Gold Coast Health Plan℠
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UB-04 BILLING INSTRUCTIONS FOR LONG-TERM CARE CLAIMS

Long-Term Care providers need to submit their claim on a UB-04 form. The UB-04 form is the standard claim form that an institutional provider can use for billing of medical health claims.

Box #	Field Name / Description	Instructions
1	Provider Name, Address, ZIP Code, Telephone Number (optional)	**Required** Enter the name and address of the facility.
2	Pay to Name / Address / ID	**Situational** Enter the name and address if different from Box 1.
3a	Patient Control Number	**Optional** Enter the patient's financial record number or account number in this field. It may consist of letters and/or numbers and may be a maximum of 20 characters.
3b	Medical Record Number	**Optional** Enter patient's medical record number (up to 24 characters).
4	Type of Bill	**Required** Enter the appropriate three-digit code as follows: 1st digit: Type of Facility • 2 = Skilled Nursing (SNF) / Long-Term Care (LTC) 2nd digit: Classification • 1 = SNF / LTC 3rd digit: Frequency Definition • 1 = Admin through discharge claim. Use this code for a claim encompassing an entire course of treatment for which payment is expected, i.e., no further claims will be submitted for this patient. • 2 = Interim – First claim. Use this code for the first of an expected series of claims for a course of treatment. • 3 = Interim – Continuing claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. • 4 = Interim – Final claim. Use this code for a claim that is the last claim. The "through date" of this bill (Box 6) is the discharge date or date of death. • 7 = Adjustment / Replacement of prior claim. Use this code to correct a previously submitted and paid / denied claim.
5	Federal Tax Identification Number (TIN)	**Required** Enter the provider's Federal TIN.
6	Statement Covers Period (From – Through)	**Required** Enter the beginning and ending service dates for this claim. (MMDDYY)
7	Future Use	**N/A**

Box #	Field Name / Description	Instructions
8a	Patient ID	**Required** Enter the patient's ID exactly as shown on the patient's GCHP / Medi-Cal identification card.
8b	Patient Name	**Required** Enter the patient's name exactly as shown on the patient's GCHP / Medi-Cal identification card. (Last name, first name, middle initial / name)
9a-e	Patient Address	**Required** Enter patient's permanent address appropriately. 9a = Street Address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus (optional)
10	Patient Birth Date	**Required** Enter the patient's date of birth, using an eight-digit MMDDYYY (month, day, year) format (for example, September 16, 1967 = 09161967).
11	Patient Gender	**Required** Enter the patient's sex with capital letter. "M" for male or "F" for female.
12	Admission Date	**Required** Enter the date of the patient's admission to the facility in a six-digit format MMDDYY.
13	Admission Hour	**Required** Enter the hour of admission. Convert to the 24-hour (00-23) format. Do not include the minutes. **Tip:** The admit time of 1:45 p.m. will be entered as 13.
14	Admission Type	**Required** 1 = Emergency 2 = Urgent 3 = Elective 5 = Trauma Center 9 = Information Not Available
15	Source of Admission	**Required** 4 = Transfer from a hospital. 5 = Transfer from a Skilled Nursing Facility (SNF). 6 = Transfer from another health care facility.
16	Discharge Hour	**Required (if applicable)** Enter the discharge hour as follows: • Do not include the minutes. • Convert discharge hour to 24-hour (00-23) format, e.g. 3:00 p.m. = 15. If the patient has not been discharged, leave this box blank.

Box #	Field Name / Description	Instructions
17	Status	**Required** This code indicates the patient's status as of the "through" date of the billing period (Box 6). 01 = Discharged to home or self-care. 02 = Discharged / transferred to another short-term general hospital for inpatient care. 03 = Discharged / transferred to a SNF. 04 = Discharged / transferred to an Intermediate Care Facility (ICF). 05 = Discharged / transferred to another type of health care institution not defined elsewhere in this code list. 09 = Admitted as inpatient to this hospital. 20 = Expired. 30 = Still a patient. 50 = Discharged / transferred to Hospice – home. 51 = Discharged / transferred to Hospice – medical facility. 61 = Discharged / transferred within this institution to hospital-based Medicare-approved swing bed. 62 = Discharged / transferred to an inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital. 66 = Discharged / transferred to a Critical Access Hospital (CAH).
18 - 24	Condition Codes	**Required** Condition codes are used to identify conditions relating to this claim that may affect payer processing. Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing three conditions – "A1", "80" and "82" – enter "80" in box 18, "82" in box 19 and "A1" in box 20. Some applicable Medi-Cal condition codes are: • 80 – For Other Health Coverage • 81 – For emergency services
29	Accident State	**Not Required**
30	Future Use	**Not Required**
31-34	Occurrence Codes and Dates	**Optional** Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom, in numeric-alpha order starting with the lowest value. Example: If billing for two occurrence codes, "24" (accepted by another payer) and "05" (accident / no medical or liability coverage), enter "05" in box 31a and "24" in box 32a.
35-36	Occurrence Spans (Code and Dates)	**Optional** Same as box 31-34 applicable to occurrences with a date span.
37	Unlabeled	**Not Required**
38	Responsible Party Name and Address	**Optional**

Box #	Field Name / Description	Instructions
39-41	Value Codes and Amounts (Patient's Share of Cost)	**Required** Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. If billing for two value codes, "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in box 39a and "30" in box 40a. If the Share of Cost (SOC) collect / obligated is $50, enter 5000, not 50. Value codes and amounts are used to relate amounts to data elements necessary to process the claim. SOC Value Codes: • "23" • "31" • "FC"
42	Revenue Code	**Required** For the room and board, enter the applicable two-digit Accommodation Code preceding with two zeros. Example: For Accommodation Code 01, enter as 0001. Enter other applicable revenue codes for billing of other services rendered with this claim.
43	Description	**Optional** Information entered in this box will help separate and identify the descriptions of each service. The description must identify the service code indicated in the HCPCS / Rates Code box (44). *NDC codes for injection codes can be entered in this box. *
44	HCPCS Code	**Required If Applicable** When billing an injection code, HCPCS code (J code) is required for processing.
45	Service Date	**Required** Enter the beginning date of service or the date of service applicable to the billed service.
46	Service Units	**Required** Enter the applicable unit(s) of the service rendered. For the room and board, enter the total unit(s) / day(s) of care by revenue code. The total units / days for each room and board revenue code must total coverage of the statement period (Box 6).
47	Total Charges	**Required** In full dollar amount, enter the usual and customary fee for the service billed. Do not enter decimal point (.) or dollar signs ($). Enter the full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter "10000" not "100"). Enter the total charges for all services on the last line or on line 23.

Box #	Field Name / Description	Instructions
50 a-c	Payer Name	**Required** Enter "I/P MEDI-CAL" to indicate inpatient / room and board claim and payer. If the patient has Other Health Coverage (OHC), enter the insurance carrier name. NOTE: If the patient has OHC, the insurance carrier must be billed prior to billing GCHP.
51 a-c	Health Plan ID	**Optional**
52 a-c	Release of Info Certification	**Optional**
53 a-c	Assignment of Benefit Certification	**Optional**
54 a-c	Prior Payments (Other Coverage)	**Required If Applicable** Enter the full dollar amount of payment received from OHC, on line A or B, that corresponds with OHC in the Payer field (Box 50). Do not enter a decimal point (.) or dollar sign ($).
55 a -c	Estimated Amount Due (Net Amount Billed)	**Required If Applicable** In full dollar amount, enter the difference between "Total Charges" (Box 47, line 23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). Example: Patient's SOC Value Codes Amount and/or OHC Prior Payments.
56	NPI	**Required** Enter your facility's appropriate 10-digit National Provider Identifier (NPI) number.
57 a-c	Other Provider ID	**Optional**
58 a-c	Insured's Name	**Required If Applicable** Enter insured's name if other than patient.
59 a-c	Patient's Relationship to Insured	**Required If Applicable**
60 a-c	Insured's Unique ID	**Required** Enter the recipient's GCHP / Medi-Cal ID number as it appears on the patient's ID Card.
61 a-c	Group Name	**Optional**
62 a-c-	Insurance Group No.	**Optional**
63 a-c	Treatment Authorization Codes	**Optional** Enter GCHP's authorization number provided with the authorization given for the service billed.
64 a-c	Document Control Number	**Not Required**
65 a-c	Employer Name	**Not Required**
66	Diagnosis Code Header	**Required** Claims with diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10 diagnosis codes.
67	Primary Diagnosis Code	**Required** Include all letters and numbers of the ICD-10 diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include a decimal point. Present of Admission (POA) indicator. Each diagnosis code may require a POA indicator. A POA indicator must be entered (unless exempt) in the shaded portion of boxes 67 and 67a – to the right of the diagnosis field – to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in hospital.

Box #	Field Name / Description	Instructions
67 a-q	Secondary Diagnosis Code	**Required If Applicable** Enter all letters and/or numbers of the secondary ICD-10 diagnosis code(s) to the highest level of specificity (when possible). Do not include a decimal point.
68	Unlabeled	**Not Required**
69	Admitting Diagnosis Code	**Required** Enter all letters and/or numbers of the admitting ICD-10 diagnosis code. Do not include a decimal point.
70	Patient Reason for Visit Code	**Not Required**
71	PPS Code	**Not Required**
72	External Cause of Injury Code	**Not Required**
73	Unlabeled	**Not Required**
74	Principal Procedure Code and Date	**Required If Applicable** Enter the appropriate ICD-10 PCS code identifying the primary medical or surgical procedure. Enter the ICD-10 PCS code without periods or spaces between the numbers. Enter the date the procedure was performed, in a six-digit format.
74 a-e	Other Procedure Codes and Dates	**Required If Applicable** Enter the appropriate ICD-10 PCS code, identifying the secondary medical or surgical procedure, without any periods or spaces between the numbers.
76	Attending Provider	**Optional** Enter the attending physician's NPI in the first box. Do not enter the group number. The attending physician's first and last name is not required.
77	Operating Physician	**Optional** Enter the operating physician's NPI in the first box. Do not enter the group number. The operating physician's first and last name is not required.
78-79	Other	**Optional** Enter other provider / physician NPI in the first box. Do not enter the group number. The provider / physician first and last name is not required.
80	Remarks	**Optional** Use this area for comments / notes regarding this claim.
81 a-d	Code-Code Field / Qualifiers	**Not Required**