ATTACHMENT 4
Sample UB-92 Claim Form for Outpatient Hospitals

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL
321 HOSPITAL RD
ANYTOWN, WI 55555
(555) 321-1234

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL: **131**

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: **020404** THROUGH: **020404**

7 COV D.: **1**

8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: **RECIPIENT, IMA H.**

13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | 17 DATE | ADMISSION 18 HR: **3** 19 TYPE: **1** 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | 24 CONDITION CODES 26 28 30 | 31

32 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38

39 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0300		80053		1	XX XX		
0310		80048		1	XX XX		
0450				1	XX XX		
0923		88142		1	XX XX		
0925		81025		1	XX XX		
0001	Total Charges				XXX XX		

50 PAYER: **45009 BLUE CROSS**, **T19 MEDICAID**

51 PROVIDER NO.: **BC111**, **87654321**

52 REL INFO | 53 ASG BEN

54 PRIOR PAYMENTS: **XX XX**

55 EST. AMOUNT DUE: **XX XX**

56

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: **1234567890** | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: **V288** | 68 CODE | OTHER DIAG. CODES 70 CODE 72 CODE 74 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID: **A12345 I.M. Referring, M.D.**

OTHER PHYS. ID

84 REMARKS: **OI-P**

85 PROVIDER REPRESENTATIVE: X *Ima H. Provider*

86 DATE: **021904**

UB-92 HCFA-1450 **OCR / Original**

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