ATTACHMENT 1
UB-92 Claim Form sample
straight Medicaid with Medicare coinsurance days claim

APPROVED OMB NO. 0938-0279

1	BILLING NURSING HOME 327 NURSING HOME ROAD ANYTOWN, WI 55555 (555) 327-5555
2	
3 PATIENT CONTROL NO.	12345
4 TYPE OF BILL	213
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	060100
THROUGH	063000
7 COV'D	30
8 N-C D. / 9 C-I D. / 10 L-R D. / 11	
12 PATIENT NAME	RECIPIENT IMA
13 PATIENT ADDRESS	
14 BIRTHDATE	11/30/18
15 SEX	F
16 MS	
17 ADMISSION DATE	04/07/00
18 HR / 19 TYPE / 20 SRC	4
21 D HR	
22 STAT	30
23 MEDICAL RECORD NO.	XXXXX
24 / 26 / 28 / 30 CONDITION CODES	
31	
32 OCCURRENCE CODE / DATE	
34 OCCURRENCE CODE / DATE	
36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT	a 84 715 00
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
	060100 - 060900	09		9	0 00		
	061000 - 063000	20		21	2100 00		
001	TOTAL CHARGES				2100 00		

- Do not attach a Medicare Remittance Advice. -

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Med - Medicare	11-2233			0 00		
B T19 - WI Medicaid	11223344					
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.	68 CODE	70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
4280	25001	9952	82120		428.0		

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	87654321
	IM Attending Physician
83 OTHER PHYS. ID	
OTHER PHYS. ID	

84 REMARKS: M-8

85 PROVIDER REPRESENTATIVE: X IM Authorized

86 DATE: MMDDYY

UB-92 HCFA-1450 OCR / Original

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