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## Surgery Billing Examples: UB-04

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Page updated: August 2020

Examples in this section are to help providers bill surgical procedures on the *UB-04* claim form. Refer to the *Surgery* sections of this manual for detailed policy information. Refer to the *UB-04 Completion: Outpatient Services* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

## **Modifier 50**

*Figure 1. Using modifier 50 to identify a bilateral procedure that requires additional significant time. This is a sample only. Please adapt to your billing situation.*

Modifier 50 is billed to identify a bilateral procedure that is more complex and/or requires additional significant time at a single operative session.

In this example, CPT® code 40701 (plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure) is the primary procedure, and code 69436 (tympanostomy [requiring insertion of ventilating tube], general anesthesia) is the secondary procedure. Both procedures are bilateral. This example is for services rendered in an outpatient hospital setting.

Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

- Line 1: Enter code 40701 with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44). (This code does not require modifier 50 because this is the primary surgery and the CPT descriptor designates this is a bilateral procedure.)
- Line 2: Enter code 69436 with modifier 51 (multiple procedures) in the *HCPCS/Rate* field (Box 44) to signify this is the secondary procedure.
- Line 3: Bill code 69436 a second time with modifier 50 (bilateral procedure) in the *HCPCS/Rate field* (Box 44) to signify the procedure requires additional significant time at a single operative session.

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The outpatient hospital’s NPI number is placed in the *NPI* field (Box 56).

In this example, appropriate ICD-10-CM codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

The referring physician’s NPI number is entered in the *Attending* field (Box 76). The rendering physician’s NPI number is placed in the *Operating* field (Box 77).

1 <b>UPTOWN MEDICAL CENTER</b>		2		3a PAT CNTRL #		4 TYPE OF BILL	
140 SECOND STREET				b. MED. REC. #		131	
ANYTOWN CA 958235555				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
8 PATIENT NAME		9 PATIENT ADDRESS					
b. <b>DOE, JANE</b>							
10 BIRTH-DATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
08242002		F				17 STAT 18 19 20 21	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
						35 OCCURRENCE SPAN FROM THROUGH	
						36 OCCURRENCE SPAN FROM THROUGH	
						37 OCCURRENCE SPAN FROM THROUGH	
						38	
						39 VALUE CODES AMOUNT	
						40 VALUE CODES AMOUNT	
						41 VALUE CODES AMOUNT	
						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		REPAIR OF DEFORMITY		40701AG		100115 1 421000	
2		TYMPANOSTOMY		6943651		100115 1 60000	
3		ADDITIONAL TIME		6943650		100115 1 60000	
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50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A O/P MEDI-CAL						54 PRIOR PAYMENTS	
B						55 EST. AMOUNT DUE	
C						56 NPI 0123456789	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A				90000000A95001			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 01234567890							
B							
C							
68 DX		69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
0		D1D1D1D		D2D2D2D		72 ECI	
						73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		QUAL	
				1234567890			
						FIRST	
77 OTHER PROCEDURE CODE		78 OTHER NPI		QUAL			
		2345678901					
						FIRST	
80 REMARKS		81CC a		79 OTHER NPI		QUAL	
		b					
		c				FIRST	
		d					
						FIRST	

**Figure 1: Using Modifier 50 to Identify a Bilateral Procedure that Requires Additional Significant Time.**

## **Modifier AG**

*Figure 2. Using modifier AG to identify the primary surgeon.*

Modifier AG is billed to indicate the primary surgeon performed the procedure. In this example, CPT code 28292 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method) is the primary procedure. This example is for services rendered in an ambulatory surgery center.

Enter the two-digit facility type code “83” (special facility – ambulatory surgery center) and one-character claim frequency code “1” as “831” in the *Type of Bill* field (Box 4).

Line 1: Enter code 28292 with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44).

Line 2: Enter code 28292 with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify the procedure requires additional significant time.

Line 3: Enter code 28090 with modifier 51 (multiple procedures) in the *HCPCS/Rate* field (Box 44) to signify this is the secondary procedure.

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic’s NPI number is placed in the *NPI* field (Box 56).

Enter the 11-digit TCN in the *Prior Authorization Number* field (Box 63).

In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Enter the referring provider’s NPI number in the *Attending* field (Box 76). The rendering physician’s NPI number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3 PAT CNTL #		4 TYPE OF BILL 831	
9 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX NO		6 STATEMENT COVERS PERIOD FROM THROUGH	
b DOE, JANE							
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION 13 HRI 14 TYPE 15 SRC	
16 DHR		17 STAT		18		19	
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## **Multiple Bilateral Procedures: Modifiers AG, 50, 51 and 99**

*Figure 3. Using modifiers AG, 50, 51 and 99 to identify multiple bilateral procedures.*

In this example, three bilateral procedures are performed on the patient's eyes and nose by the same physician during the same operative session.

Enter the two-digit facility type code "83" (special facility – ambulatory surgery center) and one-character claim frequency code "1" as "831" in the *Type of Bill* field (Box 4).

Line 1: Enter code "68720" with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44). This is the primary procedure.

Line 2: Enter code "68720" with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify this is bilateral to the primary procedure.

Line 3: Enter code "31200" with modifier 51 (multiple procedures) in the *HCPCS/Rates* field (Box 44) to signify this is the secondary procedure.

Line 4: Enter code "31200" with modifier 99 (multiple modifiers) in the *HCPCS/Rate* field (Box 44) to signify this procedure is billed with multiple modifiers.

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic's NPI number is placed in the *NPI* field (Box 56).

In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Enter the referring provider's NPI number in the *Attending* field (Box 76). The rendering physician's NPI number is placed in the *Operating* field (Box 77).

In the *Remarks* field (Box 80) document "LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. This information is required.

In addition, "SEE ATTACHMENT" is entered in the *Remarks* field. The attachment is included with the claim, because there is not enough room in the *Remarks* field to explain the procedures billed on claim lines 1 through 6. This information is optional but recommended, because it helps claim examiners identify the location of bilateral procedures and process the claim more quickly.



## **Modifiers 80 and 99**

*Figure 4. Using modifier 80 to identify the assistant surgeon and modifier 99 to identify multiple modifiers. This example is for services rendered in an ambulatory surgical center.*

In this example, CPT code 28292 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method) is the primary procedure.

Enter the two-digit facility type code “83” (special facility – ambulatory surgical center) and one-character claim frequency code “1” as “831” in the *Type of Bill* field (Box 4).

- Line 1: Enter code 28292 with modifier 80 (signifying that an assistant surgeon rendered the service) in the *HCPCS/Rate field* (Box 44).
- Line 2: Enter code 28292 with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate field* (Box 44).
- Line 3: Enter code 28090 (excision of lesion, tendon sheath, or capsule [including synovectomy] [eg, cyst or ganglion]; foot) with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate field* (Box 44).

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic’s NPI number is placed in the *NPI* field (Box 56).

In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

In the *Remarks* field (Box 80) enter wording that explains modifier 99 equals billing of both modifiers 80 (assistant surgeon) and 50 (bilateral procedure) for claim line 1, and 80 and 51 (multiple procedures) for claim line 3. This information is required.

Enter the NPI number of the referring provider in the *Attending* field (Box 76). The rendering physician NPI number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CONTL #		4 TYPE OF BILL 831	
9 PATIENT NAME DOE, JANE		9 PATIENT ADDRESS					
10 BIRTHDATE 08241980		11 SEX F		ADMISSION 13 HR 14 TYPE 15 SRC 16 CHR 17		17 STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37			
39		39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HOPS / RATE / HIPPS CODE		45 SERV. DATE	
		BUNIONECTOMY, RT FOOT		2829280		100117 1 3271	
		BUNIONECTOMY, LT FOOT		2829299		100117 1 3271	
		EXCISION OF LESION		2809099		100117 1 3228	
001		PAGE OF		CREATION DATE		TOTALS 9770	
50 PAYER NAME O/P MEDICAL		51 HEALTH PLAN ID		52 REL INFO		53 REASON	
						54 PRIOR PAYMENTS	
						55 EST. AMOUNT DUE 9770	
58 INSURED'S NAME		59 P PBL		80 INSURED'S UNIQUE ID 90000000A95001		81 GROUP NAME	
						82 INSURANCE GROUP NO	
83 TREATMENT AUTHORIZATION CODES		84 DOCUMENT CONTROL NUMBER		85 EMPLOYER NAME			
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862		863		864		865	
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890		891		892		893	
894		895		8			

## **Destruction of Five Skin Lesions**

*Figure 5. Destruction of five skin lesions – modifiers AG and 51. This example is for services rendered in an outpatient hospital clinic.*

Bill CPT code 17000 (destruction of first lesion) with modifier AG (primary surgeon) and code 17003 (destruction of second through 14 lesions) with modifier 51 (multiple procedures) in the *HCP/PCS/Rates* field (Box 44).

Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

The date of service is entered for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for code 17000 to indicate that one lesion was removed. Enter a 4 in the *Service Units* field (Box 46) for code 17003 to indicate that, in addition to the first lesion, four more lesions were removed. Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The county hospital’s NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

The rendering physician provider number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTRL # b. MED. REC. #		4 TYPE OF BILL <b>131</b>	
8 PATIENT NAME a <b>DOE, JANE</b>				9 PATIENT ADDRESS a			
10 BIRTHDATE <b>08241980</b>		11 SEX <b>F</b>		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
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		DESTRUCTION/FIRST SKIN LESION		17000AG		100115	
2		DESTRUCTION/MULT. SKIN LESION		1700351		100115	
3						1	
4						4	
5						2021	
6						4044	
7							
8							
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21							
22							
23		001 PAGE OF		CREATION DATE		TOTALS	
24		50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	
25		O/P MEDI-CAL				53 ASG BEN	
26		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
27				6065		0123456789	
28		58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID	
29						90000000A95001	
30		61 GROUP NAME		62 INSURANCE GROUP NO			
31		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
32							
33		68		69		70	
34		D1D1D1D		A		B	
35		0		C		D	
36				E		F	
37				G		H	
38				I		J	
39				K		L	
40				M		N	
41				O		P	
42				Q		R	
43				S		T	
44				U		V	
45				W		X	
46				Y		Z	
47				AA		AB	
48				AC		AD	
49				AE		AF	
50				AG		AH	
51				AI		AJ	
52				AK		AL	
53				AM		AN	
54				AO		AP	
55				AQ		AR	
56				AS		AT	
57				AU		AV	
58				AW		AX	
59				AY		AZ	
60				BA		BB	
61				BC		BD	
62				BE		BF	
63				BG		BH	
64				BI		BJ	
65				BK		BL	
66				BM		BN	
67				BO		BP	
68				BQ		BR	
69				BS		BT	
70				BU		BV	
71				BW		BX	
72				BY		BZ	
73				CA		CB	
74				CC		CD	
75				CE		CF	
76				CG		CH	
77				CI		CJ	
78				CK		CL	
79				CM		CN	
80				CO		CP	
81				CQ		CR	
82				CS		CT	
83				CU		CV	
84				CW		CX	
85				CY		CZ	
86				DA		DB	
87				DC		DD	
88				DE		DF	
89				DG		DH	
90				DI		DJ	
91				DK		DL	
92				DM		DN	
93				DO		DP	
94				DQ		DR	
95				DS		DT	
96				DU		DV	
97				DW		DX	
98				DY		DZ	
99				EA		EB	
100				EC		ED	
101				EE		EF	
102				EG		EH	
103				EI		EJ	
104				EK		EL	
105				EM		EN	
106				EO		EP	
107				EQ		ER	
108				ES		ET	
109				EU		EV	
110				EW		EX	
111				EY		EZ	
112				FA		FB	
113				FC		FD	
114				FE		FF	
115				FG		FH	
116				FI		FJ	
117				FK		FL	
118				FM		FN	
119				FO		FP	
120				FQ		FR	
121				FS		FT	
122				FU		FV	
123				FW		FX	
124				FY		FZ	
125				GA		GB	
126				GC		GD	
127				GE		GF	
128				GG		GH	
129				GI		GJ	
130				GK		GL	
131				GM		GN	
132				GO		GP	
133				GQ		GR	
134				GS		GT	
135				GU		GV	
136				GW		GX	
137				GY		GZ	
138				HA		HB	
139				HC		HD	
140				HE		HF	
141				HG		HH	
142				HI		HJ	
143				HK		HL	
144				HM		HN	
145				HO		HP	
146				HQ		HR	
147				HS		HT	
148				HU		HV	
149				HW		HX	
150				HY		HZ	
151				IA		IB	
152				IC		ID	
153				IE		IF	
154				IG		IH	
155				II		IJ	
156				IK		IL	
157				IM		IN	
158				IO		IP	
159				IQ		IR	
160				IS		IT	
161				IU		IV	
162				IW		IX	
163				IY		IZ	
164				JA		JB	
165				JC		JD	
166				JE		JF	
167				JG		JH	
168				JI		JJ	
169				JK		JL	
170				JM		JN	
171				JO		JP	
172				JQ		JR	
173				JS		JT	
174				JU		JV	
175				JW		JX	
176				JY		JZ	
177				KA		KB	
178				KC		KD	
179				KE		KF	
180				KG		KH	
181				KI		KJ	
182				KK		KL	
183				KM		KN	
184				KO		KP	
185				KQ		KR	
186				KS		KT	
187				KU		KV	
188				KW		KX	
189				KY		KZ	
190				LA		LB	
191				LC		LD	
192				LE		LF	
193				LG		LH	
194				LI		LJ	
195				LK		LL	
196				LM		LN	
197				LO		LP	
198				LQ		LR	
199				LS		LT	
200				LU		LV	
201				LW		LX	
202				LY		LZ	
203				MA		MB	
204				MC		MD	
205				ME		MF	
206				MG		MH	
207				MI		MJ	
208				MK		ML	
209				MM		MN	
210				MO		MP	
211				MQ		MR	
212				MS		MT	
213				MU		MV	
214				MW		MX	
215				MY		MZ	
216				NA		NB	
217				NC		ND	
218				NE		NF	
219				NG		NH	
220				NI		NJ	
221				NK		NL	
222				NM		NN	
223				NO		NP	
224				NQ		NR	
225				NS		NT	
226				NU		NV	
227				NW		NX	
228				NY		NZ	
229				OA		OB	
230				OC		OD	
231				OE		OF	
232				OG		OH	
233				OI		OJ	
234				OK		OL	
235				OM		ON	
236				OO		OP	
237				OQ		OR	
238				OS		OT	
239				OU		OV	
240				OW		OX	
241				OY		OZ	
242				PA		PB	
243				PC			

## **Destruction of 15 or More Skin Lesions**

*Figure 6. Destruction of 15 or more skin lesions – modifier AG. This example is for services rendered in an outpatient hospital clinic.*

Bill code 17004 (destruction of 15 or more lesions) with modifier AG (primary surgeon) in the *HCPCS/Rates* field (Box 44).

Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

Enter the date of service in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for code 17004 to indicate that 15 or more lesions were removed. Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The county hospital’s NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

The rendering physician provider number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTRL # b. MED. REC. #		4 TYPE OF BILL 131	
8 PATIENT NAME a. DOE, JANE				9 PATIENT ADDRESS a.			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
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		DESTRUCTION/MULT. SKIN LESION		17004AG		100115	
2						1	
3							
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22							
23		001 PAGE OF		CREATION DATE		TOTALS 19209	
50 PAYER NAME O/P MEDICAL		51 HEALTH PLAN ID		52 REL INFO		53 ASL BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 19209		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX D1D1D1D		67		68		69	
70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE		75		76 ATTENDING NPI		77 QUAL	
78 LAST		79 FIRST		80 LAST		81 FIRST	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
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98		99		00		01	
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06		07		08		09	
10		11		12		13	
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86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
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74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
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30		31		32		33	
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42		43		44		45	
46		47		48		49	
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66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.