Appendix 2b
UB-92 Claim Form Sample
Medicare Part A Coinsurance Days Claim

APPROVED OMB NO. 0938-0279

IM Billling Nursing Home
1 W. Williams Street
Anytown, WI 55555
(XXX) XXX-XXXX

2

3 PATIENT CONTROL NO: 12345

1 TYPE OF BILL: 212

5 FED TAX NO.

6 STATEMENT COVERS PERIOD FROM: 070195 THROUGH: 073195

7 COV D.: 31

8 N-C D

9 C-I D.: 21

10 L-R D.

11

12 PATIENT NAME: Recipient, Ima A

13 PATIENT ADDRESS: 1 W. Williams Anytown, WI 55555

14 BIRTHDATE: MMDDYY

15 SEX: F

16 MS

ADMISSION 17 DATE: 062195 18 HR 19 TYPE 20 SRC: 4

21 D HR

22 STAT: 30

23 MEDICAL RECORD NO.: 99876

CONDITION CODES 24 25 26 27 28 29 31

32 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

36 OCCURRENCE SPAN CODE FROM THROUGH

37 A B C

39 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 09	1,174 00		
b 84	125 00		
c			
d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	Semi Private Room			31	4,340 00		
250	Pharmacy				222 42		
270	Medical Supplies						
001	TOTAL CHARGE				4,627 72		

Attach a Medicare Remittance Advice.

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Med - Medicare	55 - 5555	Y	Y			
T19 - WI Medicaid	11223344					

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO
Recipient, Ima A	01	987654321A 9876543210		

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 1508

68 CODE: 2800

69 CODE: 2765

70 CODE

OTHER DIAG. CODES 72 CODE

74 CODE

76 ADM DIAG. CD: 1508

77 E-CODE

78

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

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.