license number 8 digits. (Example: If the license number is for a physician and the license number is 123456 then it would appear as 06000123456. The 060 is the profession code of the physician and the license number is 123456 with 2 zeros in front to make the license number 8 digits for a total of 11 digits.

FL 83 – Other Physician ID

If the claim requires a Referring Provider, enter the Referring Provider ID here. If entering a license number, follow the instruction in FL 82 for License number entries.

Refer to the MMIS billing manual to determine if this entry is required for **FL 82 and FL 83.**

FL 85 – Provider Representative

The form must contain an ORIGINAL signature. NO Stamped or reproduced signatures of any kind or definition are allowed. Only hand written original signatures are accepted.

APPROVED OMB NO. 0938-0279

ST-11843 1 PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7 COV D. / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11
12 PATIENT NAME	13 PATIENT ADDRESS		
14 BIRTHDATE / 15 SEX / 16 MS	ADMISSION 17 DATE / 18 HR / 19 TYPE / 20 SRC	21 D HR / 22 STAT / 23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30 / 31
32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE / 36 OCCURRENCE SPAN CODE / FROM / THROUGH
a			37 A
b			B
38			C

	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	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1						.	.	
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50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN	54 PRIOR P. AYMENTS	55 EST. AMOUNT DUE	56
A				.	.	
B				.	.	
C				.	.	
57	DUE FROM PATIENT ▶			.	.	

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR. OUP NAME	62 INSURANCE GR OUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
		A	B	
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID
	C	D	E	A
a	84 REMARKS			a
b				b
c				OTHER PHYS. ID
d				B
				a
				b
				85 PROVIDER REPRESENTATIVE / 86 DATE
				X

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.