Appendix 10
Sample UB-92 Claim Form for Inpatient Services

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 327 HOSPITAL RD ANYTOWN WI 55555 (555) 327-5555	2 111111111	3 PATIENT CONTROL NO. 123456789	4 TYPE OF BILL 111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	080901	081401	5				

12 PATIENT NAME: RECIPIENT, IMA D.

13 PATIENT ADDRESS:

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES 26 28 30	31
09251975	F		080901	07	1		1	7	03 7654321		

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

38

	39 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a				
b				
c				
d				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	ROOM — BOARD/SEMI			5	1512 60		
2	250	PHARMACY			19	243 95		
3	271	SUPPLY/NON-STER			19	65 32		
4	272	STERILE SUPPLY			8	179 44		
5	300	LABORATORY/LAB			6	513 80		
6	305	LAB/HEMATOLOGY			1	62 00		
7	324	DX X-RAY/CHEST			1	124 75		
8	350	CT SCAN			1	470 72		
9	420	PHYSICAL THERP			5	341 85		
10	424	PHYS THERP/EVAL			1	142 87		
11	450	EMERG ROOM			3	637 13		
12	730	EKG/ECG			1	132 00		
13								
14								
15								
16								
17								
18								
19								
20								
21	001	TOTAL				4426 43		
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	T19 — WI Medicaid	87654321					
B							
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.
A			1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	1234567			
B				
C				

67 PRIN. DIAG. CD.	68 CODE	70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
9661	78039	43889	72989	7813	43820	43811	9661	E8550

OTHER DIAG. CODES

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: N24680 PHYSIESON

83 OTHER PHYS. ID: 11111

OTHER PHYS. ID:

84 REMARKS

85 PROVIDER REPRESENTATIVE: X I.M. Provider

86 DATE: 081901

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

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

Appendix