CHILDREN WITH MEDICAL HANDICAPS

BILLING INSTRUCTIONS FOR THE NEW UB-04 CMS – 1450

FORM LOCATOR

1	UNLABELED FIELD
Line 1	Billing Provider Name
Line 2	Street Address
Line 3	City, State, Zip code
Line 4	Telephone Number: Not Required

2	UNLABELED FIELD
	Not Required

3a	PATIENT CONTROL NUMBER
	Enter the patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual case records. Up to 20 characters may be entered. The Patient Control Number will appear on the remittance advice for adjudicated claims.

3b	MEDICAL RECORD NUMBER
	Enter the number assigned to the patient's medical/health record by the provider.

4	TYPE OF BILL
	Enter the type of bill. Do include the leading zero.
	The following bill types are allowable for the CMH program:
0111	Hospital Inpatient admit through discharge
0112	Hospital Inpatient 1st interim bill
0113	Hospital Inpatient continuing interim bill
0114	Hospital Inpatient last interim bill
0115	Hospital Inpatient late charges
0131	Hospital Outpatient

5	FEDERAL TAX NUMBER
	Not Required

6	STATEMENT COVER PERIOD
FROM	Enter the beginning date of the period covered by this bill as month, day and year (MMDDYY)
THRU	Enter the ending date of the period covered by this bill as month, day and year (MMDDYY)

7	UNLABELED FIELD
	Leave Blank

8	PATIENT NAME
SubField a	Enter the patient's 12-digit CMH number
SubField b	Enter the patient's last name, first name and middle initial.

9	PATIENT ADDRESS
SubFields a-e	Not Required

10	PATIENT BIRTH DATE
	Enter the patient's birthdate as MMDDYYYY. Example: 07012007

11	PATIENT SEX
	Enter the sex of the patient. M = Male; F = Female; U = Unknown

12	ADMISSION/START OF CARE DATE
	Enter the start date for this episode of care. For inpatient services, this is the date of admission. For other services, it is the date the episode of care began.

13	ADMISSION HOUR
	Enter the appropriate two-digit code corresponding to the hour of admission.

14	TYPE
	Enter the appropriate one-digit code for type of admission.

15	SOURCE OF REFERRAL FOR ADMISSION OR VISIT
	Not Required

16	DISCHARGE HOUR
	Enter the appropriate two-digit code corresponding to the hour of discharge.

17	PATIENT DISCHARGE STATUS
	Enter the appropriate two-digit code for patient status upon discharge.

18 – 28	CONDITION CODES
	Enter the appropriate two-digit code. CMH collects only the first five conditions.

29	ACCIDENT STATE
	Not Required

30	UNLABELED FIELD
	Leave Blank

31-34	OCCURRENCE CODES AND DATES
	Enter the appropriate two-digit code when appropriate. NOTE: Fields 31a through 34a must be completed before the b fields. NOTE: Enter all dates as month, day, and year (MMDDYY). Example: 070107 NOTE: CMH collects only the first five conditions.

35-36	OCCURRENCE SPAN
	Not Required. Leave Blank

37	UNLABELED FIELD
	Leave Blank

38	RESPONSIBLE PARTY NAME AND ADDRESS
	Not Required. Leave Blank

39-41	VALUE CODES AND AMOUNTS
	When appropriate, enter the two-digit code and associated dollar amount. NOTE: Values must be entered into 39a through 41a before 39b through 41b, etc. CMH collects only the first eight conditions.

42	REVENUE CODE
	Enter the appropriate four-digit revenue center code in lines 1 through 22. Line 23 contains an incrementing page count and total number of pages for the claim, creation date of the claim and claim total for covered and non-covered charges. Enter claim totals on the final claim page indicated by using Revenue Code 0001 in column 42, line 23. All revenue center codes are to be entered in ascending numeric order. The exception is Revenue Code 0001 – total Charge, which is used on paper claims only and is reported on Line 23 of the last page of the claim.

43	REVENUE DESCRIPTION
	A revenue description is not required. However, if the revenue center code in Form Locator 42 indicates room and board charges, enter the daily rate in Form Locator 44 and the number of days in Form Locator 46.

44	HCPCS/RATE/HIPPS CODE
	Enter the daily rate if the revenue center codes in Form Locator 42 indicate room and board charges. Dollar values reported for room rates must include whole dollars, the decimal and the cents. Enter the appropriate HCPCS when one exists for this service line item. Include the modifier when appropriate when a modifier clarifies the HCPCS code used.

45	SERVICE DATE
	Required for each line item on an outpatient bill. Enter the six-digit date of service as (MMDDYY).

46	SERVICE UNITS
	Enter the number of units.

47	TOTAL CHARGE
	Enter the line charge for each revenue center code listed.

48	NON-COVERED CHARGES
	Not Required. Non-covered services are not to be billed to CMH.

49	UNLABELED FIELD
	Leave Blank

50	PAYER NAME
	Enter the appropriate payer codes and names. A = Primary Payer B = Secondary Payer C = Tertiary Payer

51	HEALTH PLAN ID
	Enter the number assigned to the provider by the payer indicated in Form Locator 50.

52	RELEASE OF INFORMATION CERTIFICATION INDICATOR
	Not Required

53	ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
	Not Required

54	PRIOR PAYMENTS – PAYER
	Enter the amount received from a health plan toward payment of the bill. Third-party payments received must be indicated in this Form Locator and should appear on the line Form Locator corresponding to the appropriate payer code in Form Locator 50 A, B, C.

55	EST. AMOUNT DUE
	Not Required

56	NPI (NATIONAL PROVIDER IDENTIFIER)
	Enter the National Provider Identifier assigned to the provider submitting the bill.

57	OTHER PROVIDER IDENTIFIER
	Enter the number assigned to the payer indicated in Form Locator 50 and should appear on the line Form Locator corresponding to the appropriate payer code in Form Locator 50 A,B,C. If this is the provider submitting the bill, enter the provider's Medicaid legacy number which corresponds to the provider's NPI number in Form Locator 56.

58	INSURED'S NAME
	Not Required

59	PATIENT'S RELATIONSHIP TO INSURED
	Not Required

60	INSURED'S UNIQUE IDENTIFIER
	Enter the 12-digit CMH Case Number. Numbers for other payers listed here must be listed in the same order in which the payers are indentified in Form Locator 50 A, B, C.

61	INSURED'S GROUP NAME
	Not Required

62	INSURED'S GROUP NUMBER
	Not Required

63	TREATMENT AUTHORIZATION CODE
	Not Required

64	DOCUMENT CONTROL NUMBER
	Not Required

65	EMPLOYER NAME
	Not Required

66	DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION INDICATOR)
	Not Required

67	PRINCIPAL DIAGNOSIS
	Enter the ICD-9-CM code for the principal diagnosis. Do not use decimal points.

67 A-Q	OTHER DIAGNOSIS CODES
	Enter the ICD-9-CM diagnoses codes corresponding to all conditions that coexist at the time of admission. Only 67A thru 67D will be collected.

68	UNLABELED
	Leave Blank

69	ADMITTING DIAGOSIS CODE
	Not Required

70	PATIENT'S REASON FOR VISIT
a – c	Not Required

71	PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
	Not Required

72	EXTERNAL CAUSE OF INJURY (ECI) CODE
a – c	Not Required
73	UNLABELED
	Leave Blank

74	PRINCIPAL PROCEDURE CODE AND DATE
	Enter the ICD-9-CM code identifying the principal procedure. Enter the date in the following format

	(MMDDYY).

74 a – e	OTHER PROCEDURE CODES AND DATES
	Enter the ICD-9-CM codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. CMH collects only 74a and 74b.

75	UNLABELED
	Leave Blank

76	ATTENDING PROVIDER NAME AND IDENTIFIERS
NPI	Enter the National Provider Identifier for the attending physician.
QUAL	Enter 1D then the attending physician's Medicaid legacy number. If the attending physician does not have an OHIO Medicaid legacy number, enter '9111115'.
LAST NAME	Enter the attending physician's last name.
FIRST NAME	Enter the attending physician's first name.

77	OPERATING PROVIDER NAME AND IDENTIFIERS
NPI	Enter the National Provider Identifier for the operating physician. The physician performing the principal surgical or medical procedure may also be the attending physician noted in Item 76.
QUAL	Enter 1D then the attending physician's Medicaid legacy number. If the attending physician does not have an OHIO Medicaid legacy number, enter '9111115'.
LAST NAME	Enter the operating physician's last name.
FIRST NAME	Enter the operating physician's first name.

78 – 79	OTHER PROVIDER NAMES AND IDENTIFIERS
NPI	Not Required
QUAL	Not Required
LAST NAME	Not Required
FIRST NAME	Not Required

80	REMARKS
	Not Required

81 a – d	CODE –CODE FIELD
	Not Required

MAILING INSTRUCTIONS:

Mail the original invoice when completed to:

Bureau for Children with Medical Handicaps
P.O. Box 1603
Columbus, Ohio 43216-1603