ATTACHMENT 2

Sample UB-92 claim form — End stage renal disease

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	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	010404	012504	4				

12 PATIENT NAME	13 PATIENT ADDRESS
RECIPIENT, IMA H.	

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 25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33		34 OCCURRENCE CODE	DATE	35		36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a												A	A
b												B	B
												C	C

38		39 VALUE CODES CODE	AMOUNT			41 VALUE CODES CODE	AMOUNT	
	a							a
	b							b
	c							c
	d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300		82340		3	XXX XX		1
2	0300		82570		2	XXX XX		2
3	0300		83945		1	XXX XX		3
4	0821	010404 0111 0118 0125	90935		4	XXX XX		4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22	0001	TOTAL CHARGES				XXXX XX		22
23								23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	45009 BLUE CROSS	BC111			XXXX XX		
B	MEDICARE	123456789			0 00		
C	T19 MEDICAID	87654321					
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						A
B						B
C			1234567890			C

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

67 PRIN. DIAG. CD.	68 CODE	69	70 CODE	71	72 CODE	73	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
5920											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
						a
						b
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	a
						b
					OTHER PHYS. ID	a
						b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b	OI-P	X Ima H. Provider	020104
c	M-7		
d			

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

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