UB-04 REQUIREMENTS FOR HFS ADJUDICATION
Attachment to UB-04 Billing Instructions Notice 12-08

Instructions for completion of this form follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. **For detailed form locator information, all providers should have a copy of the UB-04 Data Specifications Manual for reference.** To become a UB-04 Subscriber, refer to the following Web site: <http://www.nubc.org/become.html>. The UB-04 Data Specifications Manual contains a blank facsimile of the UB-04. Providers may also view a UB-04 facsimile on the Department's Web site at: <http://www.hfs.illinois.gov/medicalforms/>. For billing purposes, providers must still submit an original UB-04.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

COMPLETION	**FORM LOCATOR EXPLANATION AND INSTRUCTIONS FOR INPATIENT CLAIMS**
Required	1. **Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Conditionally Required	2. **Pay-To Name and Address** – If the provider has more than one payee, report the one-digit payee number prior to the name. If no payee is reported, the Department will default to the first open payee. Payees are coded numerically on the Provider Information Sheet. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL 1.
Optional	3a. **Patient Control Number**
Optional	3b. **Medical Record Number**
Required	4. **Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.

Optional   **5. Fed. Tax No.**

Required   **6. Statement Covers Period**

Conditionally   **10. Patient Birth Date** - If a birth date is entered, the Department
Required   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.

                                       A birth date is required only if the claim contains a Type of
                                       Admission 4 (newborn).

Required   **12. Admission Date**

Conditionally   **13. Admission Hour –** An admission hour is required only if the
Required   Type of Bill Frequency Code is 1 or 2.

Required   **14. Priority (Type) of Visit**

Conditionally   **15. Source of Referral for Admission -** Code 4 or D is required
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.

Required   **17. Patient Discharge Status**

Conditionally   **18-28. Condition Codes -** Required if a condition code applies to
Required   this claim, such as C1, C3, AJ, or applicable abortion
                                          codes.

Conditionally   **31-34. Occurrence Codes and Dates –** Refer to the UB-04 Data
Required   Specifications Manual for usage requirements.

Conditionally   **35-36. Occurrence Span Code/From/Through** – When reporting
Required   non-covered days, providers must indicate the non-
                                          covered date span.

Required *Corrected 06-09*	**39-41. Value Codes** – 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 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.

Required — **42. Revenue Code –** Enter the appropriate revenue code for the service provided. The 23rd 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.

Required — **43. Revenue Description**

Required — **44. HCPCS/Accommodation Rates** – For accommodation revenue codes, dollar values reported must include whole dollars, the decimal, and the cents.

Required — **46. Service Units –** For each accommodation revenue code, enter the total number of covered days associated with that revenue code. If there are no covered days associated with an accommodation revenue code, the hospital must still enter a "0" (zero) in this field.

Required — **47. Total Charges** (By Revenue Code category)
For revenue code 0001, see FL 42 above.

Conditionally Required — **48. Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.

Required   **50. Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort.

Conditionally Required   **51. Health Plan Identification Number**

HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field, until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.

TPL Code –If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.

Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.

10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Conditionally Required   **54A,B. Prior Payments** – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.

Required   **56. National Provider Identifier – Billing Provider**
Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.

Optional   **57. Other (Billing) Provider Identifier**
Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.

Required   **58. Insured's Name** – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the Department.

Required   **60. Insured's Unique Identifier (Recipient Identification Number)** – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.

Conditionally Required   **64. Document Control Number –** At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.

Required   **67. Principal Diagnosis Code and Present on Admission (POA) Indicator -** Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.

Conditionally Required   **67A-Q. Other Diagnosis Codes**
Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area.

Required   **69. Admitting Diagnosis Code** – Enter the specific ICD 9-CM
                            code without the decimal.

Conditionally   **72A-C. External Cause of Injury (ECI) Code –** The ICD diagnosis
Required   codes pertaining to external cause of injuries, poisoning, or
                            adverse effect.

Conditionally   **74. Principal Procedure Code and Date -** Required if a
Required   procedure is performed.

Conditionally   **74a-e. Other Procedure Codes and Dates –** Required if there
Required   were any additional procedures performed.

Required   **76. Attending Provider Name and Identifiers**
                            For claims received on and after October 1, 2008, the
                            Department will adjudicate claims based on the NPI. For
                            claims received prior to October 1, 2008, the Department
                            accepted the NPI, but adjudicated claims based on the
                            physician identification number reported in the Secondary
                            Identifier.

                            Secondary Identifier Qualifiers:
                            • 0B – State License Number
                            • 1G – Provider UPIN
                            • G2 – Provider Commercial Number

Conditionally   **77. Operating Physician Name and Identifiers** – Required if a
Required   surgical procedure is performed. For claims received on and
                            after October 1, 2008, the Department will adjudicate claims
                            based on the NPI. For claims received prior to October 1,
                            2008, the Department accepted the NPI, but adjudicated
                            claims based on the physician identification number reported
                            in the Secondary Identifier.

                            Secondary Identifier Qualifiers:
                            • 0B – State License Number
                            • 1G – Provider UPIN
                            • G2 – Provider Commercial Number

Conditionally   **78-79. Other Provider (Individual) Names and Identifiers –**
Required   Refer to the UB-04 Data Specifications Manual for usage
                            requirements.

Required   81. **Code-Code Field** – HFS Requirement (Needed for
                              Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy
                              Code. Taxonomy codes are identified in Chapter 300,
                              Handbook for Electronic Processing, available on the
                              Department's Web site at:
                              <http://www.hfs.illinois.gov/handbooks/chapter300.html>. This
                              form locator can also be used to report additional codes
                              related to a form locator (overflow) or to report externally
                              maintained codes approved by the NUBC for inclusion in the
                              institutional data set.

*Additional notes

Form Locator 80 Remarks – HFS utilizes this field to assign each claim's unique
Document Control Number. Providers do not utilize this field.

COMPLETION	**FORM LOCATOR EXPLANATION AND INSTRUCTIONS FOR OUTPATIENT GENERAL, REHABILITATION, AND PSYCHIATRIC CLAIMS**

Required   **1. Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.

Conditionally Required   **2. Pay-To Name and Address** – If the provider has more than one payee, report the one-digit payee number prior to the name. If no payee is reported, the Department will default to the first open payee. Payees are coded numerically on the Provider Information Sheet. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL 1.

Optional   **3a. Patient Control Number**

Optional   **3b. Medical Record Number**

Required   **4. Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.

Optional   **5. Fed. Tax No.**

Required   **6. Statement Covers Period**

Optional   **10. Patient Birth Date** - 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.

Conditionally Required   **18-28. Condition Codes** – Claims containing an abortion procedure need a corresponding abortion condition code.

Conditionally Required   **35-36. Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.

Conditionally Required

Corrected 06-09

39-41. Value Codes – 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 0270 through 0279 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 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. Revenue Code – Enter the appropriate revenue code for the service provided. The 23rd 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.

Required	**43. Revenue Description -** Refer to the UB-04 Manual for details.

NDC reporting of certain injectable drugs associated with revenue line 0636 is required. The expensive drugs that require NDC reporting are referenced on the Department's Web site at: <<u>www.hfs.illinois.gov/reimbursement/expensive.html</u>>.

- Report the N4 qualifier in the first two (2) positions, left-justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank. |
| **Required** | **44. HCPCS/Accommodation Rates –** Claims containing emergency, observation, or psychiatric department services must identify specific procedure codes. Refer to the final page of the APL Group Order List on the Web site at: <<u>http://www.hfs.illinois.gov/reimbursement/apl.html</u>>. |
| **Optional** | **45. Service Date –** If a date is entered, it will be edited. |
| **Conditionally Required** | **46. Service Units –** Claims for the following services must contain an entry:
- Observation claims must contain the number of hours of observation.
- Claims containing an expensive drug, as identified on the Department's Web site at: <u>http://www.hfs.illinois.gov/reimbursement/expensive.html</u> and associated with revenue code 0636, must contain the number of units given.
- Series claims for series-billable revenue codes must contain an entry that is at least equal to the number of Covered Days. |

| **Required** | 47. | **Total Charges** (By Revenue Code category) For revenue code 0001, see FL 42 above. |

Required

47. Total Charges (By Revenue Code category)
For revenue code 0001, see FL 42 above.

Conditionally Required

48. Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.

Required

50. Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort.

Conditionally Required

51. Health Plan Identification Number - HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.
TPL Code –If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.
Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:
01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.
10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

**Conditionally
Required**

54A,B. Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.

Required

56. National Provider Identifier – Billing Provider
Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.

Optional

57. Other (Billing) Provider Identifier
Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.

Required

58. Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the Department.

Required

60. Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.

**Conditionally
Required**

64. Document Control Number – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.

Required

67. Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for outpatient claims.

**Conditionally
Required**

67A-Q. Other Diagnosis Codes - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for outpatient claims.

**Conditionally
Required**

72A-C. External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

Required   **76. Attending Provider Name and Identifiers**
For claims received on and after October 1, 2008, the
Department will adjudicate claims based on the NPI. For
claims received prior to October 1, 2008, the Department
accepted the NPI, but adjudicated claims based on the
physician identification number reported in the Secondary
Identifier.

Secondary Identifier Qualifiers:
- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Commercial Number

Conditionally   **77. Operating Physician Name and Identifiers –** Required for
Required   general outpatient and outpatient rehabilitation claims, if a
surgical procedure is performed. For claims received on and
after October 1, 2008, the Department will adjudicate claims
based on the NPI. For claims received prior to October 1,
2008, the Department accepted the NPI, but adjudicated
claims based on the physician identification number reported
in the Secondary Identifier.

Secondary Identifier Qualifiers:
- 0B – State License Number
- 1G – Provider UPIN
- G2 – Provider Commercial Number

Conditionally   **78-79. Other Provider (Individual) Names and Identifiers –**
Required   One of these fields is required for outpatient rehabilitation
claims. For claims received on and after October 1, 2008,
the Department will adjudicate claims based on the NPI.
For claims received prior to October 1, 2008, the
Department accepted the NPI, but adjudicated claims
based on the physician identification number reported in
the Secondary Identifier.

Secondary Identifier Qualifiers:
- 0B – State License Number
- 1G – Provider UPIN
- G2 – Provider Commercial Number

Required   **81. Code-Code Field** – HFS Requirement (Needed for
                      Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy
                      Code. Taxonomy codes are identified in Chapter 300,
                      Handbook for Electronic Processing, available on the
                      Department's Web site at:
                      <http://www.hfs.illinois.gov/handbooks/chapter300.html>. This
                      form locator can also be used to report additional codes
                      related to a form locator (overflow) or to report externally
                      maintained codes approved by the NUBC for inclusion in the
                      institutional data set.

*Additional notes

FL 80 - Remarks – HFS utilizes this field to assign each claim's unique Document
Control Number. Providers do not utilize this field.

COMPLETION   **FORM LOCATOR EXPLANATION AND INSTRUCTIONS FOR RENAL DIALYSIS OUTPATIENT CLAIMS**

Required

1. **Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.

Conditionally Required

2. **Pay-To Name and Address** – If the provider has more than one payee, report the one digit payee number prior to the name. If no payee is reported, the Department will default to the first open payee. Payees are coded numerically on the Provider Information Sheet. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL 1.

Optional

3a. **Patient Control Number**

Optional

3b. **Medical Record Number**

Required

4. **Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.

Optional

5. **Fed. Tax No.**

Required

6. **Statement Covers Period**

Optional

10. **Patient Birth Date** - 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.

Required

18-28. **Condition Codes -** Identify the dialysis place of service. The Department recognizes the following codes: 71-72, 74-76

Conditionally Required

35-36. **Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.

**Conditionally
Required**

Corrected 06-09

39-41. Value Codes - 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 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The 2432, Split Billing Transmittal, must accompany the claim.

Value Code 68 – Epogen must be reported using Value Code 68.

Value Code 80 – The number of covered days is required for series claims.

Value Codes applicable to Medicare deductible or coinsurance due.

Required

42. Revenue Code – Enter the appropriate revenue code for the service provided. The 23rd 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.

Required	**43. Revenue Description** For revenue lines 0634 and 0635: Providers must report the National Drug Code (NDC) associated with the injectable drug Epogen.

For revenue line 0636: Providers must report the NDC if the drug is one of those renal dialysis injectable drugs referenced on the Department's Web site at: <<http://www.hfs.illinois.gov/reimbursement/>>.

Providers also must report the NDC if the drug is one of those expensive drugs referenced on the Department's Web site at: <www.hfs.illinois.gov/reimbursement/expensive.html>.

- Report the N4 qualifier in the first two (2) positions, left-justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Required	**44. HCPCS/Accommodation Rates –** Enter the corresponding HCPCS code associated with revenue lines 0634, 0635, or 0636.
Optional	**45. Service Date -** If a date is entered, it will be edited.
Conditionally Required	**46. Service Units –** For a series claim, an entry is required to correspond to the renal dialysis revenue code. Also, an entry is required for claims containing revenue codes 0634 and 0635 for Epogen, or revenue code 0636 for specified renal dialysis injectable drugs or specified expensive drugs.
Required	**47. Total Charges** (By Revenue Code category) For revenue code 0001, see FL 42 above.

Conditionally Required	**48. Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.
Required	**50. Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort
Conditionally Required	**51. Health Plan Identification Number -** HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.

> **TPL Code** –If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.
> **Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.
>
> The TPL Status Codes are:
> **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
> **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
> **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
> **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
> **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
> **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
> **08 – Estimated Payment:** TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.
> **10 – Deductible Not Met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
> **99 – Zero or Negative Payment:** TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Conditionally Required	**54A,B. Prior Payments** – TPL payments are identified on lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	**56. National Provider Identifier – Billing Provider** Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	**57. Other (Billing) Provider Identifier** Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.
Required	**58. Insured's Name** – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the Department.
Required	**60. Insured's Unique Identifier (Recipient Identification Number)** – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Conditionally Required	**64. Document Control Number –** At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	**67. Principal Diagnosis Code and Present on Admission (POA) Indicator -** Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for renal dialysis claims.
Conditionally Required	**67A-Q. Other Diagnosis Codes** - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for renal dialysis claims.
Conditionally Required	**72A-C. External Cause of Injury (ECI) Code –** The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

Required   **78-79. Other Provider (Individual) Names and Identifiers**
One of these fields is required for renal dialysis claims. For claims received on and after October 1, 2008, the Department will adjudicate claims based on the NPI. For claims received prior to October 1, 2008, the Department accepted the NPI, but adjudicated claims based on the physician identification number reported in the Secondary Identifier.

Secondary Identifier Qualifiers:
- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Commercial Number

Required   **81. Code-Code Field** – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the Department's Web site at: <http://www.hfs.illinois.gov/handbooks/chapter300.html>. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

*Additional notes

FL 80 - Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

MAILING INSTRUCTIONS

The provider is to submit an original UB-04 form to the Department. The pin-feed guide strip should be detached from the sides of continuous feed forms. A copy of the claim is to be retained by the provider.

UB-04 paper claims should be sent to the applicable post office box as follows:

UB-04 Claims Without Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19132
Springfield, Illinois 62794-9132

UB-04 Claims With Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19133
Springfield, Illinois 62794-9133

UB-04 Claims Requiring Special Handling by the Billing Consultants:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
P.O. Box 19128
Springfield, Illinois 62794-9128

Adjustments (Form HFS 2249):

Illinois Department of Healthcare and Family Services
MMIS Adjustments
P.O. Box 19101
Springfield, Illinois 62794-9101

Forms Requisition:

The Department does not supply the UB billing form. Adjustment forms may be requested on the Web site at http://www.hfs.illinois.gov/forms/ or by submitting an HFS 1517 as explained in Chapter 100, General Appendix 10.