CCA - Claims Requirements UB Institutional Form

Field #	Field Name	Instruction	Formatting Requirement	Description
1	Provider Name, Address, and Phone	Required	Do not use P.O. boxes	Enter the provider name, address and zip code and telephone number this section.
2	Pay-to Name, address and Secondary Identification Fields	Required (If different than 1)	Do not use P.O. boxes	Enter the provider name, address and zip code and telephone number this section.
3a	Patient Control Number	Required	Length 20 max.	This number is reflected on the Explanation of Benefits for reconciling payments if populated.
3b	Medical/Health Record Number	Optional		This number will not be reflected on EOB if populated.
4	Type of Bill	Required	4-digit code	Enter the appropriate four-character type of bill code.
5	Federal Tax Number Pay-to-provider ≠ Billing Provider	Required	10-digit number; begin with 1 9-digit number.	Enter the Federal Tax ID for the billing facility.
6	Statement Covers Period (From-Through)	Required	MMDDYY	Enter the “From” and “Through” dates of services covered on the claim if claim is for inpatient services.
7	Not Used	DO NOT USE		
8a	Patient’s Name	Required		Enter patient’s name in 8b
8b	Patient Identifier	Required		Enter patient’s last name, first name and middle initial if known. When submitting claim for a newborn using the mother’s ID, enter the infant’s name in box 8b. If the infant is unnamed, write the mother’s last name followed by “baby boy” or “baby girl.” If billing for multiple births, use “twin A”, “twin B”, etc. on separate claim forms.
9a-e	Patient’s Address, State, and Zip Code	Required		Enter Patient Address
10	Patient’s Date of Birth	Required	MMDDYYYY	Enter the patient’s date of birth in an eight-digit format, Month, Date, Year (MMDDYYYY) format.
11	Patient’s Sex	Required	F or M or U	Use the capital letter “M” for male, or “F” for female or “U” for unassigned.
12	Admission Date	Required (if applicable)	MMDDYY	Enter in a six-digit format (MMDDYY), enter the date of hospital admission.

13	Admission Hour	Required (if applicable)	Military Standard Time (00-23)	Enter hour of patient's admission.
14	Type of Admission	Required	Single digit code: 1-9	Enter the numeric code indicating the necessity for admission to the hospital. 1 - Emergency 2 – Elective
15	Source of Admission	Required	Single code: 1-9; A-Z	If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. 1 - Non-Healthcare Facility Point of Origin 2 – Clinic 4 - Transfer from a Hospital (Different Facility) 5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 - Transfer from Another Healthcare Facility 7 - Emergency Room 8 - Court/Law Enforcement 9 - Information Not Available B - Transfer from Another Healthcare Facility C - Readmission to the same Home Health Agency D - Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E - Transfer from Ambulatory Surgery Center F - Transfer from Hospice and is under a hospice plan of care or enrolled in a hospice program
16	Discharge Hour	Required (if applicable)	Military Standard Time (00-23)	Enter the discharge hour. For Inpatient only.
17	Patient Status	Required		Enter Patient Discharge Status
18-28	Condition Codes If Applicable Type of Admission	Required (if applicable)		
29	Accident State	Optional	2-digit abbreviation	If visit or stay is related to an accident, enter in which state accident occurred.
30	Not Used	DO NOT USE		
31-34	Occurrence Codes and Dates	Required (if applicable)	MMDDYYYY	Enter the codes and associated dates that define the significant even related to the claim. Occurrence Codes covered by SFHP: 01 - Auto Accident 02 - No Fault Insurance Involvement - Including Auto Accident/Other 03 - Accident/Tort Liability 04 - Employment Related 05 - Other Accident 06 - Crime Victim
35-36	Occurrence Span Codes and Dates	Required (if applicable)	MMDDYYYY	Enter Occurrence Span Codes and Dates
37	Not Used	DO NOT USE		

38	Responsible Party Name and Address	Required (if applicable)		Enter the name and address of the party responsible for payment if different from name in box 50
39-41	Value Codes and Amounts	Required (if applicable)		Enter Value Codes and Amounts
42	Revenue Code	Required	4-digit code	Enter the four-digit revenue code for the services provided, e.g. room and board, obstetrics, etc.
43	Revenue Description	Required (if applicable)		Identify the description of the particular revenue code in box 42 or HCPCS code in box 44. Include NDC/UPN Codes here, when applicable.
44	CPT/HCPCS only	Required (if applicable)		Enter the applicable HCPCS codes and modifiers. For outpatient billing do not bill a combination of HCPCS and Revenue codes on the same claim form. When billing for professional services, use CMS 1500 form.
45	Service Dates	Required	MMDDYYYY	Enter the service date in MMDDYY format for outpatient billing.
46	Units of Service	Required		Enter the actual number of times a single procedure or item was performed or provided for the date of service.
47	Total Charges	Required		Enter Total Charges (By Rev. Code)
48	Non-covered Charges	Optional		Enter Non-Covered Charges
n/a	Creation Date	Required		
n/a	Totals	Required		
49	Not Used	DO NOT USE		
50a-c	Payer Name	Required		
51a-c	National Health Plan Identifier	Optional		Enter Health Plan ID
52a-c	Release of Information Certification Indicator	Required		Check Yes or No
53a-c	Assignment of Benefits Certification Indicator	Required		Check Yes or No
54a-c	Prior Payments	Optional		Enter any prior payments received from Other Coverage in full dollar amount.
55a-c	Estimated Amount	Optional		Enter Estimated Amount Due
56	National Provider ID (NPI)	Required	10-digit number	Enter NPI number
57a-c	Other Provider ID	Optional	10-digit number	Enter Other Provider IDs

58a-c	Insured's Name	Required		Enter the mother's name if billing for an infant using the mother's ID. If any other circumstance, leave blank.
59a-c	Patient's Relationship to Insured	Required		Enter "03" (child) if billing for an infant using the mother's Identification Number
60a-c	Insured's Unique ID	Required	9-digit character 9-digit number	Enter the patient's 11-digit CCA ID number as it appears in the member's ID card.
61a-c	Insurance Group Name	Optional		Enter Insured Group Name
62a-c	Insurance Group Number	Optional		Enter Insured Group Number
63a-c	Treatment Authorization Code	Optional		Enter any authorizations numbers in this section. It is not necessary to attach a copy of the authorization to the claim. Member information from the authorization must match the claim.
64	Document Control Number (DCN)	Required for correction or voiding of a claim only		When the Type of Bill in box 4 ends in a 7 or an 8 enter the Claim ID number of the claim you are requesting to correct or void. This can be found on your Remittance Advice
65	Employer Name	Optional		Enter Employer Name
66	Diagnosis and Procedure Code Qualifier ICD Indicator:	Required	9-digit number OR 10 digit AN	Enter: 9—ICD-9-CM Diagnosis 0—ICD-10-CM Diagnosis
67	Principle Diagnosis Code	Required	10 digit AN	Enter all letters and/or numbers of the ICD-9 CM code for the primary diagnosis including the fourth and fifth digit if present
67A-Q	Other Diagnosis Code (including POA Codes)	Required (if applicable)	10 digit AN	Enter all letters and/or numbers of the secondary ICD-9 CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
68	Not Used	DO NOT USE		
69	Admitting Diagnosis	Required (if applicable)	10 digit AN	Enter Admitting Diagnosis Code
70A-C	Patient's Reason for Visit	Required (if applicable)	10 digit AN	Enter Patient's Reason for Visit Code
71	Prospective Payment System (PPS) Code	Optional		Enter PPS Code
72	External Cause of Injury (ECI) Code	Optional	10 digit AN	Enter External Cause of Injury Code
73	Not Used	DO NOT USE		
74	Principle Procedure Codes and Date	Required (if applicable)	MMDDYYYY	Enter Principal Procedure Code/Date

74a-e	Other Procedure Codes and Dates	Required (if applicable)	MMDDYYYY	Enter Other Procedure Code/Date
75	Not Used	DO NOT USE		
76	Attending Provider Name and Identifiers (including NPI)	Required (if applicable)	10-digit number	Enter Attending Name/ ID-Qualifier 1G
77	Operating Provider Name and Identifiers (including NPI)	Required (if applicable)	10-digit number	Enter Operating ID
78-79	Other Provider Name and Identifiers (including NPI)	Required (if applicable)	10-digit number	Enter Other ID
80	Remarks	Optional		Enter Remarks
81a-d	Code to Code Field	Optional		Enter Code-Code Field/Qualifiers