UB04 INSTRUCTIONS
Hospice Services

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: a. First digit-type facility 8 = Special facility (hospice) b. Second digit-classification 1 = Hospice (Non-hospital based) 2 = Hospice (Hospital based) c. Third digit-frequency 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates)	**Required.** Enter the beginning and ending service dates.	

Locator #	Description	Instructions	Alerts
	dates of the period covered by this bill.	**Note: Do not show days before the patient's entitlement began.** **Note: A claim may not span more than one month of service at a time.**	
7	Unlabeled	**Leave Blank**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required.** Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City: 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth date	**Required.** Enter the patient's date of birth using 6 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required.** Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	**Required.** Enter the admission date in MMDDYY format, which must be the same date as the effective date of the hospice election or change of election. On the first claim, the date of admission should match the	

Locator #	Description	Instructions	Alerts
		From date in the Statement Covers Period (Form Locator 6). The date of admission may not precede the physician's certification by more than two calendar days. **Note: If the Notice of Election form and the Certification of Terminal Illness are not received within 10 calendar days, the date of admission (election) will be the date that BHSF receives the proper documentation.**	
13	Admission Hour	**Leave Blank**	
14	Type Admission	**Leave Blank**	
15	Source of Admission	**Leave Blank**	
16	Discharge Hour	**Leave Blank**	

17	Patient Status	**Required.** Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6).
		
		Valid Codes
		01 = Discharged to home or self
		    care (routine discharge)
		30 = Still patient or expected to
		    return for outpatient
		    services.
		40 = Expired at home.
		41 = Expired in a medical
		    facility, such as a hospital,
		    SNF, ICF or freestanding
		    hospice.	

Locator #	Description	Instructions	Alerts
		42 = Expired - place unknown	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Required.** Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MMDDYY). If there are more occurrences than there are spaces on the form, use Form Locators 35 and 36 (Occurrence Spans) to record additional occurrences and dates. Use the following codes where appropriate: **27 = Date of Hospice Certification**. Code indicates the date of written certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. This occurrence code must be present in order to show when certification occurred for each new benefit period. If the occurrence code 27 with a date is not present for each certification or re-	

Locator #	Description	Instructions	Alerts
		certification of an individual, the claim will reject. Claims that are submitted between certifications or prior to the due date of the next certification do not require occurrence code 27. Any claim that starts a new hospice period or that contains services that overlap the next hospice period must show the occurrence code 27 and the re-certification date. **42 = Termination date**. Enter code to indicate the date on which recipient terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)	
35-36	Occurrence Spans (Code and Dates)	**Situational.** If a specific event relating to this billing period should be indicated, then enter the code(s) and associated beginning and ending date(s). Event codes are two alphanumeric characters, and dates are shown numerically as MMDDYY. Use the following code when appropriate: **M2 = Dates of Inpatient Respite Care**. Code indicates From/Through dates of a period of inpatient respite care for hospice patients.	

Locator #	Description	Instructions	Alerts
37	Unlabeled	**Leave Blank.**	
38	Responsible Party Name and Address	**Optional.**	
39-41	Value Codes and Amounts	**Required.** Enter the appropriate Value Code(s). Hospices are required to submit claims for payment for hospice care based on the geographic location where the service(s) was provided. The Value Code and Core Based Statistical Area (CSBA) code/rural state codes for each service are required for correct claim payment. Value codes must be entered horizontally across the line to match the corresponding revenue codes listed vertically in Field 42. In other words, enter fields 39a, 40a, 41a before fields 39b, 40b, 41b, and so forth. (The first line of 'a' codes is used before entering information in 'b' codes.) Enter value code 61 in the .code. section of the field; the CBSA code/rural state code in the dollar portion of the 'amount' section of the field; and double zeros (00) in the 'cents' portion of the 'amount' section of the field. Multiple Occurrences of the Same Service: Enter the value codes/CBSAs multiple	**Covered days are now reported with Value Code 80. Entry of covered days is not required on your claim form for Medicaid Services.** **If your system is programmed to enter Covered Days, they must be entered AFTER the MSA Value Codes.**

Locator #	Description	Instructions	Alerts
		times if there are multiple occurrences of the same service during the same month. (See further explanation under Form Locators 42 and 45.)	
42	Revenue Code	**Required**. Enter a revenue code for each service. Revenue codes must be listed vertically in ascending order. If there is more than one (1) occurrence of any hospice service during the billing period, list each occurrence of that revenue code on a separate line in ascending order. (See field 45 for instructions for associated dates of service.) Example: 651 Routine Home Care 07/01/05 651 Routine Home Care 07/08/05 652 Continuous Home Care 07/06/05 656 General Inpatient Care 07/31/05 Use these revenue codes to bill Medicaid: 651 = Routine Home Care (RTN Home) 652 = Continuous Home Care (CTNS Home - a minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is reported as 1 hour.) 655 = Inpatient Respite Care (IP Respite) 656 = General Inpatient Care (GNP IP)	**659: Effective 01/01/2016**

Locator #	Description	Instructions	Alerts
		657 = Physician Services (PHY Ser. must be accompanied by a physician procedure code) 659 = Service Intensity Add-On (payment will be reimbursable for a visit by an RN or a social worker, when provided during routine home care in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate.) **Note: Revenue code 001 (Total Charges) MUST always be the final revenue code.**	**HR659 may only be billed during the last 7 days of a patient's life and MUST be billed on the same claim as routine home care services.**
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Revenue Code 657 (Physician Services), entry of appropriate Procedure Code(s) is **required**. Procedure Codes should be obtained from the physician providing the service in order for the intermediary to make reasonable charge determinations when paying for physician services. Revenue Code 659 (Service intensity add-on), entry of appropriate Procedure Code(s) is **required**.	**G0299 = (registered nurse visit)** **G0155 = (medical social worker visit)**
45	Service Date	**Required.** Enter the appropriate service date	

Locator #	Description	Instructions	Alerts
		(MMDDYY) for each service. The service date must be the first date that a service began.

Multiple Occurrences of the Same Service: If the same service occurs multiple times during a month of service (i.e., there is a break in the service dates for that service - not consecutive dates), that service must be entered multiple times on separate lines. In these cases, the initial date for that SEGMENT of that service should be used as the Service Date (see example under Field 42).

For example: Routine care is provided beginning the first day of the month of service for five days; then the patient has continuous care beginning the sixth day of the month for two days, followed by routine care again for the eighth day through the 30th day of the month. The revenue code for routine care must be indicated twice, one entry with a service date of the first day of the month and one entry with a service date of the | **The CREATION DATE replaces the Date of Provider Representative Signature** |

Locator #	Description	Instructions	Alerts
		eighth day of the month. **Required**. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	

46	Units of Service	**Required.** Enter the number of units of service for each type of service on the line adjacent to the Revenue Code, Description, and Service Date.
		
		RC 651 is measured in DAYS.
		RC 652 is measured in HOURS.
		    Remember that a minimum of 8
		    hours - not necessarily consecutive- in a 24-hour period is required. Less than 8
		    hours is considered routine care.)
		RC 655 is measured in DAYS.
		RC 656 is measured in DAYS.
		RC 657 is measured in NUMBER
		    OF PROCEDURES.
		RC 659 is measured in units.
		    1 unit = 15 minutes. The maximum number of reimbursable units per day is
		    16 units.
		
		PLEASE BE SURE THAT THE
			The seven day maximum number of reimbursable units is 112 units.

Locator #	Description	Instructions	Alerts
		UNITS AND DATES BILLED FOR EACH OCCURRENCE CORRESPOND.	
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes. Must be numeric. Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue Code 001 in Form Locator 42.)	
48	Non-Covered Charges	**Leave blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spenddown form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	
52-A,B,C	Release of Information	**Optional.**	

Locator #	Description	Instructions	Alerts
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0 00' in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier	**The 10-digit National Provider Identifier (NPI) must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	**The 7-digit Medicaid provider number must be entered here.**
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to	

Locator #	Description	Instructions	Alerts

		the insured's name in Form Locator 58 B and C.
		
		Acceptable codes are as follows:
		01 = Patient is insured
		02 = Spouse
		03 = Natural child/Insured has
		      financial responsibility
		04 = Natural child/ Insured does
		      not have financial
		      responsibility
		05 = Step child
		06 = Foster child
		07 = Ward of the court
		08 = Employee
		09 = Unknown
		10 = Handicapped dependent
		11 = Organ donor
		13 = Grandchild
		14 = Niece/Nephew
		15 = Injured Plaintiff
		16 = Sponsored dependent
		17 = Minor dependent of minor
		      dependent
		18 = Parent
		19 = Grandparent	

60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	

Locator #	Description	Instructions	Alerts
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	**ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE**
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62 B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter a "7" for an adjustment or an "8" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction	**To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.**

Locator #	Description	Instructions	Alerts

		03 = Fiscal Agent Error
		90 = State Office Use Only –
		     Recovery
		99 = Other
		
		<u>Voids</u>
		10 = Claim Paid for Wrong
		     Recipient
		11 = Claim Paid for Wrong
		     Provider
		00 = Other	

65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	

66	DX Version Qualifier	**Required.** Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.
		     9 ICD-9-CM
		     0 ICD-10-CM	

67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD code for the principal diagnosis for the terminal illness. **Situational.** Enter the ICD code or codes for all other applicable diagnoses for this claim. **NOTE:** **ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as <u>non-primary</u> diagnosis codes.**	The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that code. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
68	Unlabeled	**Leave blank.**	

Locator #	Description	Instructions	Alerts
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code for the terminal illness.	**Refer to form locator 67.**
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72 A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank.**	
74	Principal Procedure Code / Date	**Leave blank.**	
74 a - e	Other Procedure Code / Date		
75	Unlabeled	**Leave blank.**	
76	Attending	**Required.** Enter the name <u>and</u> <u>NPI</u> of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Optional. Enter the taxonomy code of the attending physician behind the "QUAL" field.	**This field must be completed.** **The Attending provider name & NPI cannot be the billing provider.** **The individual attending provider information must be entered in this field.** **The Attending provider must be enrolled with LA Medicaid.**
77	Operating	**Leave blank.**	
78	Other	**Required.** Enter the word "employee" or "non-employee" in reference to whether the attending physician entered in Form Locator 76 is an employee of the hospice agency. If the attending	**ONLY ENTER "EMPLOYEE" OR "NON-EMPLOYEE" IN THIS FIELD.** **DO NOT ENTER PROVIDER NUMBER'S OR NPI'S.**

Locator #	Description	Instructions	Alerts
		physician volunteers for the hospice, he or she is considered an employee.	
79	Other	**Leave blank.**	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

SAMPLE HOSPICE CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY

1 HOSPICE CARES	2	3a PAT. CNTL. # 1111111	4 TYPE OF BILL
987 CORN ST.		b. MED. REC. # 111111111111	814
ANYWHERE, LA 71111		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 010119 THROUGH 012019 7

8 PATIENT NAME a DOE, JOHN	9 PATIENT ADDRESS a 1235 ANYSTREET			
b	b ANYWHERE	c LA	d 71111	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
MMDDYY	M	121518			40			

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 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
	a	61 10780.00	61 10780.00	61 10780.00
	b	61 10780.00	61 10780.00	61 10780.00
	c	61 10780.00	61 10780.00	
	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	651	ROUTINE HOME CARE		010119	5	400.00			1
2	651	ROUTINE HOME CARE		011819	3	80.00			2
3	652	CONTINUOUS HOME CARE		010619	18	1800.00			3
4	656	GENERAL INPATIENT CARE		010719	4	500.00			4
5	657	PHYSISICAN SERVCIES	99231	010719	1	75.00			5
6	659	SERVICE INTENSITY ADD-ON	G0299	011819	4	200.00			6
7	659	SERVICE INTENSITY ADD-ON	G0155	011919	3	150.00			7
8	659	SERVICE INTENSITY ADD-ON	G0299	012019	6	300.00			8

SAMPLE EXAMPLE

WITH AN ATTENDING PROVIDER

23	001	PAGE 1 OF 1	CREATION DATE	02/01/19	TOTALS ▶	3505.00		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890	
A MEDICAID				TPL ..		57 1234567	A
B				PAYMENT IF		OTHER	B
C				APPLICABLE		PRV ID	C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A DOE, JOHN		1234567890123	TPL CARRIER		A
B			CODE IF		B
C			APPLICABLE		C

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

66 DX M3481									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 1298765432	
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST ADAMS FIRST JANE	
				77 OPERATING NPI	
				LAST FIRST	

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

UB-04 CMS-1450   APPROVED OMB NO. 0938-0997   NUBC National Uniform Billing Committee   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1 HOSPICE CARES	2			3a PAT. CNTL. # 1111111	4 TYPE OF BILL
987 CORN ST.				b. MED. REC. # 11111111111	817
ANYWHERE, LA 71111			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 010619 THROUGH 010619	7

8 PATIENT NAME a DOE, JOHN	9 PATIENT ADDRESS a 1235 ANYSTREET		
b	b ANYWHERE	c LA d 71111	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
MMDDYY	M	121518			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	61 3880 .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	652	CONTINUOUS HOME CARE		010619	20	2000 00		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10

SAMPLE EXAMPLE

WITH AN ATTENDING PROVIDER

23	PAGE 1 OF 1	CREATION DATE 022219	TOTALS	2000 00		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890	
A MEDICAID				TPL		57 1234567	A
B				PAYMENT IF		OTHER	B
C				APPLICABLE		PRV ID	C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A DOE, JOHN		1234567890123	TPL CARRIER		A
B			CODE IF		B
C			APPLICABLE		C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A	A		A
B	9034198798700		B
C	02		C

66 DX M3481		A	B	C	D	E	F	G	H	68
0	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 1298765432 QUAL
				LAST ADAMS FIRST JANE
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST
80 REMARKS		81CC a		78 OTHER NPI QUAL
		b		LAST EMPLOYEE FIRST
		c		79 OTHER NPI QUAL
		d		LAST FIRST

UB-04 CMS-1450   APPROVED OMB NO. 0938-0997   NUBC National Uniform Billing Committee   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.