ATTACHMENT 2
Sample UB-92 Medicare Crossover Claim for Free-Standing End Stage Renal Disease

(Attach Medicare remittance advice to claim form.)

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234	2				3 PATIENT CONTROL NO. 1234JCD			4 TYPE OF BILL 721	
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 070104	THROUGH 072904	7 COV D. 13	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 | 19 TYPE | 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
0270	ADMIN SUPPLY - IV	A4657					
	07/01, 07/05, 07/10, 07/15			4	2.00		
	07/19, 07/24, 07/29			3	1.50		
0634	ERYTHROPOIETIN (EPO LESS THAN 10,000 UNITS)	Q4055					
	07/01, 07/17			2	80.00		
0250	VANCOMYCIN 500 MG	J3370					
	07/01, 07/03, 07/05, 07/08			4	28.12		
	07/10, 07/12, 07/15, 07/19			4	28.12		
	07/22, 07/26, 07/29			3	21.09		
0821	HEMODIALYSIS	90937					
	07/01, 07/03, 07/05, 07/08			4	506.16		
	07/10, 07/12, 07/15, 07/17			4	506.16		
	07/19, 07/22, 07/24, 07/26			4	506.16		
	07/29			1	126.54		
0001	TOTAL CHARGES				1805.85		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A MEDICARE	123456789	y	y	1540.68		
B T19 MEDICAID	87654321	y	y			
C						

57 DUE FROM PATIENT ▶

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

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

67 PRIN. DIAG. CD. 585 | OTHER DIAG. CODES 68 CODE 99662 | 70 CODE 28521 | 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

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X *Ima H. Provider* | 86 DATE: *8/16/04*

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

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