

Humana Dual Fully Integrated (HMO D-SNP) Provider Billing Guide

Effective: Jan. 1, 2026

PROVIDER BILLING GUIDE – ILLINOIS
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Humana Claims Payment Policies — Medical Claims

Humana makes its medical claims payment policies publicly available online to promote transparency for healthcare providers and their billing offices. By providing detailed information regarding reimbursement methodologies and acceptable billing practices, Humana assists providers in submitting accurate claims. This initiative is designed to reduce processing delays, minimize the need for rebilling, and limit additional requests for information. For further details, healthcare providers may refer to Humana's official documentation and resources available on the Humana's claims payment policies website.

Balance billing

In the event Humana Dual Fully Integrated issues a partial payment or denial for services rendered to a member due to lack of medical necessity, the provider cannot bill, charge, or seek payment or have any recourse against the member.

Educational tutorials

Providers may explore educational training and guidelines online from our Making It Easier tutorials.

Humana Medical Claim Types

Medicare Claims Processing Manual

Providers can access chapter 1 of the Medicare Claims Processing Manual on the Centers for Medicare & Medicaid Services (CMS) website for more details on how to bill a managed care plan.

Chapter 1 - Medicare Claims Processing Manual

Inpatient hospital billing

Inpatient hospital services refer to medically necessary care provided to beneficiaries who are formally admitted to a hospital with a physician's order. These services include room and board, nursing care, diagnostic and therapeutic procedures, and other hospital services provided during the patient's stay.

Chapter 3 - Medicare Claims Processing Manual

Chapter 6 - Medicare Claims Processing Manual (SNF Inpatient Part A Billing)

Outpatient hospital billing

Outpatient hospital services are medically necessary procedures, treatments, and diagnostic services provided to Medicare beneficiaries without an inpatient admission. These services are billed under the Outpatient Prospective Payment System (OPPS) using appropriate codes and documentation, and may include same-day surgeries, emergency care, laboratory tests, and imaging.

Chapter 4 - Medicare Claims Processing Manual

Chapter 5 - Medicare Claims Processing Manual (Part B Outpatient Rehabilitation and CORF/OPT Services)

Chapter 7 - Medicare Claims Processing Manual (SNF Part B Billing)

Federally qualified health clinics and rural health clinics

Federally qualified health clinics (FQHCs) are facilities that provide services that are typically furnished in an outpatient clinic setting. FQHC services consist of services that are like those furnished in rural health clinics (RHCs).

RHCs are healthcare facilities that deliver services commonly provided in an outpatient clinic setting. An RHC visit is defined as a medically necessary, face-to-face medical or mental health visit, or a qualified preventive health visit, conducted with an RHC practitioner. During such a visit, one or more RHC services must be rendered.

Follow the link below to learn more about FQHC and RHC claim billing requirements.

Chapter 9 - Medicare Claims Processing Manual

Hospice billing

Hospice services provide comprehensive, interdisciplinary care for patients with a terminal illness who elect the hospice benefit. These services include pain and symptom management, skilled nursing, counseling, social work, spiritual support, and assistance with daily living activities to promote comfort and quality of life.

Chapter 11 - Medicare Claims Processing Manual

Physician/practitioner billing

Physician services under CMS guidelines refer to medically necessary care provided by licensed physicians to Medicare beneficiaries in various settings, including offices, hospitals, and clinics. These services encompass diagnosis, treatment, surgical procedures, consultations, and preventive care.

Chapter 12 - Medicare Claims Processing Manual

Chapter 13 - Medicare Claims Processing Manual (Radiology Services)

Chapter 16 - Medicare Claims Processing Manual (Laboratory Services)

Chapter 18 - Medicare Claims Processing Manual (Preventative and Screening Services)

Durable medical equipment, prosthetics, orthotics, and supplies

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) include medically necessary equipment and supplies prescribed for use in the home by Medicare beneficiaries.

Examples include wheelchairs, walkers, oxygen equipment, prosthetic devices, and diabetic supplies.

Chapter 20 - Medicare Claims Processing Manual

Please update the 365 days from the date of service to 180 days from the last date of service.

Timely filing requirements for medical claims

Humana's timely filing requirements for all providers (in- and out-of-network) is 365 days from the date of service. If the member has other coverage, the time frame for claim submission begins on the date of payment or notification of nonpayment from the primary payer. If Medicare covers the service, the time frame begins on the date of adjudication for the Medicare claim. Humana makes available to providers an electronic means of submitting claims.

Home- and Community-based Health Waiver Providers

Managed care organizations (MCOs) implemented updated standard claims submission processes for the reimbursement of services rendered by certified and enrolled home- and community-based services (HBCS), or "waiver," providers. As required by the Illinois Department of Healthcare and Family Services (IDHFS), HCBS waiver providers are eligible to render covered services and must adhere to the following prescribed billing criteria to be reimbursed accordingly by MCOs:

Services overview

The state offers services and programs that allow members to be independent while remaining in their homes through a collaborative effort between the Illinois Department on Aging (IDoA), the Department of Human Services/Division of Rehabilitation Services (DRS), and IDHFS. It is administered by MCOs.

The state determines a member's eligibility for these service programs by performing a Determination of Need (DON) assessment. The DON is used to analyze and score the member's level of need. This scoring is the basis for the member's service plan.

There are five different waiver programs the MCO administers and for which the providers of service bill for reimbursement:

Persons who are Elderly waiver: IDoA operates this waiver population for people 60 or older, who are otherwise eligible for or at-risk for nursing facility care, as evidenced by a DON.

Person with Disabilities waiver: DRS operates this waiver population for people younger than 59 with disabilities (those aged 60 or older, who began services before age 60, may choose to remain in this waiver). MCO waiver eligibility requires that the member be severely disabled for at least 12 months or for the life of the member and be eligible for or at-risk for nursing facility care as evidenced by a DON.

Person with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) waiver: DRS administers this waiver population for people of all ages diagnosed with HIV or AIDS who are at-risk of hospital or nursing facility care as evidenced by a DON.

Persons with Brain Injuries (BI)/Traumatic Brain Injury (TBI) waiver: DRS administers this waiver population for people of all ages living with brain injuries that directly result in functional limitations, including traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain, and toxic encephalopathy. This disability must be severe and expected to last for at least 12 months or for the life of the member, placing the member at risk of placement in a nursing facility, as evidenced by a DON.

Supportive Living Program waiver: IDHFS operates the Supportive Living Program (SLP) waiver population for people 65 and older or persons with disabilities (as determined by the Social Security Administration [SSA]) 22 and older. Eligible individuals are found to be in need of nursing facility level-of-care and a supportive living program (SLP) after screening by IDHFS. Individuals must not have a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. Finally, an individual's income must be equal to or greater than current supplemental security income (SSI) and they must contribute all but $90 toward lodging, meals, and services. Food stamp benefits may be used toward meal costs.

NOTE: Refer to the IAMHP Billing Manual section for SLP providers.

IDHFS identifies individuals who are eligible for waivers on the 834 enrollment files that they share with MCOs in addition to the workflows set up directly with IDoA, care coordination units (CCUs), and DRS.

Balance billing

In the event Humana Dual Fully Integrated issues a partial payment or denial for services rendered to a member due to lack of medical necessity, the provider cannot bill, charge, or seek payment or have any recourse against the member.

Provider Type, National Provider Identifier, Other Identifiers, and Taxonomy Codes

The following IDHFS provider types are considered HCBS waiver providers that can be billed to an MCO:

IDHFS provider type	IDHFS description
090	Waiver service provider – elderly (IDoA)
092	Waiver service provider – disability (DHS/DRS)
093	Waiver service provider – HIV/AIDS (DHS/DRS)
098	Waiver service provider—TBI (DHS/DRS)

To file a claim for services that an MCO approved for one of the five HCBS waivers described above, waiver providers must register with Illinois Medicaid Advanced Cloud Technology (IMPACT), a multi-agency state initiative designed to provide a web-based system that offers more convenient and consistent provider user experiences and ensures that state beneficiaries receive timely and high-quality Medicaid services.

Many HCBS providers are considered atypical by the IDHFS IMPACT system. An atypical provider is defined as one whose Medicaid member ministrations are not considered healthcare services. These providers are not required to obtain a National Provider Identifier (NPI). CMS defines atypical providers as those who do not provide healthcare; further clarification is offered under Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations in 45 CFR 160.103.

Taxi services, home, and vehicle modifications and respite services are examples of atypical providers that may be reimbursed by the Medicaid program. If these providers submit HIPAA transactions, they do not meet the HIPAA definition of healthcare and should not receive an NPI number.

When billing HCBS services, the provider should only use their IDHFS Legacy Provider Number (Medicaid ID) and should not send in an NPI on the claim.

MCOs require the IDHFS Legacy Provider Number on the claim match the IMPACT Legacy Provider Number (Medicaid ID). MCOs do not process claims that use a number that does not

match the corresponding IDHFS Legacy Provider Number and IMPACT-registered categories of service, specialties, etc. For example, an IDHFS number registered as provider type “Waiver Service Provider – Elderly 090” should not be billed on a claim for a member who has a TBI Waiver.

A valid Medicaid ID must be on the 837P Billing Provider Secondary Identification Loop 2010BB Loop in a REF01 Segment, qualified by ‘G2’ and the REF02 equal to the provider’s Medicaid ID, as registered in IMPACT for their respective waiver provider type.

If the provider has multiple registrations with IDHFS for provider types outside the HCBS service realm, the provider should only bill their NPI on the claim for non-HCBS services.

For example, if the provider is registered as an IDHFS Home Health Provider Type (050) and registered as a HCBS Service Provider (090), the provider should bill on an 837I and must use their NPI in the 2010AA Billing Loop when billing for home health services. When billing as HCBS with IDHFS provider type 090, the claim must be on an 837P and the provider must submit their Medicaid ID without an NPI.

Personal assistants and individual providers

MCOs collaborate with each member to develop an individualized care plan that may include personal assistants. MCOs provide care coordination and oversight of provided member services. Nonagency personal assistants (PAs) and individual providers (IPs) are required to enroll in IMPACT. When seeking reimbursement, PAs and IPs do not submit claims directly to MCOs. They are required to log their time using an electronic visit verification (EVV) system. From there, the payment is issued by the state.

Categories of Service and Specialties

Although categories of service (COS) are not directly added to a claim submitted to an MCO, the specialties and subspecialties registered in the IDHFS Provider IMPACT system are critical to accurate claims payment. If the appropriate specialty or subspecialties are not registered with IDHFS, claims are denied. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by IDHFS.

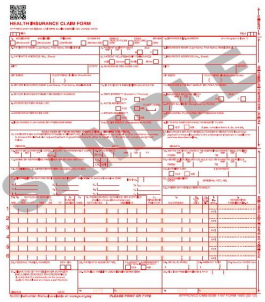
IDHFS legacy category of service	IMPACT subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN, and Therapist
093	Individual Providers PA, RN, LPN, CAN, and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite Care
097	Other HCFA-Approved Services
098	Electronic Home Response / EHR Installation

Humana-approved Claim Forms for Billing

A claim is defined as a request for payment for benefits or services rendered to a beneficiary. When you provide covered services to a Humana member, you are required to submit a claim to Humana for payment processing.

To assist healthcare providers in understanding how to properly populate approved billing forms, we created this billing guide. This document contains detailed instructions for completing the mandatory areas of the various claim form types Humana uses.

Humana allows participating network healthcare providers to submit claims in either paper or electronic format. Those submitting paper claims must use one of the following approved standard forms:

Form types	Form descriptions	Example
CMS-1500 Claim Form	The official standard form used by physicians, private insurers, managed care plans, and other provider types when submitting bills/claims for reimbursement to Medicare or Medicaid for health services. CMS-1500 contains patient demographics, diagnostic codes, CPT/HCPCS codes, diagnosis codes, and units.	
UB-04/CMS-1450 Claim Form	The UB-04 claim form is the nationally recognized bill form used by hospitals, payers, healthcare service facilities, and other institutional providers, such as nursing homes.	

Submitting Claims to Humana for Payment

Paper claim submission instructions

Humana encourages healthcare providers to submit claims electronically; however, if you need to submit via paper, Humana accepts claims submitted on the red and white (CMS-1500 and UB-04) claim forms. Although the manual entry process increases the claims processing time, Humana remains committed to paying all healthcare providers in a timely and accurate manner. All completed paper claims should be mailed to the following address for processing:

Humana
P.O. Box 14601
Lexington, KY 40512-4601

Electronic claims and electronic data interchange transactions frequently asked questions

Q: Can I submit Humana Dual Fully Integrated claims to Humana electronically?

A: Yes. Providers can submit claims through Direct Data Entry via Availity Essentials™. Availity Essentials offers a free web tool for healthcare providers to upload batch claims electronically. Healthcare providers:

- Must register for a user account on Availity Essentials
- Should have claims software with electronic data interchange (EDI) file creation capabilities

Q: How do I get started with electronic claims?

A: Healthcare providers who already have an EDI solution or electronic billing software need to set up Humana as a payer in their systems before they can submit electronic claims. Humana uses Availity Essentials as its EDI vendor. The Humana EDI payer ID is **61101**. Please use this number for arranging transfer of information from your clearinghouse to Availity Essentials.

Q: What if I don't contract directly with your clearinghouse?

A: Though Humana uses Availity Essentials as its clearinghouse for EDI claims, we do not recommend any specific EDI solution. You are free to select the vendor of your choice. If your system vendor submits claims through another clearinghouse, that intermediary clearinghouse can forward your Humana claims to Availity Essentials.

Q: How do we set up the payer ID within the software system used in my office?

A: Humana uses Availity Essentials as its EDI vendor. The Humana EDI payer ID is 61101 and must be set up in your practice management system or billing system as an available EDI claim payer ID. EDI connectivity is related to your billing system or practice system vendor. As software systems work differently, please reach out to your practice management or billing system vendor for more information or for instructions on how to add an additional payer ID to your system.

Q: Who do we contact if we have difficulty submitting claims electronically?

A: Connectivity among EDI vendors, clearinghouses, and payers is complex and comprehensive. Please contact your system vendor for answers to questions about claims connectivity for their clients.

Please be sure to the use the proper payer information for Humana Dual Fully Integrated claims. Use of a payer ID or payer information other than the one provided may result in unpaid claims due to misrouting.

Technical support is provided by Availity Essentials Customer Service at 800-282-4548.

Provider profile update request

Please contact your provider relations representative to update your demographic information.

Claim inquiries, reconsiderations, and grievances

Healthcare providers may inquire about claim status, payment amounts, or denial reasons. To check the status of outstanding claims, you may contact the Humana Claims Department at **800-787-3311 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m., Central time.

A healthcare provider also may make a simple request for reconsideration by clearly explaining the reason why the claim was not adjudicated correctly. Contact the claims department for information on how to request a claims adjustment or reconsideration. To file a claim-related grievance, please refer to the corresponding section of the provider manual provided to you or delivered to your office after contracting.

Please also refer to your provider manual for information on timely claims submissions. To request a copy of the provider manual, call Humana at **800-787-3311**. After receiving receipt of your request, an electronic version can be emailed to you within 24 to 48 hours.

Quick Contact Reference Guide

To assist you in day-to-day operations, we include this list to help you promptly reach the appropriate plan contacts.

Humana Medical/HMO D-SNP Claims
P.O. Box 14601
Lexington, KY 40512-4601

Payer: Humana **Payer ID:** 61101

Department	Function	Contact
Provider Help Line	Prior authorization requests Clinical coordination Case management contact	Telephone: **800-787-3311** TTY: 711
Claims Department	Billing assistance Claims processing Claims inquiry	
Humana Customer Care Line	Member assistance Benefit information	
Provider Relations **Participating providers**	Contracting Credentialing Education	

Submit written claims to:
P.O. Box 14601
Lexington KY 40512-4601

Contact for claims dispute:
800-787-3311

Illinois DHF https://www.dhs.state.il.us/page.aspx

Humana Dual Fully Integrated – Member https://www.humana.com/

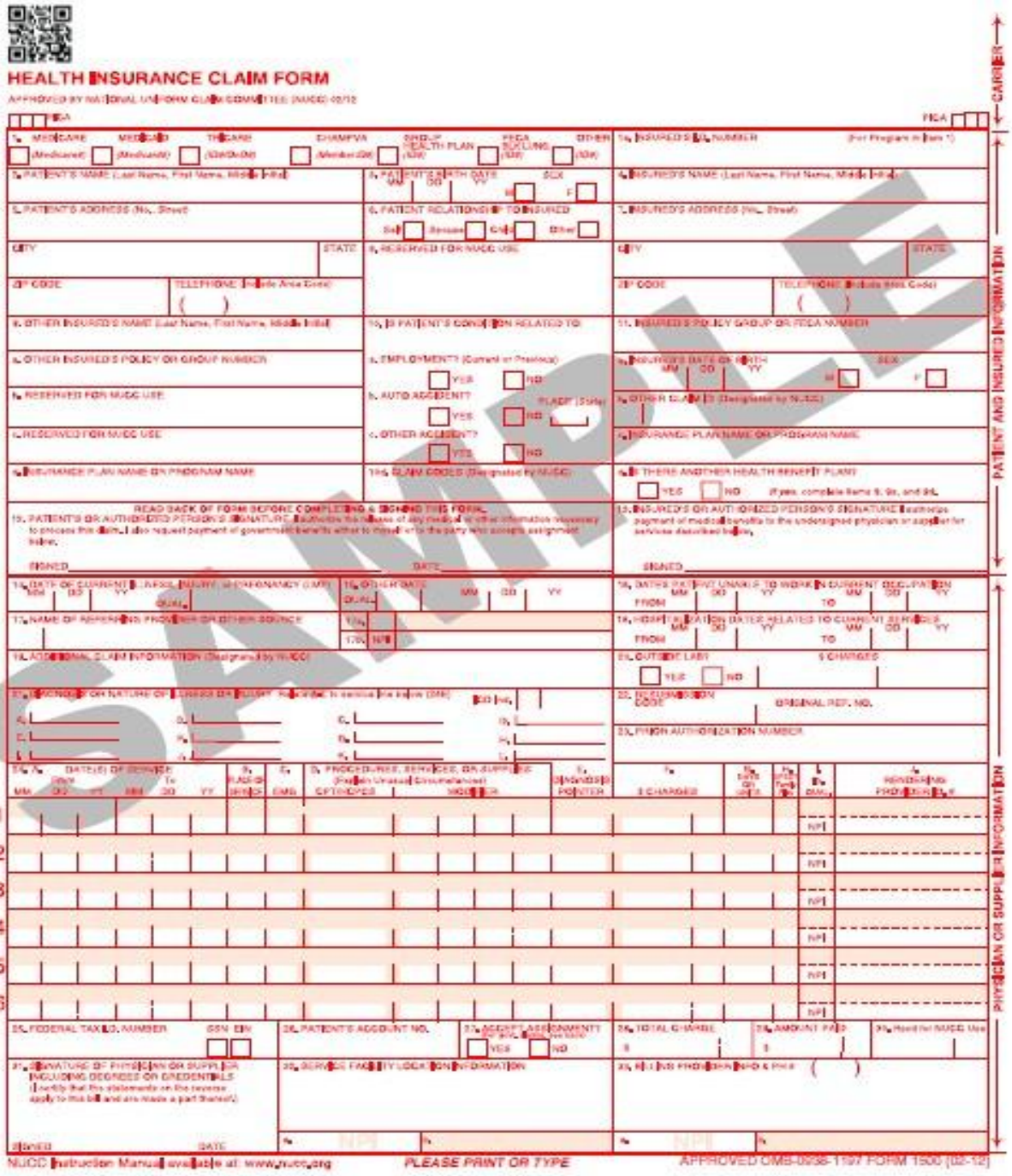
Complete the CMS-1500 Form

CMS-1500 forms can be purchased via a variety of approved suppliers, such as Office Depot. Fillable PDF versions also can be purchased through online vendors. Fillable PDF templates can be completed on a computer. The completed form must also be printed, signed and mailed.

Some healthcare provider types that bill on the CMS-1500 include:

- Adult day care
- Home maker agency
- Home health agency
- Assistive technology
- Personal care agency
- Personal emergency response system
- Service facilitators
- Environmental modifications
- Private duty nursing

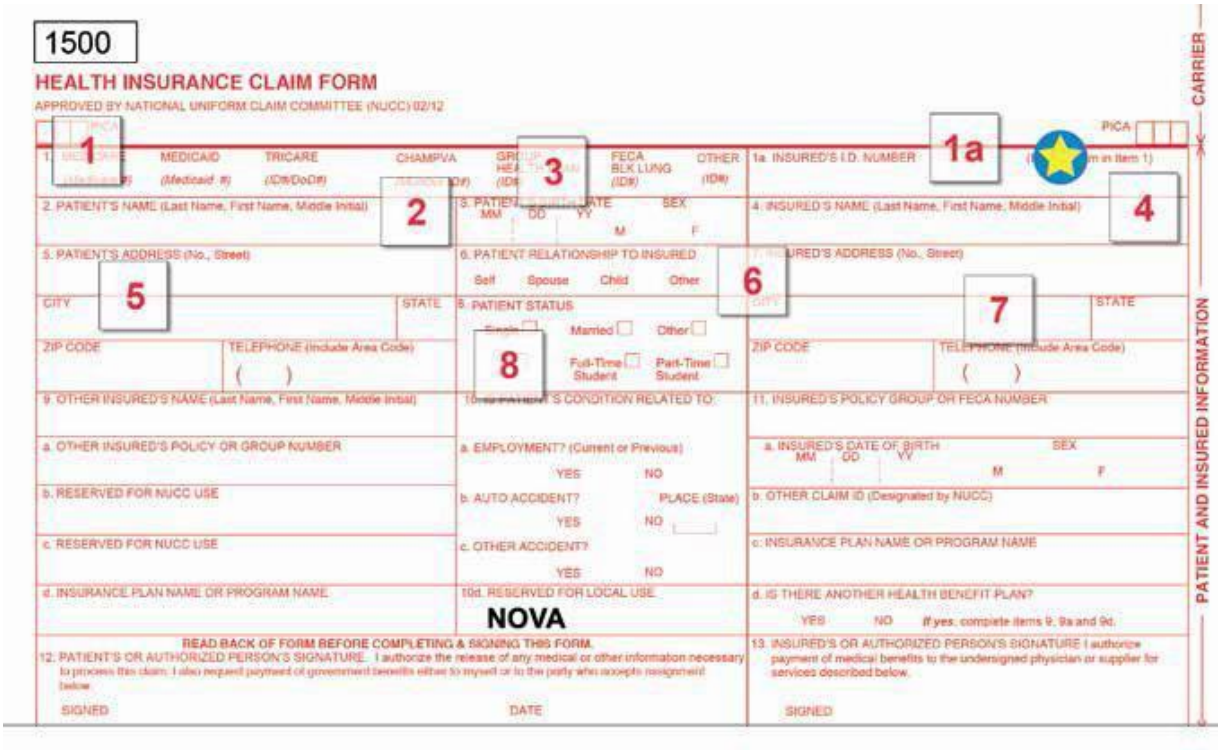
BLANK CMS-1500 CLAIM FORM



1 Subscriber information

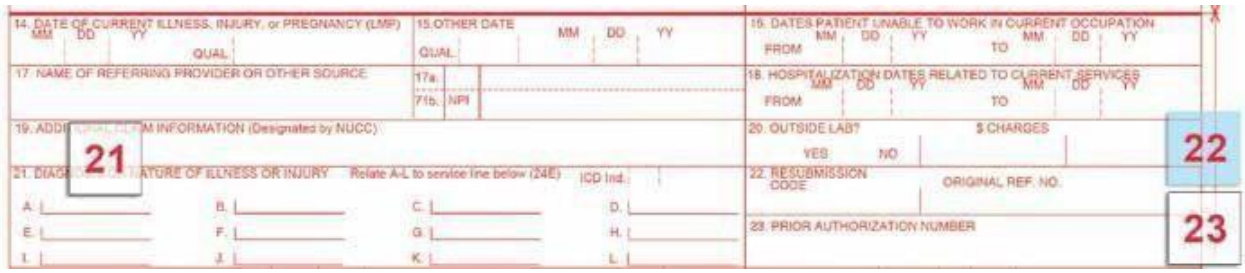
#	Field name	#	Field name
1a	**Insured's ID number** Enter the subscriber ID as it appears on the insurance card. This number replaces the Medicaid ID number.*	**5**	**Patient demographic information** Enter all patient demographic information.
2	**Patient's name (e.g., last name, first name)** Enter the patient name in the format indicated.	**6**	**Patient relationship to insured** Check the correct box to indicate the patient's relationship to the insured.
3	**Patient date of birth and gender** Enter birth date in mm/dd/yy format and check proper gender box.	**7**	**Insured demographic information** Enter the demographic information of the insured. This is a required field. If the patient and insured are the same, repeat the patient demographic information here.
4	**Insured's name (e.g., last name, first name)** Enter name of insured in the format indicated.	**8**	**Patient status (marital status only)**

*Insert the Humana plan-issued member ID.



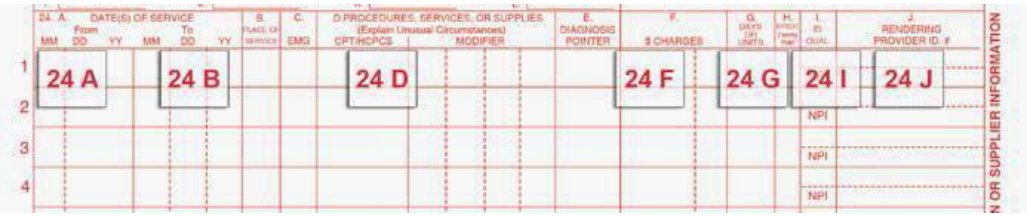
2 Diagnosis information

#	Field name	Field instructions
21	**Diagnosis or nature of illness or injury**	Enter the diagnosis code included on the authorization or service request for the patient. If there is no code on the authorization form, use code R58.31 (Other Malaise). In most cases, this is the code used.
22	**Resubmission code**	Enter code 7 (replace original claim) to indicate that this is a corrected or replacement claim. In the "Original Ref. No." section, enter the number of the original claim you are replacing. This code is required only if you resubmit a claim.
23	**Prior authorization** All services must be authorized. *Please note that an authorization is not a guarantee of payment.	Enter the authorization number listed on the service request form. If you haven't received a new authorization number from the member's new managed care plan, please contact the plan before billing to request that a new authorization be sent to you.



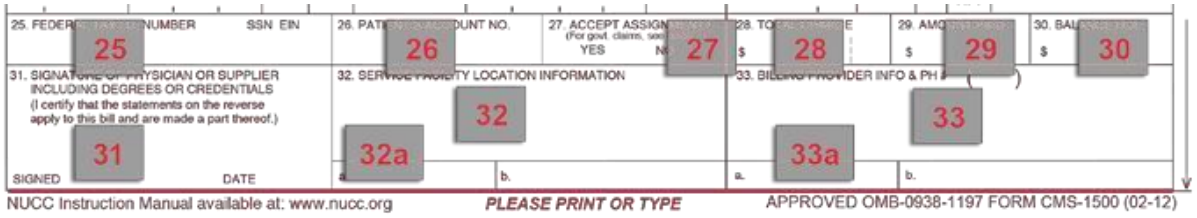
3 Service information

#	Field name	Field instructions
24a	**Date(s) of service**	Enter the date of service for each procedure, service, or supply on an individual line. (Exception: Healthcare providers on a capitated agreement may use a date range for dates of service after meeting their maximum allowable amount.) The form provides a maximum of six line entries. If the claim surpasses the lines of entries provided, complete a separate CMS-1500 form for all remaining entries.
24b	**Place of service**	Enter the two-character place of service code (as per the CMS-1500 Reference Guide). In most cases, code 12 is used in this field.
24c	**EMG**	Not applicable.
24d	**Procedures, services, or supplies**	Enter the CPT code(s) as listed on the authorization for service provided by Humana. In most cases, no modifiers are needed.
24e	**Diagnosis pointer**	Not applicable.
24f	**$ Charges**	Enter the charge amount for the service. Refer to your Humana agreement for contracted rates.
24g	**Days or units**	Enter the days or units provided for the procedure. All authorizations should indicate the proper unit increment.
24h	**EPSDT Family Plan**	Not applicable.
24i	**ID qualifier**	Enter the ID qualifier. (NPI only)
24j	**Rendering provider NPI**	Enter the NPI of the rendering provider.

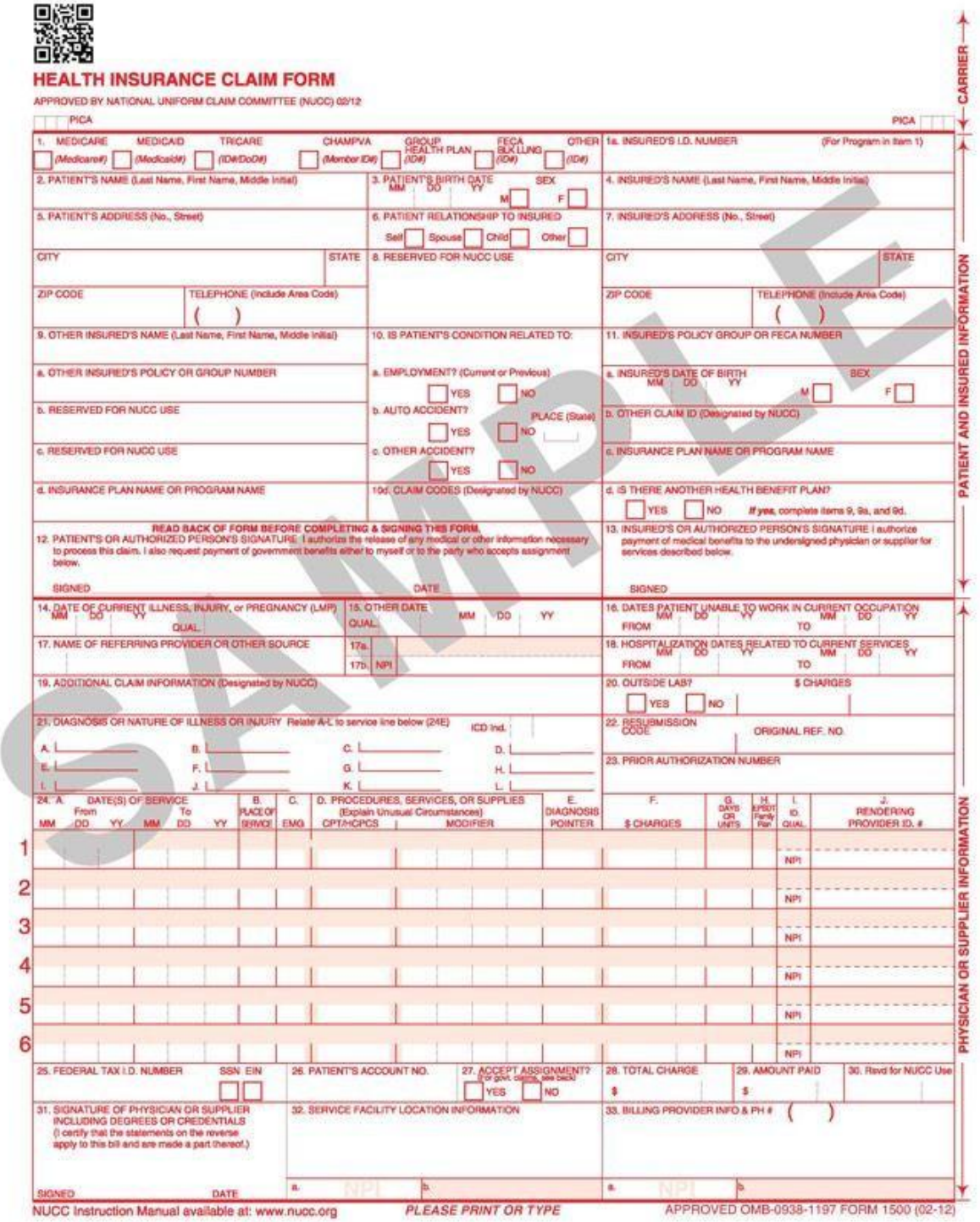


4 Billing and financial information

#	Field name	Field instructions
25	**Federal Tax ID number (TIN)**	Enter the health care provider's TIN or Social Security number (SSN) and check the box to indicate tax ID type.
26	**Patient account number**	Enter the patient's account number. This is the provider's internal account number for the patient.
27	**Accept assignment**	Check "yes" to accept the assignment.
28	**Total charge**	Enter the total charge for the services listed.
29	**Amount paid**	Enter the total amount paid by all other insurance sources.
30	**Balance due**	Enter the remaining balance due from Medicaid.
31	**Signature**	Signature of the person completing the form.
32	**Servicing provider location information**	Enter the servicing healthcare provider's name, address (including ZIP+4), and phone number.
32a	**Servicing provider NPI**	Enter the NPI of the servicing provider location. In some cases, this may differ from the billing provider location. 32b: Not applicable.
33	**Billing provider information and phone number**	Enter the billing provider's name, address, and phone number. Include ZIP code + 4. 33a: Enter the NPI (same from 24i). 33b: Not applicable.



EXAMPLE OF A CLEAN CMS-1500 CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF (SERVICE)	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Completing the UB-04/CMS-1450 Form

Best practices in billing protocol (nursing homes)

This document is meant to guide nursing homes and billing entities through the process of completing the UB-04 form. Links are included throughout this document that provide further explanation and detail about the nursing home claims process. More importantly, the links allow you to submit accurate and compliant claims to the payers.

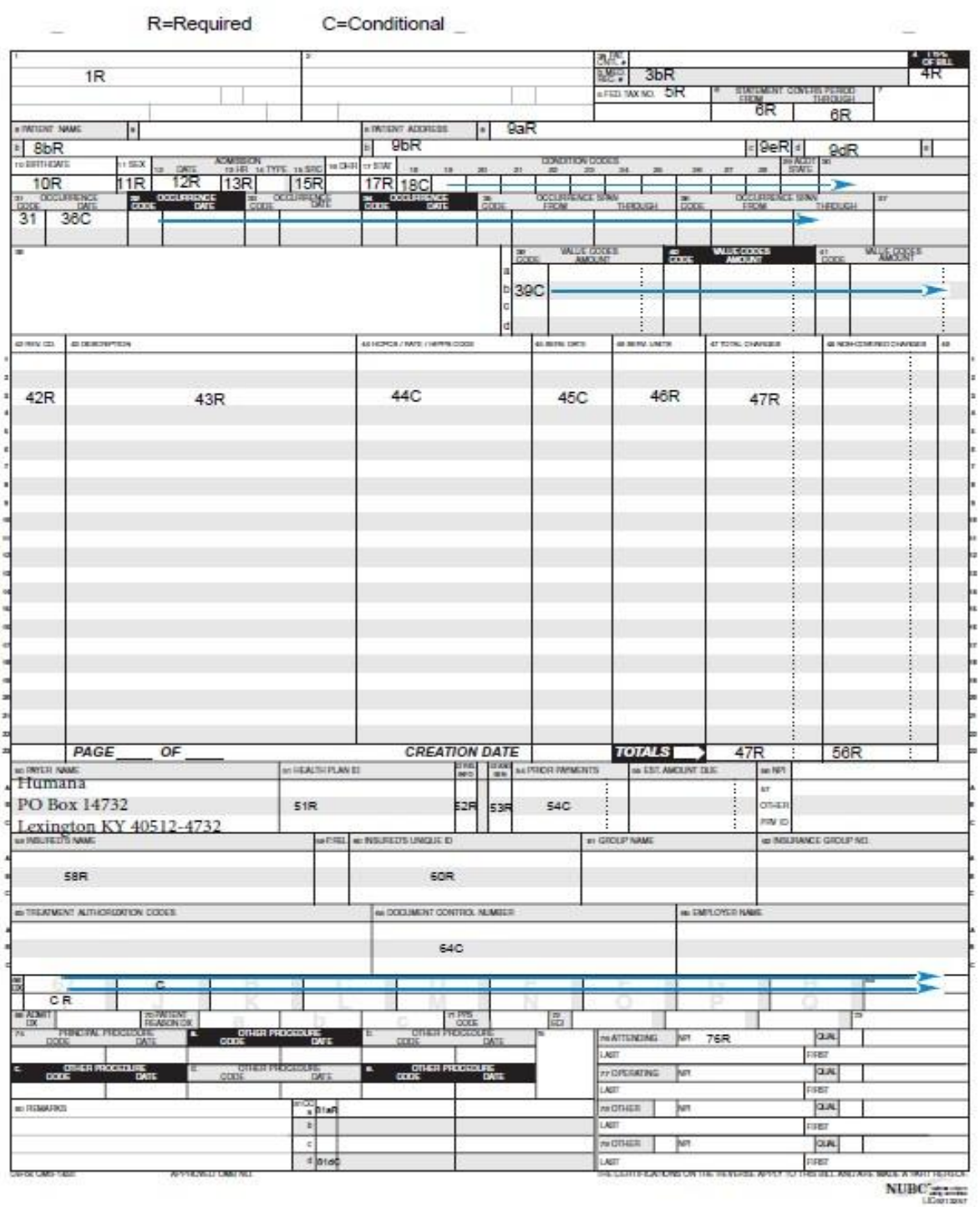
The use of reference books is critically important when billing claims. Below is a list of several documents that a billing department should have. These books can be purchased at a nominal fee from most online bookstores.

- Current Procedural Terminology (CPT®) Professional Edition codebook
- Healthcare Common Procedure Coding System (HCPCS) codebook
- International Classification of Diseases, 10th edition (ICD-10-CM) Codebook
- National Uniform Billing Committee Official UB-04 Data Specifications Manual

The most common billing errors are caused by use of improper revenue/HCPCS codes, type of bill, patient disposition (discharge status), occurrence coding (code and date span), and value codes. This document assists you in accurately completing a nursing home UB-04 claim and facilitating accurate and timely payment of your claims.

UB-04 required versus conditional fields

For healthcare providers billing on the UB-04/CMS-1450 form, we included instructions on how to properly complete and submit the paper form. Below is a labeled version of the form and the corresponding key.


R=Required
C=Conditional
1R
3bR
4R
5R
6R
6R
9aR
8bR
9bR
9eR
9dR
10R
11R
12R
13R
15R
17R
18C
31
36C
39C
42R
43R
44C
45C
46R
47R
PAGE ____ OF ____
CREATION DATE
TOTALS
47R
56R
Humana
PO Box 14732
Lexington KY 40512-4732
51R
52R
53R
54C
58R
60R
64C
C
C R
76R
81aR
81cC
NUBC

Field location	Field label name	Inpatient	Outpatient	Field content explanation or usage detail
1	Unlabeled	Required	Required	Complete healthcare provider name, phone number, and mailing address.
2	Unlabeled	Not required	Not required	
3a	Patient control number	Not required	Not required	
3b	Medical record number	Required	Required	Facility medical or health record number.
4	Type of bill	Required	Required	Enter appropriate three-digit type of bill as specified by the NUBC UB-04 Data Specs Manual (no leading zero). See the accepted list of codes below.
5	Federal Tax ID number	Required	Required	Enter the nine-digit number assigned by the federal government for tax-reporting purposes.
6	Statement covers period	Required	Required	Enter the billing period for this statement.
7	Unlabeled	Not required	Not required	
8a	Patient name	Required	Required	Enter patient's last name, first name, and middle initial.
8b	Unlabeled	Not required	Not required	
9a-d	Patient address	Required (except line e)	Required (except line e)	Enter the complete mailing address of the patient: a: Street address b: City c: State d: ZIP code e: Not required
10	Patient date of birth (DOB)	Required	Required	Enter DOB as (MMDDYYYY).
11	Patient's sex	Required	Required	Enter sex as M or F only.

12	Admission date	Required	Required	Enter date of admission as (MMDDYYYY).
13	Admission hour	Required	Required	Enter hour of admission using two-digit 24 military time (e.g., for 1:00 – 1:59 a.m., use 01; for 1:00 – 1:59 p.m., use 13; for 11:00 – 11:59 a.m., use 11; for 11:00 – 11:59 p.m., use 23).
14	Admission type	Not required	Not required	

Field location	Field label name	Inpatient	Outpatient	Field content explanation or usage detail
15	Admission source	Required	Required	Enter one-digit code indicating the source of admission: 1 - Physician referral 2 - Clinic referral 4 - Transfer from hospital 6 - Transfer from another healthcare facility 7 - Emergency room 8 - Court enforced 9 - Information not available
16	Discharge hour	Not required	Conditional	
17	Discharge status	Required	Conditional	A list of discharge statuses can be found in the NUBC UB-04 Data Specs Manual.
18-28	Condition codes	Conditional	Conditional	Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual.
29	Accident state	Not required	Conditional	

30	Unlabeled	Not required	Conditional	
31-34	Occurrence codes	Conditional	Conditional	Occurrence codes are typically used when there is a coordination of benefits. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual.
35-36	Occurrence span code	Conditional	Conditional	Occurrence span codes are typically used when there is a coordination of benefits. Additional instructions can be found in the NUBC UB-04 Data Specs Manual.
37	Unlabeled	Not required	Conditional	
38	Responsible party	Not required	Conditional	

Field location	Field label name	Inpatient	Outpatient	Field content explanation or usage detail
39-41	Patient responsibility	Required	Conditional	When patient responsibility is 0, enter value code 80 in box 39. To report patient responsibility, enter value code 31 in Box 39 and the value amount in the adjacent cells. This field is only required when reporting covered or noncovered days. **Covered days value code:** 31 - Patient responsibility 80 - Covered days 81 - Noncovered days **Value amount**

				Enter the number of covered or noncovered days in adjacent cells.
42	Revenue code	Required	Conditional	Enter the appropriate four-digit revenue code. A list of accepted codes is provided later in this section.
43	Revenue code description	Required	Conditional	A list of accepted descriptions is provided later in this section.
44	HCPCS/rates	Conditional	Conditional	Not required for inpatient nursing home claims.
45	Service date	Conditional	Conditional	Not required for inpatient nursing home claims.
46	Service units	Required	Conditional	Enter number of units/days/visits.
47	Total charges	Required	Conditional	Enter total charges for each service line.
48	Noncovered charges	Not required	Not required	
49	Unlabeled	Not required	Not required	

Field location	Field label name	Inpatient	Outpatient	Field content explanation or usage detail
50a-c	Payer	Required	Required	Enter all appropriate payers. Note: Humana is the payer for HMO D-SNP claims.
51	Health plan ID number	Required	Required	Enter appropriate payer ID for each of the corresponding payers listed in Field 50. Note: Humana is the payer for HMO D-SNP claims. Use only payer ID 61101.
52a-c	REL INFO	Required	Required	Release information is required for every payer (must be “Y”).

53	ASG BEN	Conditional	Conditional	Occurrence codes are typically used when there is a coordination of benefits. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual.
54	Prior payments	Conditional	Conditional	Used for coordination of benefits.
55	EST Due AMT	Not required	Not required	
56	NPI	Required	Required	Enter the health care provider's 10-character NPI number.
57	Other provider ID	Not required	Not required	
58	Insured's name	Required	Required	Enter the name of the person who carries the insurance policy.
59	Patient relationship	Not required	Not required	
60	Insured's unique ID	Required	Required	Enter the patient's insurance ID number.
61	Group name	Not required	Not required	
62	Insurance group number	Not required	Not required	
63	Treatment authorization codes	Not required	Not required	
64	Document control number	Conditional	Conditional	
65	Employer name	Not required	Not required	
66	Diagnosis code qualifier	Not required	Not required	Required to indicate the version submitted: 0 = ICD-10
Field location	**Field label name**	**Inpatient**	**Outpatient**	**Field content explanation or usage detail**
67a-q	Other diagnosis codes	Conditional	Conditional	Usually does not apply to nursing home claims.
68	Unlabeled	Not required	Not required	
69	Admitting diagnosis code	Required	Required	Enter the diagnosis code the patient had at the time of admission.

70	Patient reason code	Not required	Not required	
71	PPS/DRG code	Not required	Not required	
72	External cause code	Not required	Not required	
73	Unlabeled	Not required	Not required	
74	Principal procedure code/date	Not required	Not required	
75	Unlabeled	Not required	Not required	
76	Attending physician	Required	Required	
77	Operating physician	Not required	Not required	
78-79	Other physician	Not required	Not required	
80	Remarks	Not required	Not required	
81a	Code to code	Required	Required	Taxonomy number of billing healthcare provider.
81d	Level of care	Conditional	Conditional	Use this field to indicate level of care. Refer to the level-of-care codes table in this guide or to the NUBC UB-04 Data Specs Manual, pages 1–48.

Nursing home type of bill codes

Medicaid expanded the number of bill code types that are valid for nursing facility providers. The following table below contains a list of the valid nursing facility type of bill codes according to provider type:

Nursing facility provider types #9 (hospital-based skilled unit) and #10 (nursing facility)		
21X	Skilled nursing inpatient	Skilled nursing facility (SNF) Date of admission: the same as the first date of service Date of discharge: the same as the last date of service
211	Skilled nursing admit-through-discharge	Skilled nursing admit-through-discharge
213	Skilled nursing interim continuing claim	Skilled nursing interim continuing claim
214	Skilled nursing final claim	Skilled nursing final claim
215	Skilled nursing late charges-only claim	Late charges-only claim
217	Skilled nursing replacement of prior claim	Skilled nursing replacement of prior claim

218	Skilled nursing void/cancel of prior claims	Skilled nursing void/cancel of prior claim

Level-of-care codes

For Field 81d, long-term care facilities (SNFs and ICF/DDs) need to:

- In the first field, enter qualifier code 02.
- In the second field, enter the established level-of-care (LOC) code to indicate the type of care that the recipient requires.
- In the third field, enter the facilities per diem. For level of care X, enter the respective Medicare per diem.

Level of care codes	Code explanation
In the second field, enter the established LOC code to indicate the type of care the recipient requires:	
1	Skilled
2	Intermediate I
3	Intermediate II
4	State Mental Health Hospital
6 - 9	ICF-DD Levels of Care
H	AIDS Per Diem
U	Skilled Fragile Children Under 21
X	Medicare Part A Coinsurance Payment

Revenue codes room and board

Long-term care facility (skilled nursing facility and ICF/DD) claims: Enter the appropriate revenue code:

0185	**Hospital leave days** (Bed-hold days.)
0182	**Home leave days** (Therapeutic bed-hold days.)
0022	**SNF distinct billing period** In addition to billing the revenue codes for room and board and ancillary services, each nursing facility claim must contain one revenue code “0022” for each distinct billing period of the nursing facility stay. The Resource Utilization Group (RUG) code determined by the RUG-III 34-grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment should be reported in the last two digits of the HIPPS rate code. The total charges for revenue code 0022 should be zero.

UB-04 Patient disposition codes (discharge status)

This field must contain the code indicating the patient status as of the ending service date of the period covered through date on this bill.

Code	Description
01	Discharged/transferred to home or self-care (Routine discharge)
02	Discharged/transferred to another short-term hospital for inpatient care
03	Discharged/transferred to a SNF
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care or organized home health services
07	Left against medical advice or discontinued care
08	Reserved for national assignment
10-14	Reserved for national assignment
15	Planned acute care hospital inpatient
16-19	Reserved for national assignment
20	Expired
21	Discharged/transferred to court/law enforcement
22-29	Reserved for national assignment
30	Still patient
31-39	Reserved for national assignment
43	Discharged/transferred to federal assignment
44-49	Reserved for national assignment
50	Hospice-home
51	Hospice-medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to hospital-based, Medicare-approved swing bed
62	Discharged/transferred to inpatient rehabilitation facility (IRF) including district part units of hospital (Effective retroactive to Jan. 1, 2000)
63	Discharged/transferred to Medicare-certified long-term-care hospital (LTCH)
64	Discharged/transferred to a nursing facility under Medicaid, but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
67-68	Reserved for national assignment
69	Discharged/transferred to a designated disaster alternate care

70	Discharged/transferred to another type of healthcare institution not defined elsewhere
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to short-term general hospital for inpatient care with a panned acute hospital readmission
Code	**Description**
83	Discharged/transferred to a SNF with Medicare certification with a planned acute hospital readmission
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute hospital
87	Discharged/transferred to court/law enforcement with a planned acute hospital inpatient readmission
88	Discharged/transferred to a federal healthcare facility with a planned acute hospital inpatient readmission
89	Discharged/transferred to a hospital-based, Medicare-approved swing bed with a planned acute hospital inpatient readmission
90	Discharged/transferred to an IRF including rehabilitation distinct part units of a hospital with a planned acute hospital inpatient readmission
91	Discharged/transferred to a Medicare-certified LTCH with a planned acute hospital inpatient readmission
92	Discharged/transferred to a nursing facility certified under Medicaid, but not certified under Medicare with a planned acute hospital inpatient readmission
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital With a planned acute hospital inpatient readmission
94	Discharged/transferred to a CAH with a planned acute hospital inpatient readmission
95	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute hospital inpatient readmission

Occurrence codes

Code	Description	Guidelines
1	Auto accident/auto liability insurance involved	Enter the date of the auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
2	Auto or other accident/no fault involved	Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.
3	Accident/tort liability	Enter the date of an accident (excluding automobile) resulting from the actions of a third party. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability. Refer to subsection 4.13.6, "Third Party Liability – Tort" in section 4, "Client Eligibility" (Vol. 1, General Information).
4	Accident/employment related	Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with workers' compensation insurance or an employer. Only services not covered by workers' compensation may be considered for payment by Medicaid.
5	Other accident	Enter the date of an accident not described by the above codes. Use this code to report no other casualty-related payers have been determined.
6	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
11	Onset of symptoms	Indicate the date the patient first became aware of the symptoms or illness being treated.
16	Date of last therapy	Indicate the last day of therapy services for occupational therapy (OT), physical therapy (PT), or speech therapy (ST).
17	Date outpatient OT plan established or last reviewed	Indicate the date a plan was established or last reviewed for OT.

24	Date other insurance denied	Enter the date of denial coverage by a third-party resource (TPR).
25	Date benefits terminated by primary payer	Enter the last date for which benefits are being claimed.
27	Date home health plan of treatment was established	Enter the date the current plan of treatment was established.
29	Date outpatient PT plan established or last reviewed	Indicate the date a treatment plan was established or last reviewed for PT.
Code	**Description**	**Guidelines**
30	Date outpatient speech pathology plan established or last reviewed	Indicate the date a plan of treatment for speech pathology was establish or last reviewed.
35	Date treatment started for PT	Indicate the date services were initiated for PT.
44	Date treatment started for OT	Indicate when OT services were initiated.
45	Date treatment started for speech language pathology	Indicate when speech language pathology services were initiated.
50	Date other insurance paid	Indicate the date the other insurance paid the claim.
51	Date claim filed with other insurance	Indicate the date the claim was filed to the other insurance.
52	Date renal dialysis initiated	Indicate the date renal dialysis was initiated.

837I Mapping of required fields

The following are the required fields for successfully transmitting 837I batch claims:

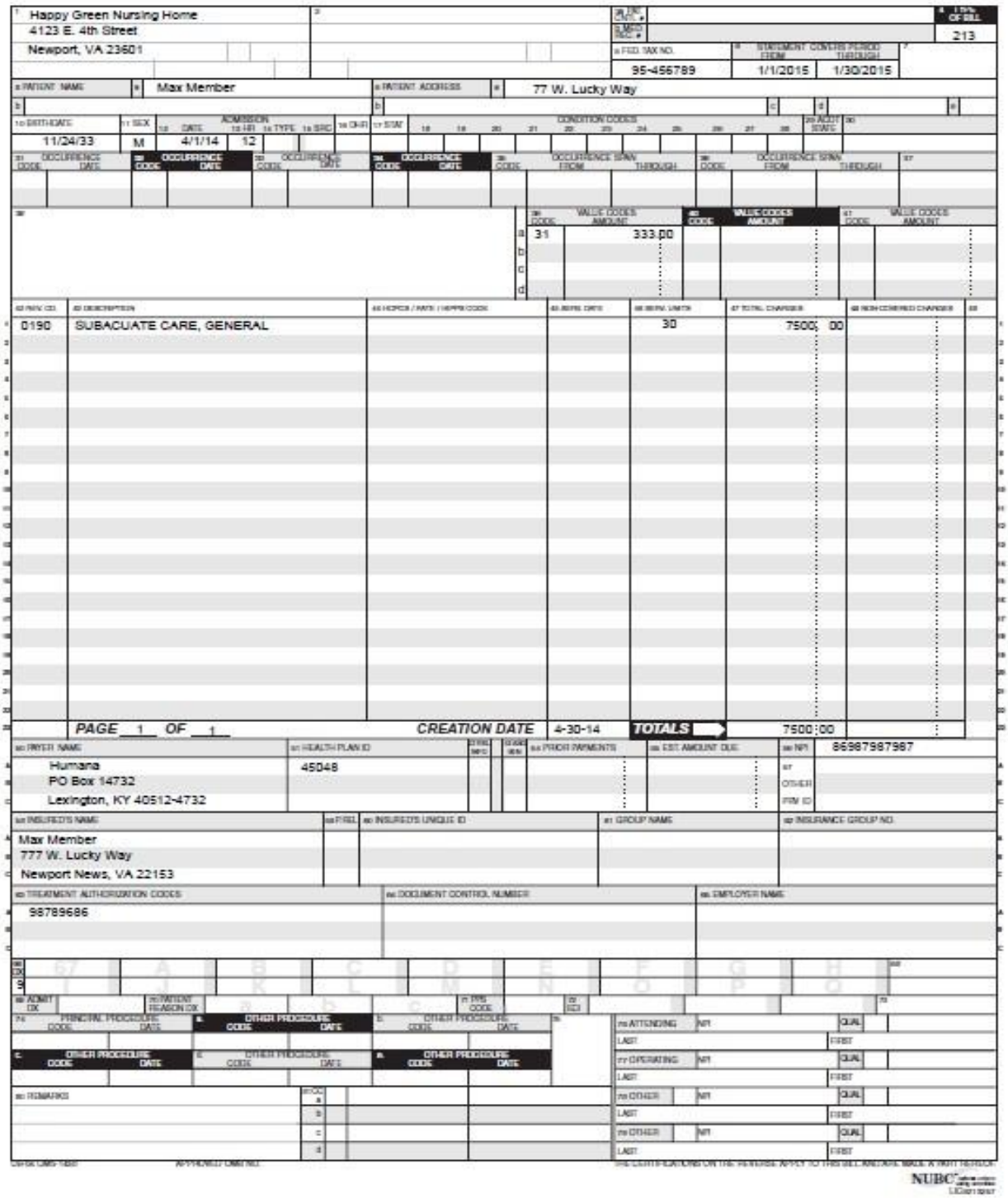
837I Mapping (required fields)	
Field name	**Loop/segment**
PROVIDER_NAME	NM1-2010AA
PROVIDER_STREET	N3-2010AA
PROVIDER_CITY	N4-2010AA
PROVIDER_STATE	N4-2010AA
PROVIDER_ZIP	N4-2010AA
PAY_TO_STATE	N4-2010AB
PAY_TO_ZIP	N4-2010AB
TYPE_OF_BILL	CLM05-2300
FEDERAL_TAX_NUMBER	REF-2010AA
NATIONAL PROVIDER IDENTIFIER_QUALIFIER	NM108-2010AA
NATIONAL PROVIDER INDENTIFIER _VALUE	NM109-2010AA
PATIENT_NAME	NM1-2010CA
PATIENT_NAME_LAST	NM1-2010CA
PATIENT_NAME_FIRST	NM1-2010CA
PATIENT_STATE	N4-2010CA
PATIENT_ZIP	N4-2010CA
PATIENT_BIRTH_DATE	DMG02-2010BA
ADMISSION_TYPE	CL1-2300
ADMISSION_SOURCE	CL1-2300
PRINCIPAL_DIAGNOSIS	HI-2300
INSURED_ID	NM1-2010BA
REV_CODE	SV2-2400
TOTAL_SUBMITTED_CHARGES	CLM02 - 2300
ADMISSION_DATE	CLM01 - 2300

For further information on how to transmit batch claims, consult the X12 Institutional and Professional Claim Standard Companion Guide via Availity Essentials.

Providers can submit claims through Direct Data Entry via Availity Essentials. Availity Essentials offers a free web tool for healthcare providers to upload batch claims electronically. To upload batch claims:

- Healthcare providers must register for an Availity Essentials user account.
- Healthcare providers should have claims software with EDI file creation capabilities.

EXAMPLE OF A CLEAN UB-04 FORM



Happy Green Nursing Home
4123 E. 4th Street
Newport, VA 23601

TYPE OF BILL: 213

FED TAX NO.: 95-456789
STATEMENT COVERS PERIOD: FROM 1/1/2015 THROUGH 1/30/2015

PATIENT NAME: Max Member
PATIENT ADDRESS: 77 W. Lucky Way

BIRTHDATE	SEX	ADMISSION DATE	HR	TYPE	SRC	DHR	STAT
11/24/33	M	4/1/14	12				

VALUE CODES: a 31 333.00

REV CD	DESCRIPTION	SERV. UNIT	TOTAL CHARGES	NON-COVERED CHARGES
0190	SUBACUATE CARE, GENERAL	30	7500.00	
	PAGE 1 OF 1	CREATION DATE 4-30-14	TOTALS	7500.00	

PAYER NAME: Humana
PO Box 14732
Lexington, KY 40512-4732

HEALTH PLAN ID: 45048

PRIOR PAYMENTS:
EST. AMOUNT DUE:
NPI: 86987987987
OTHER PRV ID:

INSURED'S NAME: Max Member
777 W. Lucky Way
Newport News, VA 22153

INSURED'S UNIQUE ID:
GROUP NAME:
INSURANCE GROUP NO.:

TREATMENT AUTHORIZATION CODES: 98789686
DOCUMENT CONTROL NUMBER:
EMPLOYER NAME:

ADMIT DX:
PATIENT REASON DX:
PRINCIPAL PROCEDURE CODE/DATE:
OTHER PROCEDURE CODE/DATE:
OTHER PROCEDURE CODE/DATE:
OTHER PROCEDURE CODE/DATE:
OTHER PROCEDURE CODE/DATE:
OTHER PROCEDURE CODE/DATE:
PPS CODE:

ATTENDING NPI QUAL LAST FIRST
OPERATING NPI QUAL LAST FIRST
OTHER NPI QUAL LAST FIRST
OTHER NPI QUAL LAST FIRST

REMARKS:

NUBC

Billing codes by service type

Always use billing codes and rates provided by IDHFS. You may view the fee schedule at the following link:

HFS Medicaid Reimbursement

NOTES