ND Health Enterprise MMIS
UB-04 Claim Form Instructions

These instructions address the North Dakota Health Enterprise MMIS paper claim requirements.

You must be an enrolled ND Medicaid provider to submit a claim. If you are not an enrolled provider, you can apply at:
https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment.

Enrollment instructions, updates, billing manuals, and companion guides are available online at http://www.nd.gov/dhs/info/mmis.html.

Questions

If you have any questions, please call the ND Health Enterprise MMIS Call Center at 1-877-328-7098.

Claims Mailing Address

ND Department of Human Services
Medical Services Division
Department 325
600 East Boulevard Ave
Bismarck, ND 58505-0250

Table of Contents

Field Requirement Definitions

Required

Fields marked **Required** in the claim form instructions are required on all paper claim submissions. The claim will be denied if a **Required** field is incomplete.

Not Required

Fields marked Not Required are not used in processing the claim. Providers are free to populate the field if desired.

Recommended

Fields marked <u>Recommended</u> are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house patient account number is provided, it will be returned on the remittance advice, thereby allowing billing staff to cross reference the claim with the provider's records.

Situational

Fields marked *Situational* are required when they apply to the claim.

Field	Requirement	Field Name and Description
1	**Required**	Billing Provider Name and Address: Enter the name and address of the billing provider.
2	Not Required	Pay to name and address
3a	<u>Recommended</u>	Patient Control Number: Enter the member's unique control number assigned by the provider (internal patient account number).
3b	Not Required	Medical/Health Record Number
4	**Required**	Type of bill: Enter the appropriate type of bill code. To replace or void a claim, see information on page 7.
5	<u>Recommended</u>	Federal Tax Number: Enter the provider's number assigned by the federal government for tax reporting purposes (also known as a Tax Identification Number (TIN) or Employer Identification Number (EIN)).
6	**Required**	Statement Covers Period: Enter the beginning service date in the From portion and the last service date in the Through portion of this field. For services provided on a single day, use the same From and Through dates.
7	Not Required	Reserved for assignment by the NUBC
8a	Not Required	Patient Name Identifier
8b	**Required**	Patient Name: Enter the member's last name, first name, and middle initial.
9a-e	Not Required	Patient Address
10	**Required**	Patient Birth Date
11	**Required**	Patient Sex
12	**Required**	Admission/Start of Care Date: Enter the start date for this episode of care.
13	*Situational*	Admission Hour: If inpatient, enter the hour when the member was admitted.
14	**Required**	Priority (Type) of Admission or Visit: Enter the type of the admission/visit.
15	*Situational*	Source of Referral for Admission or Visit: If inpatient, enter the source for this admission.
16	*Situational*	Discharge Hour: If inpatient, enter the hour when the member was discharged.
17	*Situational*	Patient Discharge Status: If inpatient, enter the member's disposition or discharge status at the end of service for the period covered on this bill.
18-28	*Situational*	Condition Codes: Enter conditions or events relating to this claim.
29	*Situational*	Accident State: If services reported on this claim relate to an auto accident, enter the 2-digit state abbreviation where the accident occurred.
30	Not Required	Reserved for assignment by the NUBC

31-34	*Situational*	Occurrence Codes and Dates: For claims with TPL, enter an occurrence code and associated date on Lines a and b according to proper billing order.
35-36	*Situational*	Occurrence Span Codes and Dates: Enter an occurrence span code and corresponding dates relating to this claim. (Complete all Fields in Line a before using the Line b Fields.)
37	Not Required	Reserved for assignment by the NUBC
38	Not Required	Responsible Party Name and Address
39-41	*Situational*	Value Codes and Amounts: Required when there is a value code that applies to this claim.
42	**Required**	Revenue Code: Enter one 4-digit revenue code per line as needed in Lines 1-22. Do not skip Lines. The revenue code must be current for the date(s) of service on the claim.
43	Not Required	Description of Services
44	*Situational*	HCPCS/Accommodation Rates/HIPPS Rate Codes: Enter the appropriate procedure code (HCPCS or CPT) and up to four modifiers. Note: On the 23rd Line of each page (including the first and last pages), enter the page number and total number of pages.
45	*Situational*	Service Date: Enter the date the service was provided. Note: The date in Field 45 must be within the date range indicated in Field 6.
46	**Required**	Service Units: Enter the total number of covered accommodation days, units of service, or visits.
47	**Required**	Total Charges: Enter charges per Line for covered and non-covered services during the billing period shown in Field 6.
48	*Situational*	Non-Covered Charges: Enter the charge for non-covered services.
49	Not Required	Reserved for assignment by NUBC
50A	**Required**	Payer Name: • If Medicaid is primary, enter the word **Medicaid**. • If Medicare is primary, enter the word **Medicare**. • If there is TPL, enter the name of the primary insurance.
50B-C	50b & 50c *Situational*	Payer Name: Enter the name of the secondary and tertiary insurance on Lines B and C, respectively. • **Required if** Medicaid is secondary/tertiary, enter the word **Medicaid**. • **Required if** Medicare is secondary/tertiary, enter the word **Medicare**. • **Required if** there is TPL, enter the name of the secondary/tertiary insurance.

51A-C	Not Required	Health Plan ID: Enter the carrier code for the member's TPL on Lines A and B, according to proper billing order.
52A-C	Not Required	Release of Information Certification Indicator
53A-C	Not Required	Assignment of Benefits Certification Indicator
54A-C	*Situational*	Prior Payments: Enter payment received from other insurance according to proper billing order. Do not include write-off or contractual adjustment amounts. Do not enter an amount on the line that lists the payer, Medicaid. If the claim has TPL, complete Field 54 on the first page. This information is not necessary on any other page of the claim.
55A-C	55A **Required**, 55B & 55C *Situational*	Estimated Amount Due: Single page claim or last page of a multi-page claim. • If Medicaid is primary; enter the amount of total covered charges for all pages on Line A. • If there is TPL, enter the total charges less prior payment. Do not include write-off or contractual adjustment amounts.
56	**Required**	National Provider Identifier-Billing Provider (NPI): Enter the billing provider's NPI.
57A-C	Not Required	Other Billing Provider Identifier
58A-C	Not Required	Insured's Name: Enter the insured's name for the primary, secondary, and tertiary insurance on Lines A, B, and C, according to proper billing order. On the line that shows payer, Medicaid, enter the member's name.
59A-C	Not Required	Patient's Relationship to Insured
60A	**Required**	Insured's Unique Identifier: Enter the insured's unique identifier for the primary, secondary and tertiary insurance on Lines A, B and C according to proper billing order. On the line that shows payer, Medicaid, enter the 9-digit Member ID.
60B-C	*Situational*	Required if 50B and 50C are completed
61A-C	Not Required	Insured's Group Name
62A-C	Not Required	Insured's Group Number
63A-C	*Situational*	Service Authorization Code: If you obtained a 12-digit authorization number from Medicaid for the service/item, enter it on the line that shows payer, Medicaid. Only one authorization number may be entered per claim.

64A-C	*Situational*	Document Control Number: When replacing or voiding a previously paid claim, enter the claim's last paid Transaction Control Number (TCN) on the line that shows payer, Medicaid. Only one TCN may be entered per claim. To replace or void a claim, see information on page 7.
65A-C	Not Required	Employer Name (of the Insured)
66	**Required**	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)
67	**Required**	Principal Diagnosis Code and Present on Admission Indicator: Enter the diagnosis code for the member's primary condition.
68	Not Required	Reserved for assignment by the NUBC
69	*Situational*	Admitting Diagnosis Code: If inpatient, enter the diagnosis code describing the member's reason for admission.
70A-C	*Situational*	Patient's Reason for Visit: Enter up to 3 diagnosis codes to describe the patient's reason for the visit at the time of outpatient registration.
71	Not Required	Prospective Payment System (PPS) Code
72A-C	*Situational*	External Cause of Injury (ECI) Code: Enter up to 3 diagnosis codes and present on admission indicator. This is required when a diagnosis describes an injury, poisoning or adverse effect.
73	Not Required	Reserved for assignment by the NUBC
74	*Situational*	Principal Procedure Code and Date: Enter a claim level diagnosis code that identifies the principal inpatient procedure and the date on which the procedure was performed. This is only required on inpatient claims when a procedure was performed.
74a-e	*Situational*	Other Procedure Codes and Dates: Enter diagnosis codes to identify all significant procedures (other than the principal) and the dates on which each procedure was performed. This Field is required on inpatient claims when additional procedures must be reported.
75	Not Required	Reserved for assignment by the NUBC
76	**Required**	Enter the Attending Provider's NPI, and Last and First Name.
77	*Situational*	For paper forms enter the Operating Provider's Role qualifier, NPI, Taxonomy code, and Last and First Name.
78	*Situational*	For paper forms enter the Other Provider's Role qualifier, NPI, Taxonomy code, and Last and First Name.
79	*Situational*	For paper forms enter Other Provider's NPI, Taxonomy code, and Last and First Name.

80	**Required**	Enter the Attending Provider's Taxonomy on line 1. ** Box 76 may continue to be used for Attending providers' Taxonomy if the software is already configured to accept it. Enter remarks/comments in lines 2 & 3.
81a-d	**Required**	Code Field: Enter the qualifier code of B3 followed by billing provider's Taxonomy code.

Replacing a Claim

A claim replacement may be submitted to modify a previously paid claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

- Field 4: Use 7 as the last digit in the Type of Bill code
- Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).

  - If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
  - If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:
  Legacy ICN: 1015015320010
  Replaced Legacy ICN: 10**20**15015320010

Voiding a Claim

Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

- Field 4: Use 8 as the last digit in the Type of Bill code.
- Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).

  - If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
  - If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:
  Legacy ICN: 1015015320010
  Replaced Legacy ICN: 10**20**15015320010

Revision History

Section	Topic	Location	Revision Date
All	Change header revision date from June 2015 to Oct 2015	All pages	10/26/15
Intro	Remove mmisinfo email.	Page 1	10/26/15
76	Strike qualifier ZZ	Page 6	10/26/15
77	Strike qualifier ZZ	Page 6	10/26/15
78	Strike qualifier ZZ	Page 6	10/26/15
79	Strike qualifier ZZ	Page 6	10/26/15
50 b &c	Added Required if to each bullet	Page 4	11/18/15
76	Remove Taxonomy Code	Page 6	9/1/16
80	Added Attending Provider Taxonomy	Page 7	9/1/16

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a			
b		b		c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	PAGE ____ OF ____	CREATION DATE	TOTALS ➡						23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A						57 OTHER PRV ID	A
B							B
C							C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI QUAL
				LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST

80 REMARKS	81CC a	78 OTHER NPI QUAL
	b	LAST FIRST
	c	79 OTHER NPI QUAL
	d	LAST FIRST

UB-04 CMS-1450   APPROVED OMB NO. 0938-0997   **NUBC**™ National Uniform Billing Committee   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.