# ATTACHMENT 9

## Sample UB-92 claim form for private duty nursing

APPROVED OMB NO. 0938-0279

| | | | |
|---|---|---|---|
| IM BILLING PROVIDER<br>1 W. WILLIAMS<br>ANYTOWN, WI 55555<br>(555) 321-1234 | 2 | 3 PATIENT CONTROL NO.<br>12345ABCD | 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 | 13 PATIENT ADDRESS |
|---|---|
| RECIPIENT, IM A. | |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | 03 7654321 | 01 | | | | |

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

38

| | 39 CODE | VALUE CODES AMOUNT | 41 CODE | VALUE CODES 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 | 0550 | 120103 | S9123 UH | | 4.0 | XXX XX | | |
| 2 | 0550 | 120203 | S9123 UJ UH | | 8.0 | XXX XX | | |
| 3 | 0550 | 120303 | S9123 UJ | | 4.0 | XXX XX | | |
| 4 | | | | | | | | |
| 5 | 0001 | TOTAL CHARGES | | | | XXXX XX | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |
| 12 | | | | | | | | |
| 13 | | | | | | | | |
| 14 | | | | | | | | |
| 15 | | | | | | | | |
| 16 | | | | | | | | |
| 17 | | | | | | | | |
| 18 | | | | | | | | |
| 19 | | | | | | | | |
| 20 | | | | | | | | |
| 21 | | | | | | | | |
| 22 | | | | | | | | |
| 23 | | | | | | | | |

| | 50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|---|
| A | T19 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 | OTHER DIAG. CODES 72 CODE | 74 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78 |
|---|---|---|---|---|---|---|---|
| V461 | | | | | | | |

| 79 P.C | 80 PRINCIPAL PROCEDURE CODE | DATE | 81 OTHER PROCEDURE CODE | DATE | 82 ATTENDING PHYS. ID | |
|---|---|---|---|---|---|---|
| | | | | | 12345678 | I.M. ATTENDING |
| | OTHER PROCEDURE CODE | DATE | OTHER PROCEDURE CODE | DATE | 83 OTHER PHYS. ID | |
| | | | | | | |
| | | | | | OTHER PHYS. ID | |
| | | | | | | |

| | 84 REMARKS | 85 PROVIDER REPRESENTATIVE | 86 DATE |
|---|---|---|---|
| a | | | |
| b | | | |
| c | | X I.M. Provider | MMDDYY |
| d | | | |

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

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