TrailBlazer Health Enterprises
UB-04 Rural Health Clinic
Billing Examples

Published September 2012

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On-Site Billing Example

1	2	3a PAT. CNTL #	Required	4 TYPE OF BILL
Provider Name	Pay-to Name	b. MED. REC. #	Recommended	0711
Street Address	Street Address or Post Office Box	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
City, State, ZIP Code	City, State, ZIP Code	XX-XXXXXXXX	MMDDYY	MMDDYY
Telephone; Fax; Country Code				

8 PATIENT NAME	9 PATIENT ADDRESS					
a	a	Street Address or Post Office Box				
b Patient Last, First, Middle Initial	b City	c State	d ZIP Code	e Country Code		

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

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521			MMDDYY	1	55 45			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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	55 45			23

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

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Beneficiary Last, First Name	XX	XXXXXXXXXX		A
B					B
C					C

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

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

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

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

80 REMARKS	81 CC					
	a				78 OTHER	NPI QUAL
	b				LAST	FIRST
	c				79 OTHER	NPI QUAL
	d				LAST	FIRST

Off-Site Billing Example

1	2	3a PAT. CNTL #	Required	4 TYPE OF BILL
Provider Name	Pay-to Name	b. MED. REC. #	Recommended	0711
Street Address	Street Address or Post Office Box	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH
City, State, ZIP Code	City, State, ZIP Code	XX-XXXXXXXX	MMDDYY	MMDDYY
Telephone; Fax; Country Code				

8 PATIENT NAME		9 PATIENT ADDRESS		
b	Patient Last, First, Middle Initial	b City	c State	d ZIP Code	e Country Code
		a	Street Address or Post Office Box	

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

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0528			MMDDYY	1	65 50			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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	65 50			23

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

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Beneficiary Last, First Name	XX	XXXXXXXXXX		
B				
C				

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

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

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
	a				LAST	FIRST		
	b				79 OTHER	NPI	QUAL	
	c				LAST	FIRST		
	d							

Home Visit Billing Example

1	2	3a PAT. CNTL #	Required	4 TYPE OF BILL
Provider Name	Pay-to Name	b. MED. REC. #	Recommended	0711
Street Address	Street Address or Post Office Box	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH
City, State, ZIP Code	City, State, ZIP Code	XX-XXXXXXXX	MMDDYY	MMDDYY
Telephone; Fax; Country Code				

8 PATIENT NAME	9 PATIENT ADDRESS				
Patient Last, First, Middle Initial	Street Address or Post Office Box	City	State	ZIP Code	Country Code

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
MMDDCCYY	X			X			XX			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0522			MMDDYY	1	65 50		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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	65 50		23

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

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Beneficiary Last, First Name	XX	XXXXXXXXXX		A
B					B
C					C

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

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

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
	a							
	b				LAST		FIRST	
	c				79 OTHER	NPI	QUAL	
	d				LAST		FIRST	

Skilled Nursing Facility (SNF) Covered Stay Billing Example

1	2	3a PAT. CNTL #	Required	4 TYPE OF BILL
Provider Name	Pay-to Name	b. MED. REC. #	Recommended	0711
Street Address	Street Address or Post Office Box	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH
City, State, ZIP Code	City, State, ZIP Code	XX-XXXXXXXX	MMDDYY	MMDDYY
Telephone; Fax; Country Code				

8 PATIENT NAME	9 PATIENT ADDRESS				
Patient Last, First, Middle Initial	Street Address or Post Office Box	City	State	ZIP Code	Country Code

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

	31 OCCURRENCE CODE	31 DATE	32 OCCURRENCE CODE	32 DATE	33 OCCURRENCE CODE	33 DATE	34 OCCURRENCE CODE	34 DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0524			MMDDYY	1	85 50		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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	85 50		23

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

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Beneficiary Last, First Name	XX	XXXXXXXXXX		A
B					B
C					C

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

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

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

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

76 ATTENDING	NPI	XXXXXXXXXX	QUAL	
LAST	Last Name	FIRST	First Name	
77 OPERATING	NPI		QUAL	
LAST		FIRST		
78 OTHER	NPI		QUAL	
LAST		FIRST		
79 OTHER	NPI		QUAL	
LAST		FIRST		

80 REMARKS	81 CC			
	a			
	b			
	c			
	d			

SNF Non-Covered Stay Billing Example

1	2	3a PAT. CNTL # / b. MED. REC. #	4 TYPE OF BILL
Provider Name	Pay-to Name	Required	
Street Address	Street Address or Post Office Box	Recommended	0711
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM / THROUGH; 7
Telephone; Fax; Country Code		XX-XXXXXXXX	MMDDYY / MMDDYY

8 PATIENT NAME	9 PATIENT ADDRESS
a	a Street Address or Post Office Box
b Patient Last, First, Middle Initial	b City; c State; d ZIP Code; e Country Code

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
MMDDCCYY	X			X			XX			

31 OCCURRENCE CODE DATE; 32 OCCURRENCE CODE DATE; 33 OCCURRENCE CODE DATE; 34 OCCURRENCE CODE DATE; 35 OCCURRENCE SPAN CODE FROM THROUGH; 36 OCCURRENCE SPAN CODE FROM THROUGH; 37

38; 39 VALUE CODES CODE AMOUNT; 40 VALUE CODES CODE AMOUNT; 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0525			MMDDYY	1	85 50		
0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	85 50		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicare		X				XXXXXXXXXX

57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Beneficiary Last, First Name	XX	XXXXXXXXXX		

63 TREATMENT AUTHORIZATION CODES; 64 DOCUMENT CONTROL NUMBER; 65 EMPLOYER NAME

66 DX: 9; 67: XXXXX X; A B C D E F G H; I J K L M N O P Q; 68

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

74 PRINCIPAL PROCEDURE CODE DATE; a. OTHER PROCEDURE CODE DATE; b. OTHER PROCEDURE CODE DATE; c. OTHER PROCEDURE CODE DATE; d. OTHER PROCEDURE CODE DATE; e. OTHER PROCEDURE CODE DATE; 75

76 ATTENDING NPI XXXXXXXXXX QUAL; LAST Last Name FIRST First Name

77 OPERATING NPI QUAL; LAST FIRST

78 OTHER NPI QUAL; LAST FIRST

79 OTHER NPI QUAL; LAST FIRST

80 REMARKS; 81 CC a b c d

Psychiatric Billing Example

1 Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code	2 Pay-to Name Street Address or Post Office Box City, State, ZIP Code	3a PAT. CNTL # Required b. MED. REC. # Recommended	4 TYPE OF BILL 0711
5 FED. TAX NO. SubID: XX-XXXXXXXX	6 STATEMENT COVERS PERIOD FROM: MMDDYY	THROUGH: MMDDYY	7

8 PATIENT NAME a / b Patient Last, First, Middle Initial

9 PATIENT ADDRESS a Street Address or Post Office Box; b City; c State; d ZIP Code; e Country Code

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
MMDDCCYY	X			X			XX			

31 OCCURRENCE CODE DATE · 32 OCCURRENCE CODE DATE · 33 OCCURRENCE CODE DATE · 34 OCCURRENCE CODE DATE · 35 OCCURRENCE SPAN CODE FROM THROUGH · 36 OCCURRENCE SPAN CODE FROM THROUGH · 37

38 · 39 VALUE CODES CODE AMOUNT · 40 VALUE CODES CODE AMOUNT · 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 090X			MMDDYY	1	120 75		
23 0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	120 75		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicare		X				XXXXXXXXXX

57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Beneficiary Last, First Name	XX	XXXXXXXXXX		

63 TREATMENT AUTHORIZATION CODES · 64 DOCUMENT CONTROL NUMBER · 65 EMPLOYER NAME

66 DX 9: XXXXX X · 67 A–Q · 68

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

74 PRINCIPAL PROCEDURE CODE DATE · a. OTHER PROCEDURE CODE DATE · b. OTHER PROCEDURE CODE DATE · c. OTHER PROCEDURE CODE DATE · d. OTHER PROCEDURE CODE DATE · e. OTHER PROCEDURE CODE DATE · 75

76 ATTENDING NPI XXXXXXXXXX QUAL · LAST Last Name · FIRST First Name

77 OPERATING NPI QUAL · LAST · FIRST

78 OTHER NPI QUAL · LAST · FIRST

79 OTHER NPI QUAL · LAST · FIRST

80 REMARKS · 81 CC a b c d

Two Visits (Same Day) Billing Example

1 Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code	2 Pay-to Name Street Address or Post Office Box City, State, ZIP Code	3a PAT. CNTL #	Required	4 TYPE OF BILL 0711
		b. MED. REC. #	Recommended	
		5 FED. TAX NO. SubID XX-XXXXXXXX	6 STATEMENT COVERS PERIOD FROM MMDDYY	THROUGH MMDDYY

8 PATIENT NAME	9 PATIENT ADDRESS							
b Patient Last, First, Middle Initial	b City	c State	d ZIP Code	e Country Code				
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
MMDDCCYY	X			X			XX	

19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	052X			MMDDYY	2	168 75		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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	168 75		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
A	Medicare		X				XXXXXXXXXX	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	Beneficiary Last, First Name	XX	XXXXXXXXXX		A
B					B
C					C

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

66 DX												68
	XXXXX X	XXXXX X	B	C	D	E	F	G	H			
9	I	J	K	L	M	N	O	P	Q			

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
First visit was for diagnosis (define condition).	a				LAST	FIRST		
Second visit was for diagnosis (define condition).	b				79 OTHER	NPI	QUAL	
Two visits, same day, not related.	c				LAST	FIRST		
	d							

Medicare Secondary Payer (MSP) Conditional Billing Example

1 Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code	2 Pay-to Name Street Address or Post Office Box City, State, ZIP Code	3a PAT. CNTL # b. MED. REC. #	Required Recommended	4 TYPE OF BILL 0711
		5 FED. TAX NO. SubID XX-XXXXXXXX	6 STATEMENT COVERS PERIOD FROM MMDDYY	THROUGH MMDDYY

8 PATIENT NAME	9 PATIENT ADDRESS							
a	a Street Address or Post Office Box							
b Patient Last, First, Middle Initial	b City	c State	d ZIP Code	e Country Code				

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

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a 24	MMDDYY														a
b															b

38	39 VALUE CODES CODE	AMOUNT		40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
	a XX	00	00					
	b							
	c							
	d							

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0521			MMDDYY	1	120	00				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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	120	00				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX	
A	"C" Primary Insurance	XXXXXXXXXX	X				57		A
B	Medicare						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	Beneficiary Last, First Name	XX	XXXXXXXXXX	Insurance Name	Insurance Group Number
B	Beneficiary Last, First Name	XX	XXXXXXXXXX		
C					

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

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

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
Enter comment on why primary insurance did not	a				LAST	FIRST		
pay. Use occurrence code 24 and date of denial.	b				79 OTHER	NPI	QUAL	
	c				LAST	FIRST		
	d							

MSP Liability Conditional Billing Example

Field	Entry
1	Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code
2	Pay-to Name Street Address or Post Office Box City, State, ZIP Code
3a PAT. CNTL #	Required
b. MED. REC. #	Recommended
4 TYPE OF BILL	0711
5 FED. TAX NO.	SubID XX-XXXXXXX
6 STATEMENT COVERS PERIOD FROM / THROUGH	MMDDYY / MMDDYY
8 PATIENT NAME b	Patient Last, First, Middle Initial
9 PATIENT ADDRESS a	Street Address or Post Office Box
9 b / c / d / e	City / State / ZIP Code / Country Code
10 BIRTHDATE	MMDDCCYY
11 SEX	X
14 TYPE	X
17 STAT	XX
31 OCCURRENCE CODE / DATE (a)	24 / MMDDYY
39 VALUE CODES CODE / AMOUNT (a)	XX / 00 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0521			MMDDYY	1	120 00	
0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	120 00	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	56 NPI
A	"C" Primary Insurance	XXXXXXXXXX	X	XXXXXXXXXX
B	Medicare			

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Beneficiary Last, First Name	XX	XXXXXXXXXX	Insurance Name	Insurance Group Number
B	Beneficiary Last, First Name	XX	XXXXXXXXXX		

Field	Entry
65 EMPLOYER NAME	Employer Name
66 DX	9
67	XXXXX X
76 ATTENDING NPI	XXXXXXXXXX
76 LAST / FIRST	Last Name / First Name
80 REMARKS	Forgoing lien; please pay conditionally.

MSP Primary Paid Billing Example

1 Provider Name	2 Pay-to Name	3a PAT. CNTL #	Required	4 TYPE OF BILL
Street Address	Street Address or Post Office Box	b. MED. REC. #	Recommended	0711
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH
Telephone; Fax; Country Code		XX-XXXXXXXX	MMDDYY	MMDDYY

8 PATIENT NAME		9 PATIENT ADDRESS		
b	Patient Last, First, Middle Initial	b City	c State	d ZIP Code e Country Code

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

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															
b															

38		39 VALUE CODES CODE	AMOUNT		40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	XX	25	00				
	b							
	c							
	d							

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0521			MMDDYY	1	120 00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	120 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX
A	"X" Primary Insurance	XXXXXXXXXX	X				57	
B	Medicare						OTHER	
C							PRV ID	

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Beneficiary Last, First Name	XX	XXXXXXXXXX	Insurance Name	Insurance Group Number
B	Beneficiary Last, First Name	XX	XXXXXXXXXX		
C					

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

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

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
Primary paid $25.	a				LAST	FIRST		
	b				79 OTHER	NPI	QUAL	
	c				LAST	FIRST		
	d							

Initial Preventive Physical Examination (IPPE) and Clinic Visit (Same Day) Billing Example

1 Provider Name	2 Pay-to Name	3a PAT. CNTL #	Required	4 TYPE OF BILL
Street Address	Street Address or Post Office Box	b. MED. REC. #	Recommended	0711
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
Telephone; Fax; Country Code		XX-XXXXXXXX	MMDDYY	MMDDYY

8 PATIENT NAME	9 PATIENT ADDRESS							
a	a Street Address or Post Office Box							
b Patient Last, First, Middle Initial	b City	c State	d ZIP Code	e Country Code				

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

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	052X	Clinic Visit		MMDDYY	1	75 00		1
2	052X	IPPE	G0402	MMDDYY	1	50 25		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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	125	25	23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
A	Medicare		X				XXXXXXXXXX	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	Beneficiary Last, First Name	XX	XXXXXXXXXX		A
B					B
C					C

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

66 DX												68
	XXXXX X	XXXXX X	B	C	D	E	F	G	H			
9	I	J	K	L	M	N	O	P	Q			

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
	a							
	b				LAST	FIRST		
	c				79 OTHER	NPI	QUAL	
	d				LAST	FIRST		

IPPE Billing Example

1 Provider Name	2 Pay-to Name	3a PAT. CNTL #	Required	4 TYPE OF BILL
Street Address	Street Address or Post Office Box	b. MED. REC. #	Recommended	0711
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
Telephone; Fax; Country Code		XX-XXXXXXXX	MMDDYY	MMDDYY

8 PATIENT NAME		9 PATIENT ADDRESS		
b Patient Last, First, Middle Initial		b City	c State	d ZIP Code e Country Code

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

	31 OCCURRENCE CODE	31 DATE	32 OCCURRENCE CODE	32 DATE	33 OCCURRENCE CODE	33 DATE	34 OCCURRENCE CODE	34 DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

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 / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	052X	IPPE	G0402	MMDDYY	1	50	25		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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS →	50	25		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX	
A	Medicare		X				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	Beneficiary Last, First Name	XX	XXXXXXXXXX			A
B						B
C						C

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

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

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

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

80 REMARKS	81 CC				78 OTHER	NPI	QUAL	
	a							
	b				LAST	FIRST		
	c				79 OTHER	NPI	QUAL	
	d				LAST	FIRST		

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) and Clinic Visit (Same Day) Billing Example

1 Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code

2 Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code

3a PAT. CNTL # Required
b. MED. REC. # Recommended

4 TYPE OF BILL 0711

5 FED. TAX NO. SubID XX-XXXXXXXX

6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY

7

8 PATIENT NAME a
b Patient Last, First, Middle Initial

9 PATIENT ADDRESS a Street Address or Post Office Box
b City c State d ZIP Code e Country Code

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

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	052X	Clinic Visit		MMDDYY	1	75 00			1
2	052X	AAA	G0389	MMDDYY	1	50 25			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	0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	125 25			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A Medicare		X			
B					
C					

56 NPI XXXXXXXXXX
57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Beneficiary Last, First Name	XX	XXXXXXXXXX		
B				
C				

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9
67 XXXXX X XXXXX X B C D E F G H
I J K L M N O P Q
68

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

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI XXXXXXXXXX QUAL
LAST Last Name FIRST First Name
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

Ultrasound Screening for AAA Billing Example

1	2	3a PAT. CNTL # / b. MED. REC. #	4 TYPE OF BILL
Provider Name	Pay-to Name	3a PAT. CNTL #: Required	
Street Address	Street Address or Post Office Box	b. MED. REC. #: Recommended	0711
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO.: SubID	6 STATEMENT COVERS PERIOD FROM / THROUGH; 7
Telephone; Fax; Country Code		XX-XXXXXXX	MMDDYY / MMDDYY

8 PATIENT NAME	9 PATIENT ADDRESS
a	a Street Address or Post Office Box
b Patient Last, First, Middle Initial	b City; c State; d ZIP Code; e Country Code

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
MMDDCCYY	X			X			XX			

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
052X	AAA	G0389	MMDDYY	1	50 25		
0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	50 25		

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

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Beneficiary Last, First Name	XX	XXXXXXXXXX		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

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

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

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI XXXXXXXXXX	QUAL	
LAST Last Name		FIRST First Name	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS | 81 CC a b c d

Telehealth Originating Site Billing Example

Field	Entry
1	Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code
2	Pay-to Name Street Address or Post Office Box City, State, ZIP Code
3a PAT. CNTL #	Required
b. MED. REC. #	Recommended
4 TYPE OF BILL	0711
5 FED. TAX NO.	SubID XX-XXXXXXXX
6 STATEMENT COVERS PERIOD FROM	MMDDYY
THROUGH	MMDDYY
7	
8 PATIENT NAME a	
b	Patient Last, First, Middle Initial
9 PATIENT ADDRESS a	Street Address or Post Office Box
b	City
c	State
d	ZIP Code
e	Country Code
10 BIRTHDATE	MMDDCCYY
11 SEX	X
ADMISSION 12 DATE	
13 HR	
14 TYPE	X
15 SRC	
16 DHR	
17 STAT	XX
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0780	Originating Site	Q3014	MMDDYY	1	30 00		
23 0001	*PAGE* 1 *OF* 1		*CREATION DATE* MMDDYY	*TOTALS*	30 00		

Field	Entry
50 PAYER NAME	A Medicare
51 HEALTH PLAN ID	
52 REL INFO	X
53 ASG BEN	
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56 NPI	XXXXXXXXXX
57 OTHER PRV ID	
58 INSURED'S NAME	A Beneficiary Last, First Name
59 P.REL	XX
60 INSURED'S UNIQUE ID	XXXXXXXXXX
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	9
67	XXXXX X
67 A–Q	
68	
69 ADMIT DX	
70 PATIENT REASON DX a, b, c	
71 PPS CODE	
72 ECI a, b, c	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
OTHER PROCEDURE a–e CODE / DATE	
75	
76 ATTENDING NPI	XXXXXXXXXX
QUAL	
LAST	Last Name
FIRST	First Name
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

Telehealth Originating Site and Clinic Visit Billing Example

Field	Value
1	Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code
2	Pay-to Name Street Address or Post Office Box City, State, ZIP Code
3a PAT. CNTL #	Required
b. MED. REC. #	Recommended
4 TYPE OF BILL	0711
5 FED. TAX NO. SubID	XX-XXXXXXXX
6 STATEMENT COVERS PERIOD FROM	MMDDYY
THROUGH	MMDDYY
8 PATIENT NAME b	Patient Last, First, Middle Initial
9 PATIENT ADDRESS a	Street Address or Post Office Box
b	City
c	State
d	ZIP Code
e	Country Code
10 BIRTHDATE	MMDDCCYY
11 SEX	X
14 TYPE	X
17 STAT	XX

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
052X	Clinic Visit		MMDDYY	1	75 00		
0780	Originating Site	Q3014	MMDDYY	1	30 0		
0001	PAGE 1 OF 1	CREATION DATE	MMDDYY	TOTALS	105 00		

Field	Value
50 PAYER NAME	Medicare
52 REL INFO	X
56 NPI	XXXXXXXXXX
58 INSURED'S NAME	Beneficiary Last, First Name
59 P.REL	XX
60 INSURED'S UNIQUE ID	XXXXXXXXXX
66 DX	9
67	XXXXX X
A	XXXXX X
76 ATTENDING NPI	XXXXXXXXXX
LAST	Last Name
FIRST	First Name