CLAIM EXAMPLES NURSING FACILITIES ELIGIBLE TO BE LICENSED AS SPEDIALISED MENTAL HEALTH REHABILITATION FACILITIES (SMHRFs) – (PT 38)

EXAMPLE ~ SMHRF1:
Claim with no leave of absence days.

Statement Period: 10/01/16 – 10/31/16
Value Code 80 = 31
Legacy Claim Coding:
10/01/16 – 10/31/16 (COS 71)

```
ISA*00*          *00*          *01*030230130      *ZZ*37-5555555     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*310500000X~
NM1*85*2*SMHRF LTC TEST****XX*2957979356 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-SMHRF1*5000***65:A:2**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201610011900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BE:23:::500*BE:80:::31~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
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LX*1~
SV2*0110**5000*DA*31~
REF*6R*EI122215247135640-01~
SE*36*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE -SMHRF1	4 TYPE OF BILL
SMHRF LTC TEST 555 NORTH STREET CHICAGO, IL 60614502		b. MED. REC. #	00712	0652
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
		213456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4		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	23	500.00	80	31.00		
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	0110	ROOM-BOARD/ PVT		100116	31	5000.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	5000.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	2957979356
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		

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

66 DX										68
	Z5189	16350								

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73
M6281								

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	310500000X
	b		
	c		
	d		

EXAMPLE ~ SMHRF2:
Claim with leave of absence days.

Statement Period: 10/01/16 – 10/31/16
Occurrence Span Code 74: 10/04/16 – 10/04/16
Occurrence Span Code 74: 10/20/16 – 10/24/16
Value Code 80 = 25
Value Code 81 = 6
Legacy Claim Coding:
10/01/16 – 10/03/16 (COS 71)
10/04/16 – 10/04/16 (COS 71 with BR Type)
10/05/16 – 10/19/16 (COS 71)
10/20/16 – 10/24/16 (COS 71 with BR Type)
10/25/16 – 10/31/16 (COS 71)

```
ISA*00*          *00*          *01*030230130      *ZZ*37-5555555     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*310500000X~
NM1*85*2* SMHRF LTC TEST****XX*2957979356~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-SMHRF2*4600***65:A:3**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201510151900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BI:74:RD8:20161004-20161004*BI:74:RD8:20161020-20161024~
HI*BE:23:::500*80:::25*BE:81:::6~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
```

PRV*AT*PXC*207R00000X~
LX*1~
SV2*0110**4500*DA*25~
REF*6R*EI122215247135641-01~
LX*2~
SV2*0185**100*DA*6~
REF*6R*EI122215247135641-02~
SE*40*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT CNTL #	EXAMPLE -SMHRF2	4 TYPE OF BILL
SMHRF LTC TEST 555 NORTH STREET CHICAGO, IL 60614502		b MED REC. #	00712	0653
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
		213456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	101515	19	3	4		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								74	100416	100416	74	102016	102416	a
b														b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	25.00	81	6.00
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	0110	ROOM-BOARD/ PVT		100116	25	4500.00		
2	0185	LOA/NURS HOME		100416	6	100.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	4600.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A ILLINOIS MEDICAID	37-1320188	Y	Y			2957979356	
B							
C							

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		
B				
C				

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

66 DX										67
	Z5189	16350								

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73
M6281								

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC a	B3	310500000X
	b		
	c		
	d		

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

EXAMPLE ~ SMHRF3:
Claim with a leave of absence day and TPL reported on claim.

Statement Period: 10/01/16 – 10/31/16
Occurrence Span Code 74: 10/05/16 – 10/5/16
Value Code 80 = 30
Value Code 81 = 1
Legacy Claim Coding:
10/01/16 – 10/04/16 (COS 71)
10/05/16 – 10/05/16 (COS 71 with BR Type)
10/06/16 – 10/31/16 (COS 71)

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ISA*00*          *00*          *01*030230130      *ZZ*37-5555555     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*310500000X~
NM1*85*2*SMHRF LTC TEST*****XX*2957979356 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-SMHRF3*4250***65:A:3**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201609301900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350 ~
HI*ABF: Z5189~
HI*BI:74:RD8:20161005-20161005~
HI*BE:23:::500*80:::30*81:::1~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
SBR*P*18** HCSC-BCBS OF IL-STD A & B *****BC~
```

CAS*CO*45*3150.00***~
CAS*PR*2*50.00~
AMT*D*1050.00~
OI***Y***Y~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
NM1*PR*2*HCSC-BCBS OF IL-STD A & B*****PI*30024~
N3*300 EAST RANDOLPH, 13TH FLOOR~
N4*CHICAGO*IL*60601~
DTP*573*D8*20161210~
REF*2U*00601~
LX*1~
SV2*0110**4150*DA*30~
REF*6R*EI122215247135642-01~
LX*2~
SV2*0182**100*DA*1~
REF*6R*EI122215247135642-02~
SE*53*0001~
GE*1*528986~
IEA*1*000525985~

1	2	3a PAT CNTL #	EXAMPLE -SMHRF3	4 TYPE OF BILL
SMHRF LTC TEST 555 NORTH STREET CHICAGO, IL 60614502		b. MED REC. #	00712	0653
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
		213456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	093016	19	3	4		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									74	100516	100516				
b															

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	30.00	81	1.00
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	0110	ROOM-BOARD/ PVT		100116	30	4150.00		
2	0182	LOA/PT CONV		100516	1	100.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	4250.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	2957979356
A	HCSC-BCBS OF IL-STD A&B	00601			1050.00		57 OTHER PRV ID	
B	ILLINOIS MEDICAID	37-1320188	Y	Y				
C								

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209A		
B	DOE, JOHN	18	011545209		
C					

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

66 DX									68
	Z5189	16350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	310500000X
	b		
	c		
	d		

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.

EXAMPLE ~ SMHRF4:
Claim for Medicaid covered days prior to discharge to hospital.
Medicaid Primary
Statement Period: 10/01/16 – 10/15/16
Discharge Status Code = 02
Value Code 80 = 14
Value Code 81 = 1
Legacy Claim Coding:
10/01/16 – 10/14/16 (COS 71)

```
ISA*00*          *00*          *01*030230130      *ZZ*37-5555555     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*70009~
HL*1**20*1~
PRV*BI*PXC*310500000X~
NM1*85*2*SMHRF LTC TEST*****XX*2957979356 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*70009~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE - SMHRF 4*1400***65:A:1**A*Y*Y~
DTP*096*TM*1300~
DTP*434*RD8*20161001-20161015~
DTP*435*DT*201610011900~
CL1*3*4*02~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:23:::500*BE:80:::14*BE:81:::1~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X
LX*1~
SV2*0110**1400*DA*14~
```

REF*6R*EI122215247135643-01~
SE*37*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL. #	EXAMPLE -SMHRF4	4 TYPE OF BILL
SMHRF LTC TEST		b. MED. REC. #	00712	0651
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		213456789	100116 / 101516	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4	13	02													

CONDITION CODES

	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	23	500.00	80	14.00		
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	0110	ROOM-BOARD/ PVT		100116	14	1400.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	1400.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	2957979356
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		

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

66 DX: Z5189 | 16350 | 67

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL
LAST JACKSON	FIRST IGOR	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS

81CC			
a	B3	310500000X	
b			
c			
d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

EXAMPLE ~ SMHRF5:
Claim for Medicaid covered days prior to discharge due to death.
Medicaid Primary
Statement Period: 10/01/16 – 10/15/16
Discharge Status Code = 20
Value Code 80 = 15
Legacy Claim Coding:
10/01/16 – 10/15/16 (COS 71)

```
ISA*00*          *00*          *01*030230130      *ZZ*37-5555555     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*310500000X~
NM1*85*2*SMHRF LTC TEST*****XX*2957979356 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE –SMHRF5*1400***65:A:4**A*Y*Y~
DTP*096*TM*1300~
DTP*434*RD8*20161001-20161015~
DTP*435*DT*201609301900~
CL1*3*4*20~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:23:::500*BE:80:::15~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X
LX*1~
SV2*0110**1400*DA*15~
REF*6R*EI122215247135644-01~
```

SE*37*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE -SMIIRF5	4 TYPE OF BILL
SMIIRF LTC TEST 555 NORTH STREET CHICAGO, IL 60614502		b. MED. REC. #	00712	0654
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
		213456789	100116 / 101516	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	093016	19	3	4	13	20													

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 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	500.00	80	15.00		
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	0110	ROOM-BOARD/ PVT		100116	15	1400.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	1400.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	2957979356
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		

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

66 DX									68
	Z5189	I6350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC a	B3	310500000X
	b		
	c		
	d		

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