

## Appendix H-2a

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
<b>Required</b>	1.	<b>Provider Name</b> – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
<b>=Conditionally Required</b> <i>Revised October 2010 – Effective October 2010</i>	2.	<p><b>Pay-To Name and Address</b> - Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI.</p> <p><b>For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.</b> Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4.</p> <p>Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information.</p> <p>The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.</p>
<b>Optional</b>	3a.	<b>Patient Control Number</b>
<b>Optional</b>	3b.	<b>Medical Record Number</b>
<b>Required</b>	4.	<b>Type of Bill</b> – A four-digit field is required. Do not drop the leading zero in this field.
<b>Optional</b>	5.	<b>Fed. Tax No.</b>
<b>Required</b>	6.	<b>Statement Covers Period</b>
<b>Conditionally Required</b>	10.	<p><b>Patient Birth Date</b> - If a birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If a birth date is not entered, the department will not attempt corrections.</p> <p>A birth date is required only if the claim contains a Type of Admission 4 (newborn).</p>

<b>Completion</b>	<b>Form Locator</b>	<b>Form Locator Explanation and Instructions For Inpatient Claims</b>
<b>Required</b>	<b>12.</b>	<b>Admission Date</b>
<b>Conditionally Required</b>	<b>13.</b>	<b>Admission Hour</b> – An admission hour is required only if the Type of Bill Frequency Code is 1 or 2.
<b>Required</b>	<b>14.</b>	<b>Priority (Type) of Visit</b>
<b>Conditionally Required</b>	<b>15.</b>	<b>Source of Referral for Admission</b> - Code 4 or D is required when a patient is transferred from another hospital or transferred from hospital inpatient in the same facility, resulting in a separate claim to the payer.
<b>Required</b>	<b>17.</b>	<b>Patient Discharge Status</b>
<b>Conditionally Required</b>	<b>18-28.</b>	<b>Condition Codes</b> - Required if a condition code applies to this claim, such as C1, C3, AJ, or applicable abortion codes.
<b>Conditionally Required</b>	<b>31-34.</b>	<b>Occurrence Codes and Dates</b> – Refer to the UB-04 Data Specifications Manual for usage requirements.
<b>Conditionally Required</b>	<b>35-36.</b>	<b>Occurrence Span Code/From/Through</b> – When reporting non-covered days, providers must indicate the non-covered date span.
<b>Required</b>	<b>39-41.</b>	<b>Value Codes</b> – Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.

Value Code 80 is required for all inpatient claims (the number of days covered by the primary payer). The other value codes below are conditionally required based upon the particular claim.

Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.

Value Code 81 – The number of days of care not covered by the primary payer.

Value Codes applicable to Medicare deductible or coinsurance due.

## Appendix H-2b

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient, Outpatient Rehabilitation, and Outpatient Psychiatric Claims
<b>Required</b>	1.	<b>Provider Name</b> – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
<b>=Conditionally Required</b> <i>Revised October 2010 – Effective October 2010</i>	2.	<p><b>Pay-To Name and Address</b> – Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI.</p> <p><b>For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.</b> Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4.</p> <p>Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information.</p> <p>The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.</p>
<b>Optional</b>	3a.	<b>Patient Control Number</b>
<b>Optional</b>	3b.	<b>Medical Record Number</b>
<b>Required</b>	4.	<b>Type of Bill</b> – A four-digit field is required. Do not drop the leading zero in this field.
<b>Optional</b>	5.	<b>Fed. Tax No.</b>
<b>Required</b>	6.	<b>Statement Covers Period</b>
<b>Optional</b>	10.	<b>Patient Birth Date</b> - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient, Outpatient Rehabilitation, and Outpatient Psychiatric Claims
Conditionally Required	18-28.	<b>Condition Codes</b> – Claims containing an abortion procedure need a corresponding abortion condition code.
Conditionally Required	35-36.	<b>Occurrence Span Code/From/Through</b> – When reporting non-covered days, providers must indicate the non-covered date span.
Conditionally Required	39-41.	<b>Value Codes</b> – The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.  Value Code 24 – Required for Medicare crossover claims to identify the number of departments visited. The department multiplies the reimbursement rate by the total departments visited during the billing period to arrive at the department allowable amount. A department is defined as a group of 10 revenue codes; for example, Revenue Codes 270 through 279 would be considered one department. If total units are not indicated on the UB, the calculation will be made using one unit.  Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.  Value Code 80 – The number of covered days is required for series claims.  Value Codes applicable to Medicare deductible or coinsurance due.
Required	42.	<b>Revenue Code</b> – Enter the appropriate revenue code for the service provided. The 23 <sup>rd</sup> Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

## Appendix H-2c

Completion	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
<b>Required</b>	1.	<b>Provider Name</b> – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
<b>=Conditionally Required</b> <i>Revised October 2010 – Effective October 2010</i>	2.	<p><b>Pay-To Name and Address</b> – Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI.</p> <p><b>For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.</b> Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4.</p> <p>Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information.</p> <p>The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.</p>
<b>Optional</b>	3a.	<b>Patient Control Number</b>
<b>Optional</b>	3b.	<b>Medical Record Number</b>
<b>Required</b>	4.	<b>Type of Bill</b> – A four-digit field is required. Do not drop the leading zero in this field.
<b>Optional</b>	5.	<b>Fed. Tax No.</b>
<b>Required</b>	6.	<b>Statement Covers Period</b>
<b>Optional</b>	10.	<b>Patient Birth Date</b> - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.

Completion	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
Required	18-28.	<b>Condition Codes</b> - Identify the dialysis place of service. The department recognizes the following codes: 71-72, 74-76
Conditionally Required	35-37.	<b>Occurrence Span Code/From/Through</b> – When reporting non-covered days, providers must indicate the non-covered date span.
Conditionally Required	39-41.	<p><b>Value Codes</b> - The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.</p> <p>Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.</p> <p>Value Code 68 – Epogen must be reported using Value Code 68.</p> <p>Value Code 80 – The number of covered days is required for series claims.</p> <p>Value Codes applicable to Medicare deductible or coinsurance due.</p>
Required	42.	<b>Revenue Code</b> – Enter the appropriate revenue code for the service provided. The 23 <sup>rd</sup> Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.