# ATTACHMENT 6
## Sample UB-92 claim form for respiratory care services

APPROVED OMB NO. 0938-0279

| | | | |
|---|---|---|---|
| IM PROVIDER<br>987 N ELM ST<br>ANYTOWN, WI 55555<br>(555) 321-1234 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL<br>333 |
| 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<br>RECIPIENT, IMA H. | 13 PATIENT ADDRESS<br>1234 OAK ST ANYTOWN, WI 55555 | | |
| 14 BIRTHDATE<br>092775 | 15 SEX<br>F | 16 MS / 17 ADMISSION DATE / 18 HR / 19 TYPE / 20 SRC / 21 D HR / 22 STAT | 23 MEDICAL RECORD NO.<br>03 7654321 |
| 24 / 26 / 28 / 30 CONDITION CODES | 31 | | |
| 32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE CODE / DATE |
| 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37 A B C | | |
| 38 | 39 VALUE CODES CODE / AMOUNT | 40 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 |
|---|---|---|---|---|---|---|---|---|
| 1 | 0550 | MMDDYY | 99504 TD UG | | 9.5 | XXX XX | | |
| 2 | 0550 | MMDDYY | 99504 TD UF | | 9.5 | XXX XX | | |
| 3 | 0550 | MMDDYY | 99504 TD UF | | 6.0 | XXX XX | | |
| 4 | 0550 | MMDDYY, MMDD, MMDD, MMDD | 99504 TD UG | | 24.0 | XXX XX | | |
| 5 | 0969 | MMDDYY, MMDD, MMDD, MMDD | 99504 U1 UF | | 4.0 | XXX XX | | |
| 6 | | | | | | | | |
| 7 | 0001 | TOTAL CHARGES | | | | XXXX XX | | |
| 8–23 | | | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 50 PAYER<br>XYZ INSURANCE<br>T19 MEDICAID | 51 PROVIDER NO.<br>87654321 | 52 REL INFO / 53 ASG BEN | 54 PRIOR PAYMENTS<br>XXX XX | 55 EST. AMOUNT DUE | 56 |
| 57 | DUE FROM PATIENT ▶ | | | | |
| 58 INSURED'S NAME | 59 P.REL | 60 CERT. - SSN - HIC. - ID NO.<br>1234567890 | 61 GROUP NAME | 62 INSURANCE GROUP NO. | |
| 63 TREATMENT AUTHORIZATION CODES<br>1234567 | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION | | |
| 67 PRIN. DIAG. CD.<br>V46.1 | 68 CODE / 69 CODE / 70 CODE / 71 CODE / 72 CODE / 73 CODE / 74 CODE (OTHER DIAG. CODES) | | | 76 ADM. DIAG. CD. / 77 E-CODE | 78 |
| 79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE | | 82 ATTENDING PHYS. ID<br>IM PRESCRIBING X12345 | |
| | OTHER PROCEDURE CODE / DATE | | OTHER PROCEDURE CODE / DATE | 83 OTHER PHYS. ID | |
| 84 REMARKS<br>OI-P | | | | OTHER PHYS. ID | |
| | | | | 85 PROVIDER REPRESENTATIVE<br>X I.M. Provider | 86 DATE<br>121503 |

UB-92 HCFA-1450 **OCR / Original** I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.