# Appendix 2d
## UB-92 Claim Form Sample
## Straight Wisconsin Medicaid Claim with Bedhold Days

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

212

5 FED TAX NO.

6 STATEMENT COVERS PERIOD FROM 050195 THROUGH 053195

7 COV D. 31

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

ADMISSION 17 DATE 060190 18 HR 19 TYPE 4 20 SRC

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: 84 221 00

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 |
|---|---|---|---|---|---|---|---|
| | 050195 - 050595 | 20 | | 5 | 375 55 | | |
| | 050695 - 051595 | 30 | | 10 | 638 40 | | |
| | 051695 - 053195 | 20 | | 16 | 1,201 76 | | |
| 001 | TOTAL CHARGE | | | | 2,215 71 | | |

50 PAYER: MED01 - Medicare; T19 - WI Medicaid

51 PROVIDER NO.: 11223344

52 REL INFO

53 ASG BEN

54 PRIOR PAYMENTS: 0 00

55 EST. AMOUNT DUE

56

57

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P.REL

60 CERT. - SSN - HIC - ID NO: 9876543210

61 GROUP NAME

62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 4280

68 CODE: 78052

69 CODE: 5640

70 CODE: 7806

OTHER DIAG. CODES 71 CODE: 7862

72 CODE

74 CODE

76 ADM DIAG CD: 4280

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