ATTACHMENT 5
Sample UB-92 claim form for personal care services

APPROVED OMB NO. 0938-0279

IM BILLING PROVIDER 1 W. WILSON ANYTOWN, WI 55555 (555) 321-1234	2	3 PATIENT CONTROL NO. JED 1234	4 TYPE OF BILL 4
	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
12 PATIENT NAME RECIPIENT, IM A.	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. 03 7654321	24 / CONDITION CODES 26 / 28 / 30 / 31
32 OCCURRENCE CODE / DATE (a, b)	34 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37 A B C
38	39 VALUE CODES CODE / AMOUNT (a, b, c, d)		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
0570	111003, 1113, 1125, 1130	T1019		16.0	XXXX		
0570	111003, 1113, 1125, 1130	T1019 U3		8.0	XXXX		
0550	113003	99509 TD		1.0	XXXX		
0001	TOTAL				XXXXX		

50 PAYER	51 PROVIDER NO.	52 REL. INFO. / 53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
XYZ INSURANCE 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.
		1234567890		

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

67 PRIN. DIAG. CD.	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
5750							

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

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
OI-D	X Ima H. Provider	110103

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

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