UB04 Claim Form Submission Instruction

Providers must use UB04 form when submitting claims to Contra Costa Health Plan (CCHP) for inpatient and outpatient services performed at institution facilities. The data elements are the same for both paper and electronic claims submission. All fields must be completed unless otherwise noted in these instructions.

Field Number	Requirement	Description and Additional Requirements
1	Required	Rendering provider's name and full address including city, state, zip code, and phone number
2	Required	Pay-to provider's name and full address including city, zip code, and phone number
3a	Optional	Patient Control Number – this number is reflected on the explanation of benefits for reconciling payments if needed
3b	Not required	Medical Record Number – not required (please see instruction for box 60)
4	Required	Type of Bill – enter the four-character type of bill code as specified in the National Uniform Billing Committee (NUBC) UB04 data specifications manual
5	Required	Federal Tax Number – Enter the federal tax ID for the billing facility
6	Required	Statement Covers Period – Enter the "from" and "through" dates covered in the claim
7	Not required	Not used
8a	Not required	Not used. Please use box 8b for patient's name
8b	Required	Please enter patient's last name, first name, and middle initial. If you are submitting a claim for a newborn, please enter infant's name in box 8b.
9	Optional	Patient Address
10	Required	Patient Birthdate – enter patient's birthday in the month, date, and year (MMDDYYYY) format
11	Required	Patient Sex – use the capital letter "M" for male or "F" for female
12	Required	Admission Date – enter the date of hospital admission in the six-digit: month, date, and year (MMDDYY) format
13	Required	Admission Hour – enter the hour of patient's admission
14	Required	Admission / Visit Type – enter the numeric code indicating the necessity for admission to the hospital. 1 – Emergency, 2 – Elective
15	Required	Admission Source – enter the numeric code indicating the source of admission or transfer:

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		1 – Non-Healthcare Facility Point of Origin 2 – Clinic or physician's office 4 – Transfer from a Hospital (Different facility) 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 – Transfer from Another Healthcare Facility 7 – Emergency Room 8 – Court / Law Enforcement 9 – Information Not Available D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E – Transfer from Ambulatory Surgery Center (ASC) F – Transfer from a Hospice Facility
16	Required	Discharge hour – enter the discharge hour for inpatient only
18-28	Optional	Condition Codes – enter the Medi-Cal codes used to identify the condition(s) relating to this claim
29	If applicable	Accident State – If the service is related to an accident, enter the state in which the accident occurred
30	Not required	Not Used
31-34	If applicable	Occurrence Codes and Dates – enter the codes and associated dates related to the claim
35-36	Not required	Occurrence Span Codes and Dates
37	Not required	Internal Control Number / Document Control Number
38	If applicable	Responsible Party's Name and Address - Enter if the party responsible for payment is different from the name in box 50
39-41	Not required	Value Codes and Amounts
42	Required	Revenue Code – For inpatient billing, enter the four-digit revenue code for the services provided
43	Required	Revenue Description – Identify the description of the revenue code entered in box 42 or HCPCS code in box 44. If applicable, include NDC/UPN Codes in this box
44	Required	HCPCS / Rate – Enter the applicable HCPCS codes and modifiers
45	Required	Service Date – Enter the service date in MMDDYY format for outpatient billing

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46	Required	Units of Service – Enter the actual number of times or units a single procedure or item was performed or provided for the date of service
47	Required	Total Charges for the procedure or item
48	Not required	Non-Covered Charges
49	Not required	Not Used
50	Required	Payer Name – Enter “Contra Costa Health Plan”
51	Not required	Health Plan ID
52	Not required	Release of Info Certification
53	Not required	Assignment of Benefit Certification
54	If applicable	Prior Payments – Enter any prior payments received from Other Coverage in full dollar amount
55	Not required	Estimated Amount Due
56	Required	NPI – Enter NPI number
57	Not required	Other Provider IDs
58	If applicable	Insured’s Name – enter the mother’s name if billing for an infant using mother’s ID. Otherwise, leave blank
59	If applicable	If billing for an infant using the mother’s ID, enter “03” for child
60	Required	Insured’s Unique ID – enter the patient’s CCHP ID as it appears in the member’s ID card. Enter the mother’s ID number for a newborn infant for the month of birth and the month after only. Do not use the SSN
61	Not required	Insured Group Name
62	Not required	Insured Group Number
63	If applicable	Treatment Authorization Code – Enter any authorization numbers in this field. Member information from the authorization must match the claim
64	Not required	Document Control Number
65	Not required	Employer Name
66	Required	Diagnosis / Procedure Code Qualifier
67	Required	Principal Diagnosis Code / Other Diagnosis Codes – Enter all letters and/or numbers of the ICD-10 CM code describing the chief reason for performing the service
68	If applicable	Other Diagnosis Codes – Enter all letters and/or numbers of the secondary ICD-10 CM code

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69	If applicable	Admitting Diagnosis – Enter all letters and/or numbers of the ICD-10 CM code describing the patient's diagnosis or reason for visit at the time of admission
70	Optional	Patient's Reason for Visit
71	Optional	Prospective Payment System Code
72	Not required	External Cause of Injury Code
73	Not required	Not Used
74	If applicable	Principal Procedure Code / Date
75	Not required	Not Used
76	Required	Attending Provider's NPI, name, and ID-Qualifier
77	If applicable	Operating Provider's NPI, name, and ID-Qualifier
78-79	If applicable	Other Provider's NPI, name, and ID-Qualifier
80	If applicable	Remarks
81CC	Not required	Code – Code Field / Qualifiers