# Appendix 2e
## UB-92 Claim Form Sample
## Straight Wisconsin Medicaid Claim - Recipient Death

APPROVED OMB NO. 0938-0279

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

| 2 | 3 PATIENT CONTROL NO | 4 TYPE OF BILL |
|---|---|---|
| | 12345 | 214 |

| 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 |
|---|---|---|---|---|---|---|---|
| | 050195 | 052495 | 24 | | | | |

| 12 PATIENT NAME | 13 PATIENT ADDRESS |
|---|---|
| Recipient, Im A | |

| 14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO | CONDITION CODES 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 060190 | | | 4 | | 20 | 99876 | | | | | | | | |

| 32 OCCURRENCE CODE | DATE | 33 | 34 OCCURRENCE CODE | DATE | 35 | 36 OCCURRENCE SPAN CODE | FROM | THROUGH | 37 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | A B C |

| 39 VALUE CODES CODE | AMOUNT | 40 | 41 VALUE CODES CODE | AMOUNT |
|---|---|---|---|---|
| a 84 | 221 00 | | | |
| 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 |
|---|---|---|---|---|---|---|---|
| | 050195 - 052495 | 20 | | 24 | 1,846 44 | | |
| 001 | TOTAL CHARGE | | | | 1,846 44 | | |

| 50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|
| 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 |
|---|---|---|---|---|
| | | 9876543210 | | |

| 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |
|---|---|---|---|
| | | | |

| 67 PRIN. DIAG. CD | 68 CODE | 69 | 70 CODE | 71 | 72 CODE | 73 | 74 CODE | 75 | 76 ADM DIAG. CD | 77 E-CODE | 78 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4280 | 78052 | | | | | | | | 4280 | | |

| 79 P.C. | 80 PRINCIPAL PROCEDURE CODE | DATE | 81 OTHER PROCEDURE CODE | DATE | 82 ATTENDING PHYS. ID |
|---|---|---|---|---|---|
| | | | | | 87654321 |
| | | | | | IM Attending Physician |
| | OTHER PROCEDURE CODE | DATE | OTHER PROCEDURE CODE | DATE | 83 OTHER PHYS. ID |
| | | | | | |

84 REMARKS

OTHER PHYS. ID

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.