

TrailBlazer Health Enterprises UB-04 Rural Health Clinic Billing Examples



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On-Site Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 0521	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 55		48 NON-COVERED CHARGES 45					
23 0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		55 45	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		X A J		B K		C L	
D M		E N		F O		G P	
H Q		67 70 PATIENT REASON DX a b c		71 PPS CODE a b c		72 ECI a b c	
73 74 PRINCIPAL PROCEDURE CODE DATE a		OTHER PROCEDURE CODE DATE b		OTHER PROCEDURE CODE DATE c		75 ATTENDING NPI XXXXXXXXXXXX LAST First Name LAST First Name	
OTHER PROCEDURE CODE DATE d		OTHER PROCEDURE CODE DATE e		OTHER PROCEDURE CODE DATE f		76 OPERATING NPI LAST First Name LAST First Name	
80 REMARKS		81 CC a b c d		78 OTHER NPI LAST First Name LAST First Name		79 OTHER NPI LAST First Name LAST First Name	

Off-Site Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 VALUE CODES CODE AMOUNT a b c d	
42 REV. CD. 0528		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 65		48 NON-COVERED CHARGES 50		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 65 50	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		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		75		76 ATTENDING NPI XXXXXXXXXXXX LAST First Name 77 OPERATING NPI LAST First Name 78 OTHER NPI LAST First Name 79 OTHER NPI LAST First Name	
80 REMARKS		81 CC a b c d		82		83	

Skilled Nursing Facility (SNF) Covered Stay Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		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-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
19 20 21 22 23 24 25 26 27 28		29 ACDT STATE 30					
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 0524	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 85		48 NON-COVERED CHARGES 50					
49							
23 0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		85 50	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX 9		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		75 ATTENDING NPI XXXXXXXXXXXX LAST Last Name FIRST First Name	
OTHER PROCEDURE CODE DATE d		OTHER PROCEDURE CODE DATE e		OTHER PROCEDURE CODE DATE f		76 OPERATING NPI LAST Last Name FIRST First Name	
77 OTHER NPI LAST Last Name FIRST First Name		78 OTHER NPI LAST Last Name FIRST First Name		79 OTHER NPI LAST Last Name FIRST First Name		80 REMARKS 81 CC a b c d	

SNF Non-Covered Stay Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		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-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN CODE FROM THROUGH X		36 OCCURRENCE SPAN CODE FROM THROUGH X		37 OCCURRENCE SPAN CODE FROM THROUGH X		38 OCCURRENCE SPAN CODE FROM THROUGH X	
39 VALUE CODES CODE AMOUNT X		40 VALUE CODES CODE AMOUNT X		41 VALUE CODES CODE AMOUNT X		42 VALUE CODES CODE AMOUNT X	
43 DESCRIPTION 0525		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 85		48 NON-COVERED CHARGES 50					
0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		85 50	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		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	
74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE		b OTHER PROCEDURE CODE DATE		75 ATTENDING NPI XXXXXXXXXXXX	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST Last Name FIRST First Name	
76 ATTENDING NPI XXXXXXXXXXXX		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
80 REMARKS		81 CC a b c d		LAST FIRST		LAST FIRST	

Psychiatric Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code										Pay-to Name Street Address or Post Office Box City, State, ZIP Code										Ba PAT. CNTL # b. MED. REC. # Required Recommended 5 FED. TAX NO. SubID XX-XXXXXXX					4 TYPE OF BILL 0711 6 STATEMENT COVERS PERIOD FROM THROUGH 7 MMDDYY MMDDYY																																							
8 PATIENT NAME a										9 PATIENT ADDRESS 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 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT MMDDCCYY X										ADMISSION 18 19 20 21 22 23 24 25 26 27 28 29 ACDT 30 STATE 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																			
090X																									MMDDYY					1					120					75																								
23 0001										PAGE 1 OF 1										CREATION DATE					MMDDYY					TOTALS					120					75																								
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																								
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										X										A					B					C					D					E					F					G					H					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					75					76 ATTENDING NPI XXXXXXXXXX					QUAL																													
c OTHER PROCEDURE CODE DATE										d OTHER PROCEDURE CODE DATE										e OTHER PROCEDURE CODE DATE					LAST Last Name					FIRST First Name					QUAL																													
77 OPERATING NPI																				LAST					FIRST					QUAL																																		
78 OTHER NPI																				LAST					FIRST					QUAL																																		
79 OTHER NPI																				LAST					FIRST					QUAL																																		
80 REMARKS										81 CC a										b					c					d																																		

Two Visits (Same Day) Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		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-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN CODE FROM THROUGH X		36 OCCURRENCE SPAN CODE FROM THROUGH X		37 OCCURRENCE SPAN CODE FROM THROUGH X		38 OCCURRENCE SPAN CODE FROM THROUGH X	
39 VALUE CODES CODE AMOUNT X		40 VALUE CODES CODE AMOUNT X		41 VALUE CODES CODE AMOUNT X		42 VALUE CODES CODE AMOUNT X	
43 DESCRIPTION 052X		44 HCPCS / RATE / HIPPS CODE 052X		45 SERV. DATE MMDDYY		46 SERV. UNITS 2	
47 TOTAL CHARGES 168		48 NON-COVERED CHARGES 75					
23 0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS 168 75			
50 PAYER NAME Medicare		51 HEALTH PLAN ID X		52 REL INFO X		53 ASG BEN X	
54 PRIOR PAYMENTS X		55 EST. AMOUNT DUE X		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID X	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME X	
62 INSURANCE GROUP NO. X		63 TREATMENT AUTHORIZATION CODES X		64 DOCUMENT CONTROL NUMBER X		65 EMPLOYER NAME X	
66 DX 9		X		X		X	
69 ADMIT DX 9		70 PATIENT REASON DX a		71 PPS CODE b		72 ECI c	
74 PRINCIPAL PROCEDURE CODE DATE X		OTHER PROCEDURE CODE DATE X		OTHER PROCEDURE CODE DATE X		75 ATTENDING NPI XXXXXXXXXXXX	
OTHER PROCEDURE CODE DATE X		OTHER PROCEDURE CODE DATE X		OTHER PROCEDURE CODE DATE X		LAST Last Name FIRST First Name	
80 REMARKS First visit was for diagnosis (define condition).		81 CC a		b		77 OPERATING NPI X	
Second visit was for diagnosis (define condition).		c		d		LAST Last Name FIRST First Name	
Two visits, same day, not related.		78 OTHER NPI X		79 OTHER NPI X		LAST Last Name FIRST First Name	

Medicare Secondary Payer (MSP) Conditional Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		17 STAT XX			
31 OCCURRENCE CODE DATE 24 MMDDYY		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN CODE FROM THROUGH MMDDYY		36 OCCURRENCE SPAN CODE FROM THROUGH MMDDYY		37 OCCURRENCE SPAN CODE FROM THROUGH MMDDYY			
39 VALUE CODES CODE AMOUNT a XX 00 00		40 VALUE CODES CODE AMOUNT b		41 VALUE CODES CODE AMOUNT c		d	
42 REV. CD. 0521		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 120		48 NON-COVERED CHARGES 00		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 120 00	
50 PAYER NAME "C" Primary Insurance Medicare		51 HEALTH PLAN ID XXXXXXXXXXXX		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name Beneficiary Last, First Name		59 P.REL. XX XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX XXXXXXXXXXXX		61 GROUP NAME Insurance Name	
62 INSURANCE GROUP NO. Insurance Group Number		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Employer Name	
66 DX 9		X A J		B K		C L	
67 D M		E N		F O		G P	
68 H Q		I R		J S		K T	
69 ADMIT DX DX		70 PATIENT REASON DX a b c		71 PPS CODE		72 ECI a b c	
73		74 PRINCIPAL PROCEDURE CODE DATE a		75 OTHER PROCEDURE CODE DATE b		76 ATTENDING NPI XXXXXXXXXXXX	
77 OPERATING NPI LAST FIRST		78 OTHER NPI LAST FIRST		79 OTHER NPI LAST FIRST		80 REMARKS Enter comment on why primary insurance did not pay. Use occurrence code 24 and date of denial.	
81 CC a b c d		82 a b c d		83 a b c d		84 a b c d	

MSP Primary Paid Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		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	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a XX 25 b c d		40 VALUE CODES CODE AMOUNT a 00 b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 0521	
43 DESCRIPTION PAGE 1 OF 1		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 120		48 NON-COVERED CHARGES 00		49		50 PAYER NAME "X" Primary Insurance Medicare	
51 HEALTH PLAN ID XXXXXXXXXXXX		52 REL INFO X		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE 120		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID		58 INSURED'S NAME Beneficiary Last, First Name Beneficiary Last, First Name	
59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME Insurance Name		62 INSURANCE GROUP NO. Insurance Group Number	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Employer Name		66 DX 9	
67 A B C D E F G H I J K L M N O P Q		68		69 ADMIT DX a b c		70 PATIENT REASON DX a b c	
71 PPS CODE a b c		72 ECI a b c		73		74 PRINCIPAL PROCEDURE CODE DATE OTHER PROCEDURE CODE DATE	
75		76 ATTENDING LAST Last Name FIRST First Name		77 OPERATING LAST FIRST		78 OTHER LAST FIRST	
79 OTHER LAST FIRST		80 REMARKS Primary paid \$25.		81 CC a b c d		82 a b c d	

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

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711		
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY						
8 PATIENT NAME a		9 PATIENT ADDRESS 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 MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX		14 TYPE 15 SRC
16 DHR XX		17 STAT XX		18 CONDITION CODES XX		19 THROUGH XX		20 THROUGH XX
31 OCCURRENCE CODE DATE XX		32 OCCURRENCE CODE DATE XX		33 OCCURRENCE CODE DATE XX		34 OCCURRENCE CODE DATE XX		35 OCCURRENCE SPAN FROM THROUGH XX
36 OCCURRENCE SPAN FROM THROUGH XX		37 OCCURRENCE SPAN FROM THROUGH XX						
38 VALUE CODES CODE AMOUNT a b c d		39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d		42 VALUE CODES CODE AMOUNT a b c d
42 REV. CD. 052X		43 DESCRIPTION Clinic Visit		44 HCPCS / RATE / HIPPS CODE G0402		45 SERV. DATE MMDDYY		46 SERV. UNITS 1
47 TOTAL CHARGES 75.00		48 NON-COVERED CHARGES 50.25						
49		50		51		52		53
54		55		56		57		58
59		60		61		62		63
64		65		66		67		68
69		70		71		72		73
74		75		76		77		78
79		80		81		82		83
84		85		86		87		88
89		90		91		92		93
94		95		96		97		98
99		100		101		102		103
104		105		106		107		108
109		110		111		112		113
114		115		116		117		118
119		120		121		122		123
124		125		126		127		128
129		130		131		132		133
134		135		136		137		138
139		140		141		142		143
144		145		146		147		148
149		150		151		152		153
154		155		156		157		158
159		160		161		162		163
164		165		166		167		168
169		170		171		172		173
174		175		176		177		178
179		180		181		182		183
184		185		186		187		188
189		190		191		192		193
194		195		196		197		198
199		200		201		202		203
204		205		206		207		208
209		210		211		212		213
214		215		216		217		218
219		220		221		222		223
224		225		226		227		228
229		230		231		232		233
234		235		236		237		238
239		240		241		242		243
244		245		246		247		248
249		250		251		252		253
254		255		256		257		258
259		260		261		262		263
264		265		266		267		268
269		270		271		272		273
274		275		276		277		278
279		280		281		282		283
284		285		286		287		288
289		290		291		292		293
294		295		296		297		298
299		300		301		302		303
304		305		306		307		308
309		310		311		312		313
314		315		316		317		318
319		320		321		322		323
324		325		326		327		328
329		330		331		332		333
334		335		336		337		338
339		340		341		342		343
344		345		346		347		348
349		350		351		352		353
354		355		356		357		358
359		360		361		362		363
364		365		366		367		368
369		370		371		372		373
374		375		376		377		378
379		380		381		382		383
384		385		386		387		388
389		390		391		392		393
394		395		396		397		398
399		400		401		402		403
404		405		406		407		408
409		410		411		412		413
414		415		416		417		418
419		420		421		422		423
424		425		426		427		428
429		430		431		432		433
434		435		436		437		438
439		440		441		442		443
444		445		446		447		448
449		450		451		452		453
454		455		456		457		458
459		460		461		462		463
464		465		466		467		468
469		470		471		472		473
474		475		476		477		478
479		480		481		482		483
484		485		486		487		488
489		490		491		492		493
494		495		496		497		498
499		500		501		502		503
504		505		506		507		508
509		510		511		512		513
514		515		516		517		518
519		520		521		522		523
524		525		526		527		528
529		530		531		532		533
534		535		536		537		538
539		540		541		542		543
544		545		546		547		548
549		550		551		552		553
554		555		556		557		558
559		560		561		562		563
564		565		566		567		568
569		570		571		572		573
574		575		576		577		578
579		580		581		582		583
584		585		586		587		588
589		590		591		592		593
594		595		596		597		598
599		600		601		602		603
604		605		606		607		608
609		610		611		612		613
614		615		616		617		618
619		620		621		622		623
624		625		626		627		628
629		630		631		632		633
634		635		636		637		638
639		640		641		642		643
644		645		646		647		

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

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		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-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 052X	
43 DESCRIPTION Clinic Visit		44 HCPCS / RATE / HIPPS CODE G0389		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 75 00		48 NON-COVERED CHARGES 50 25					
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		00	
01		02		03		04	
05		06		07		08	
09		10		11		12	
13		14		15		16	
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49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
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89		90		91		92	
93		94		95		96	
97		98		99		00	
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05		06		07		08	
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57		58		59		60	
61		62		63		64	
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77		78		79		80	
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85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		00	
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05		06		07		08	
09		10		11		12	
13		14		15		16	
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49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
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89		90		91		92	
93		94		95		96	
97		98		99		00	
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05		06		07		08	
09		10		11		12	
13		14		15		16	
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37		38		39		40	
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45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
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85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		00	
01		02		03		04	
05		06		07		08	
09		10		11		12	
13		14		15		16	
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37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71			

Ultrasound Screening for AAA Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
				5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
8 PATIENT NAME		9 PATIENT ADDRESS		Street Address or Post Office Box			
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT	
30		31		32		33	
34		35		36		37	
38		39		40		41	
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			
2		3		4		5	
6		7		8		9	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	

Telehealth Originating Site Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
				5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
8 PATIENT NAME		9 PATIENT ADDRESS		Street Address or Post Office Box			
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
0780		Originating Site		Q3014		MMDDYY	
1		2		3		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

Telehealth Originating Site and Clinic Visit Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT X		40 VALUE CODES CODE AMOUNT X		41 VALUE CODES CODE AMOUNT X		42 VALUE CODES CODE AMOUNT X	
43 DESCRIPTION Clinic Visit Originating Site		44 HCPCS / RATE / HIPPS CODE Q3014		45 SERV. DATE MMDDYY MMDDYY		46 SERV. UNITS 1 1	
47 TOTAL CHARGES 75:00 30:00		48 NON-COVERED CHARGES 00 00		49 00 00		50 PAYER NAME Medicare	
51 HEALTH PLAN ID X		52 REL INFO X		53 ASG BEN X		54 PRIOR PAYMENTS X	
55 EST. AMOUNT DUE 105:00		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID XXXXXXXXXXXX		58 INSURED'S NAME Beneficiary Last, First Name	
59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME XXXXXXXXXXXX		62 INSURANCE GROUP NO. XXXXXXXXXXXX	
63 TREATMENT AUTHORIZATION CODES XXXXX X XXXXX X		64 DOCUMENT CONTROL NUMBER B C D E F G H		65 EMPLOYER NAME I J K L M N O P Q		66 DX 9	
69 ADMIT DX b		70 PATIENT REASON DX c		71 PPS CODE a b c		72 ECI a b c	
74 PRINCIPAL PROCEDURE CODE DATE a		OTHER PROCEDURE CODE DATE b		OTHER PROCEDURE CODE DATE c		75 ATTENDING Last Name First Name NPI XXXXXXXXXXXX	
OTHER PROCEDURE CODE DATE d		OTHER PROCEDURE CODE DATE e		OTHER PROCEDURE CODE DATE f		77 OPERATING Last Name First Name NPI	
80 REMARKS a b c d		81 CC a b c d		78 OTHER Last Name First Name NPI		79 OTHER Last Name First Name NPI	