UB-04 Completion: Inpatient Services

Page updated: February 2025

The *UB-04* claim form is used to submit claims for inpatient hospital accommodations (for example, medical/surgical intensive care, burn care and coronary care) and ancillary charges (for example, labor and delivery, anesthesiology and central services and supplies).

‹‹Most claims for inpatient services can also be submitted via the ASC X12N 837 v. 5010 claim. For more information about 837 claims, refer to the *Electronic Data Interchange (EDI) 837 Claims Overview* section in the Part 1 manual.››

Important additional billing information is included in the following sections of this manual:

- *Administrative Days*
- *Diagnosis-Related Groups (DRG): Inpatient Services*
- *Inpatient Rehabilitation Services*
- *UB-04 Special Billing Instructions for Inpatient Services*
- *UB-04 Submission and Timeliness Instructions*
- *UB-04 Tips for Billing: Inpatient Services*

For crossover billing information, refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services and Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* sections.

Medi-Cal does not process credits or adjustments on the *UB-04* claim form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Inpatient Services* sections in this manual for information about claim adjustments.

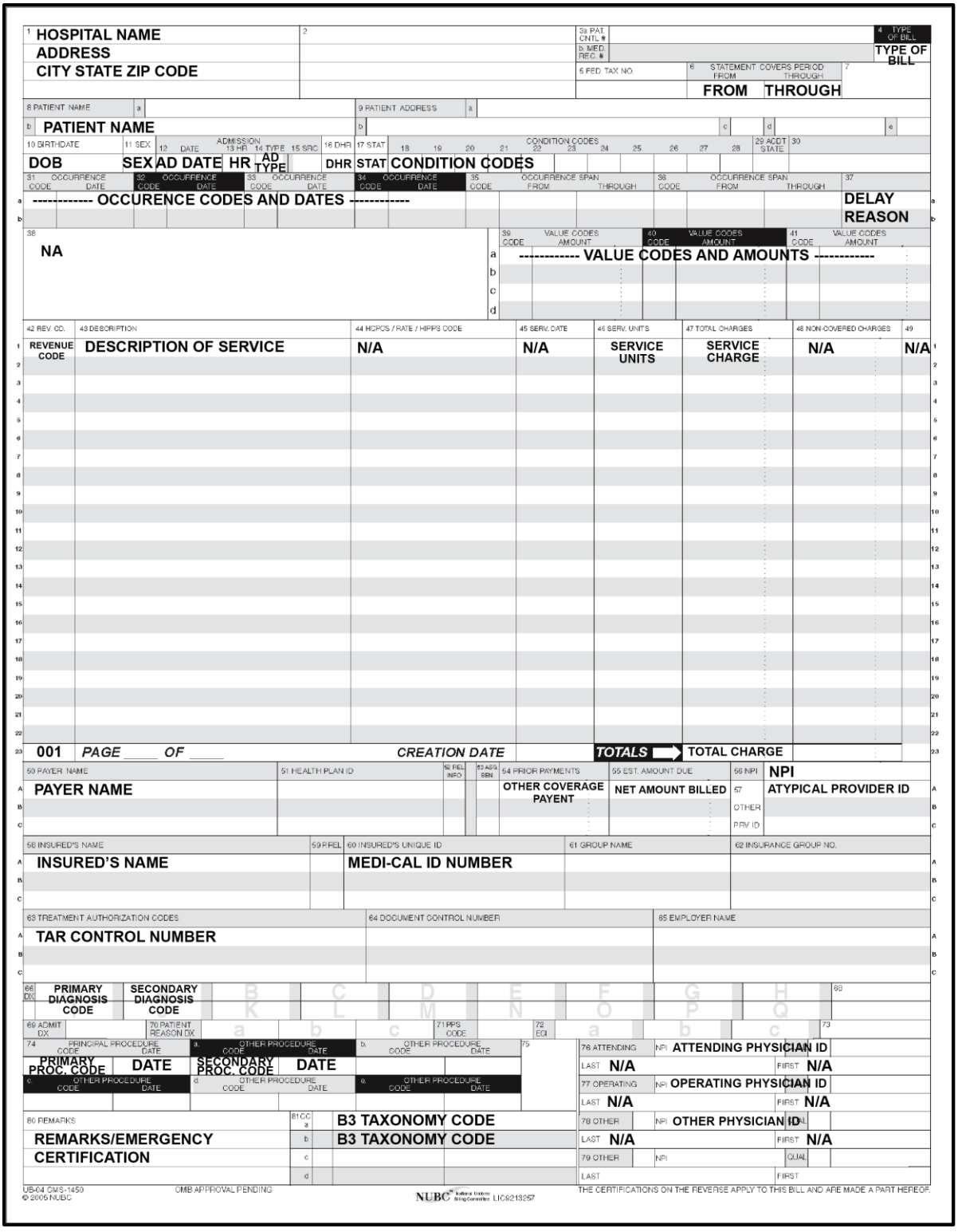


Figure 1: UB-04 Medi-Cal Required Fields for Inpatient Claims.

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *UB-04* on the previous page. All items must be completed unless otherwise noted.

Note: Items described as "Not required by Medi-Cal" may be completed for other payers, but are not recognized by the Medi-Cal claims processing system.

Table of Form Items Descriptions

Item	Description
1.	**Unlabeled** (Use for hospital information). Enter the hospital name. ‹‹Enter service facility location address where services were rendered, without a comma between the city and state, and include a nine-digit ZIP code, without a hyphen.›› A telephone number is optional in this field. **Note:** ‹‹The nine-digit zip code entered in this field must match the provider's service facility location zip code on file for claims to be reimbursed correctly.››
2.	**Unlabeled**. For FI use only. This field must be left blank on all claims submitted to Medi-Cal.
3A.	**Patient control number**. This is an optional field that will help you to easily identify a recipient on *Remittance Advices* (RAs). Enter the patient's financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RA. Refer to the *Remittance Advice Details (RAD) Examples: Inpatient Services section* in this manual for patient control number information.
3B.	**Medical record number**. Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RAD for recipient clarification. The patient control number (Item 3) will appear on the RAD.
4.	**Type of bill.** Enter the appropriate three-character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual.* This is a required field when billing Medi-Cal. The following facility type codes are a subset of the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual f*acility type codes commonly used by Medi-Cal. Use one of the following codes in the table below as the first two digits of the three-character type of bill code.

‹‹Table of Facility Type Code Descriptions (Item 4)››

Code	Facility Type
11	Hospital – Inpatient (when billing for a recipient with Medicare Part A)
12	Hospital – Inpatient (when billing for a recipient with Part A Exhaust or Inpatient Medicare Part B only)
18	Hospital – Swing Beds
21	Skilled Nursing – Inpatient (when billing for a recipient with Medicare Part A
22	Skilled Nursing – Inpatient (when billing for a recipient with Part A Exhaust or Inpatient Medicare Part B only)
28	Skilled Nursing – Swing Beds
41	Religious Non-Medical Health Care Institutions – Hospital Inpatient
65	Intermediate Care – Intermediate Care Level I
66	Intermediate Care – Level II
86	Special Facility – Residential Facility

‹‹Table of Form Items Descriptions (continued)››

Item	Description
5.	**Federal tax number.** Not required by Medi-Cal.
6.	**Statement covers period (from –through).** In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. The date of discharge should be entered in the *through* Box, even though this date is not reimbursable (unless the day of discharge is the date of admission). For “From-Through” billing instructions, refer to the *UB-04 Special Billing Instructions for Inpatient Services* section in this manual.
7.	**Unlabeled.** Not required by Medi-Cal.
8A.	**Patient name – ID**. Not required by Medi-Cal.
8B.	**Patient name**. Enter the patient’s last name, first name and middle initial (if known). Avoid nicknames or aliases.

Newborn Infant

When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s name in Box 8B. If the infant has not yet been named, write the mother’s last name followed by “Baby Boy” or “Baby Girl” (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.

‹‹Refer to the *Obstetrics: UB-04 Billing Examples for Inpatient Services: Designated Public Hospitals* section in this manual for various billing examples relating to birth.››

Enter the infant's date of birth and sex in Boxes 10 and 11. Enter the mother's name in Box 58 (*Insured's Name*), and enter "03" (child) in Box 59 (*Patient's Relationship to Insured*).

Organ Donors

When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 *(Insured's Name*) and enter "11" (donor) in Box 59 (*Patient's Relationship to Insured*).

Table of Form Items Descriptions (continued)

Item	Description
9A thru E.	**Patient address.** Not required by Medi-Cal.
10.	**Birthdate**. Enter the patient's date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors, see Item 8B on a previous page.)
11.	**Sex**. Use the capital letter "M" for male, or "F" for female. (For newborns and organ donors, see Item 8B on a previous page.)
12 thru 13.	**Admission date and hour**. In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows: • Eliminate the minutes • Convert the hour of admission/discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15)

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
14.	**Admission type.** Enter the numeric code indicating the necessity for admission to the hospital: • Emergency – 1 • Elective – 3 • Newborn – 4 If the delivery was outside the hospital, use admit type code “1” (emergency) in the Type of Admission, and admission source code “4” (extramural birth) in the Source of Admission field (Box 15).
15.	**Admission source**. If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code “1” or “3” must be entered in Box 14 to indicate whether the transfer was an emergency or elective. A baby born outside the hospital: In cases where the type of admission code in Box 14 is “4” (newborn [used by Medi-Cal only when a baby is born outside the hospital]), submit the claim with source of admission code “4” (extramural birth) in Box 15 and the appropriate revenue code in Box 42.

‹‹**Table of Admission Code Source Descriptions (Item 15)**››

Admission Code Source	Description
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
16.	**Discharge hour**. Enter the discharge hour as follows: • Eliminate the minutes • Convert the hour of discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15) If the patient has not been discharged, leave this box blank.
17.	**Status.** Enter one of the following numeric codes ‹‹from the table below›› to explain patient status as of the “Through” date indicated in (Box 6) under “Statement Covers Period.”

‹‹Table of Code Descriptions (Item 17)››

Code	Explanation
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an Intermediate Care Facility
05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
09	Admitted as inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	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
63	Discharged/transferred to a Medicare certified Long Term Care hospital
64	Discharged/transferred to a nursing facility certified 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)
70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this code list

‹‹Table of Code Descriptions (Item 17) (continued)››

Code	Explanation
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/transferred to a Skilled Nursing Facility with Medicare certification with a planned acute care hospital inpatient readmission
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
90	Discharged/transferred to an Inpatient Rehabilitation Facility including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
91	Discharged/transferred to a Medicare certified Long Term Care Hospital with a planned acute care hospital inpatient readmission
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/transferred to a Critical Access Hospital with a planned acute care hospital inpatient readmission
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

‹‹Table of Form Items Descriptions (continued)››

Item	Description
18 thru 24.	**Condition codes**. Condition codes are used to identify conditions relating to this claim that may affect payer processing. Although the Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. The claims processing system ignores all codes not applicable to Medi-Cal. Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, “A1”, “80” and “82”, enter “80” in Box 18, “82” in Box 19 and “A1” in Box 20. Applicable Medi-Cal codes are: Other Coverage: Enter code “80” if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately. Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual.

Table of Form Items Descriptions (continued)

Item	Description
18 thru 24.	**Condition codes (continued).** Emergency Certification: Enter code "81" when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the *Remarks* field (Box 80). The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required authorization, such as emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the *Remarks* field (Box 80), attach the statement to the claim. An emergency certification statement is required for medical transportation providers. Refer to the *Medical Transportation – Ground and Medical Transportation – Air* sections of the appropriate Part 2 provider manual for additional instructions. Family Planning: Enter code "AI" or "A4" if the services rendered are related to Family Planning (FP). Enter code "A1" if the services rendered are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening related. Leave blank if not applicable. Submit a separate claim form for bills that contain more than one FP code.

Table of Code Descriptions (Items 18 thru 24)

Code	Description
A1	EPSDT››
A4	Family Planning
AI	‹‹Consent for Sterilization Form (DHCS 8649) must be attached if code "AI" is entered››

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
18 thru 24.	**Condition Codes (continued).** Medicare Status: Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the *Condition Codes* fields (Boxes 18 thru 24) blank on the *UB-04* claim. The Medicare status codes are:

‹‹**Table of Code Descriptions (Items 18 thru 24)**››

Code	Description
Y0	Under 65, does not have Medicare coverage
Y1 *	Benefits exhausted
Y2 *	Utilization committee denial or physician non-certification
Y3 *	No prior hospital stay
Y4 *	Facility denial
Y5 *	Non-eligible provider
Y6 *	Non-eligible recipient
Y7 *	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9 *	PSRO denial
Z1 *	Medi/Medi Charpentier: Benefit Limitations
Z2 *	Medi/Medi Charpentier: Rates Limitations
Z3 *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
25 thru 28.	**Condition Codes.** The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 thru 24.
29.	**ACDT state**. Not required by Medi-Cal.
30.	**Unlabeled.** Not required by Medi-Cal.
31 thru 34A thru B.	**Occurrence Codes and Dates**. Occurrence codes and dates are used to identify significant events relating 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 sequence starting with the lowest value. For 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. Refer to *Figure 2* below.

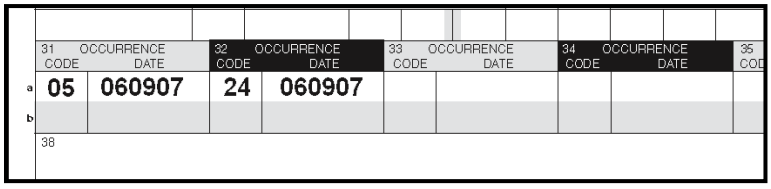


Figure 2: Occurrence Codes Example.

‹‹Table of Form Items Descriptions (continued)››

Item	Description
31 thru 34A thru B.	**Occurrence Codes and Dates (continued)**. Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers may include codes and dates billed to other payers in Boxes 31 thru 34. The claims processing system will ignore all codes not applicable to Medi-Cal. Applicable Medi-Cal codes are: Enter code “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes ‹‹from the table below›› if the accident or injury was non-employment related:

‹‹Table of Code Descriptions (Items 31 thru 34A thru B)››

Code	Description
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

‹‹Table of Form Items Descriptions (continued)››

Item	Description
31 thru 34A thru B.	**Occurrence Codes and Dates (continued).** **Discharge Date**. In six-digit MMDDYY (Month, Day, Year) format, enter code “42” and the date of hospital discharge when the date of discharge is different than the “Through” date in Box 6.
35 thru 36A thru B.	**Occurrence Span Codes and Dates**. Not required by Medi-Cal.

‹‹Table of Form Items Descriptions (continued)››

Item	Description
37A.	**Unlabeled (Use for delay reason codes).** Enter one of the following delay reason codes ‹‹in the following table››, and include the required documentation, if there is an exception to the six-month from the month of service billing limit.

‹‹Table of Code Description Documentation (Item 37A)››

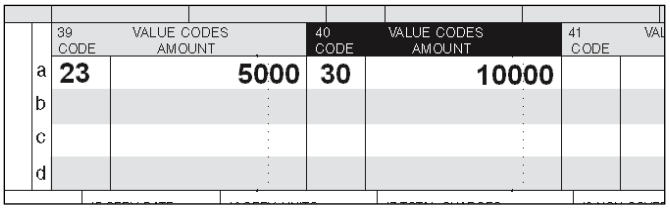
Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None ¥
11	Other (theft, sabotage)	Attachment ¥
15	Natural disaster	Attachment

‹‹Table of Form Items Descriptions (continued)››

Item	Description
37A.	**Unlabeled (Use for delay reason codes) (continued).** For hospitals that are not reimbursed according to the diagnosis-related group (DRG) model: Providers must use claim frequency code “5” in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay and the original stay was already billed. Refer to the *UB-04 Submission* and *Timeliness Instructions* section in this manual for detailed information about codes and documentation requirements.
37B.	**Unlabeled**. Not required by Medi-Cal.
38.	**Unlabeled**. Not required by Medi-Cal.

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
39 thru 41A thru D.	**Value Codes and Amount**. Patient's Share of Cost. Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value. For example, 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. (See Figure 3 below.) Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 thru 41. The claims processing system will ignore all codes not applicable to Medi-Cal. Enter code "23" and the amount of the patient's Share of Cost for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even (for example, if billing for $100, enter 10000 not 100). For more information about Share of Cost, see *the Share of Cost: UB-04 for Inpatient Services* section in this manual.



	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VAL
a	23	5000	30	10000		
b						
c						
d						

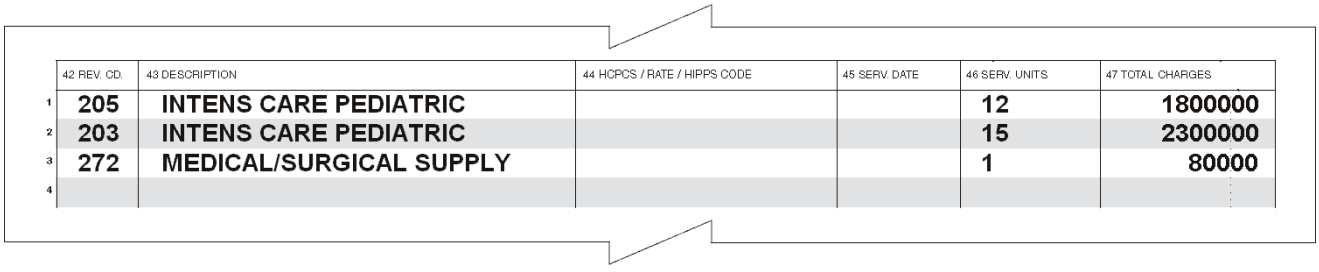
Figure 3: Value Codes Example

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
42.	**Revenue Code**. Enter the appropriate revenue or ancillary code. Refer to the *Revenue Codes for Inpatient Services* section in this manual. Ancillary codes are listed in the *Ancillary Codes* section in this manual. **Total Charges**: Enter "001" on line 23, and enter the total amount on line 23, field 47.
43.	**Description.** Enter the description of the revenue or ancillary code used in Box 42. Refer to *the Revenue Codes for Inpatient Services* and *Ancillary Codes* sections in this manual for the appropriate description. **Note:** If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
44.	**HCPCS/rate/HIPPS code**. Not required by Medi-Cal.
45.	**Service Date**. Not required by Medi-Cal.
46.	**Service Units** (Accommodation Days). Enter the number of days of care by revenue code. Units of service are not required for ancillary services. **Note**: Although this is a seven-digit field, Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on two or more lines.
47.	**Total charges.** In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents even if the amount is even (for example, if billing for $100, enter 10000 not 100). **Note:** Medi-Cal cannot process credits or adjustments on the UB-04 claim form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Inpatient Services* sections in this manual for information regarding claim adjustments. Enter the "Total Charge" for all services on Line 23. Enter code 001 in *Revenue Code* field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a preceding page).
48.	**Non-covered charges.** Not required by Medi-Cal.
49.	**Unlabeled**. Not required by Medi-Cal. **Note:** Providers may enter up to 22 lines of detail data (Items 42 thru 49). It is also acceptable to skip lines. To delete a line, mark through the boxes as shown in Figure 4. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.



	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	205	INTENS CARE PEDIATRIC			12	1800000
2	203	INTENS CARE PEDIATRIC			15	2300000
3	272	MEDICAL/SURGICAL SUPPLY			1	80000
4						

Figure 4: UB-04 Claim Line Deletion Example.

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
50A thru C.	**Payer name. Enter "I/P MEDI-CAL"** to indicate type of claim and payer. Use capital letters only. Refer to Figure 5 below. When completing Boxes 50 thru 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers. If Medi-Cal is the only payer billed, all information in Boxes 50 thru 65 (excluding Box 56) should be entered on Line A. **Reminder:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.

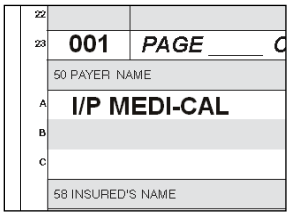


Figure 5: UB-04 Payer Name Example

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
51A thru C.	**Health plan ID**. Not required by Medi-Cal.
52A thru C.	**Release of Information Certification Indicator.** Not required by Medi-Cal.
53A thru C.	**Assignment of Benefits Certification Indicator.** Not required by Medi-Cal.
54A thru B.	**Prior Payment (Other Coverage)**. Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage "payer" (Box 50). Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Leave blank if not applicable. **Note:** For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section in this manual.

Table of Form Items Descriptions (continued)

Item	Description
55A thru C.	**Estimated amount due (net amount billed).** In full dollar amount, enter the difference between “Total Charges” and any deductions (for example, patient’s Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign ($).

Table of Estimated Amounts (Item 55A thru C)

Dollar Amount	Location on Form
Total Charges	(Box 47) Revenue code 001
Deductions (Minus) –	Share of Cost (Box 39, 40 or 41A thru D/ Value code 23) and Other Coverage (Box 54A or B)
Net Billed (Equals) =	(Boxes 55A thru C)

Table of Form Items Descriptions (continued)

Item	Description
56.	‹‹**NPI.** Enter the enrolled National Provider Identifier (NPI) where the payment is issued.››
57A thru C.	**Other (billing) provider ID (used by atypical providers only).** Not required by Medi-Cal for inpatient providers. **Note:** Required prior to the mandated NPI implementation date when an additional identification number is necessary to identify the provider, or if on and after the mandated NPI implementation, the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.
58A thru C.	**Insured’s Name**. If billing for an infant using the mother’s ID or for an organ donor, enter the Medi-Cal recipient’s name here and the patient’s relationship to the Medi-Cal recipient in Box 59 (*Patient’s Relationship to Insured*). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.

Table of Form Items Descriptions (continued)

Item	Description
59A thru C.	**Patient's Relationship to Insured**. If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [child] or "11" [donor]). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.
60A thru C.	**Insured's Unique ID.** ‹‹Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card, or the 9-character recipient ID number as it appears on the Medi-Cal Eligibility Confirmation Letter.›› **Note:** Medi-Cal does not accept Medicare ID numbers.

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 8B on a previous page.)

Table of Form Items Descriptions (continued)

Item	Description
61A thru C.	**Group Name.** Not required by Medi-Cal.
62A thru C.	**Insurance Group Number**. Not required by Medi-Cal.
63A thru C.	**Treatment Authorization Codes**. For services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim.

Extension TAR Control Numbers

Inpatient claims must be submitted with a TAR Control Number, even if an extension TAR was issued for the same stay. (Enter the extension TAR Control Number in the *Remarks* field [Box 80].)

Note: TAR-approved inpatient stays should not be billed on the same claim with inpatient stays that do not require a TAR.

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
64A thru C.	**Document Control Number.** Not required by Medi-Cal.
65A thru C.	**Employer Name**. Not required by Medi-Cal.
66.	**Diagnosis Code Header**. For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator “0” in the white space below the *Diagnosis Code* field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
67.	**Unlabeled (Use for primary diagnosis code).** Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets Centers for Medicare & Medicaid Services (CMS) standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67Q. See Figure 6 in Item 67A. **Note**: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A. However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 thru 67Q) so the claim is reimbursed at the appropriate level. Paper claims accommodate up to 18 diagnosis codes.
67A.	**Unlabeled (Use for secondary diagnosis code)**. If applicable, enter all letters and/or numbers of the ICD-10-CM code for the secondary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets CMS standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67Q.

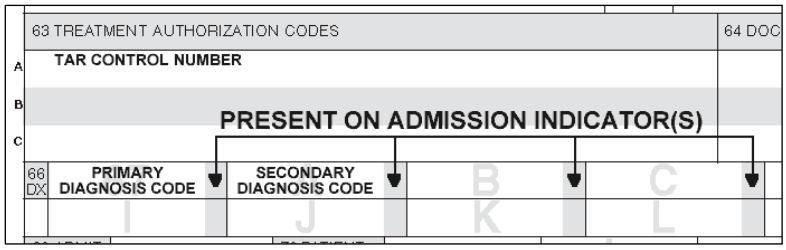


Figure 6: Arrows show shaded areas where present on admission (POA) indicators are placed; next to their associated diagnosis codes.

‹‹Table of Form Items Descriptions (continued)››

Item	Description
67A.	**Unlabeled (Use for secondary diagnosis code) (continued).** **Note**: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A. However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 thru 67Q) so the claim is reimbursed at the appropriate level. Paper claims accommodate up to 18 diagnosis codes.
67B thru Q.	**Unlabeled**. Not required by Medi-Cal. See “Note” in Item 67A.
68.	**Unlabeled.** Not required by Medi-Cal.
69.	**Admitting Diagnosis**. Not required by Medi-Cal.
70.	**Patient Reason Diagnosis.** Not required by Medi-Cal.
71.	**PPS code.** Not required by Medi-Cal.
72.	**External Cause of Injury Code**. Not required by Medi-Cal.
73.	**Unlabeled**. Not required by Medi-Cal.

‹‹**Table of Form Items Descriptions (continued)**››

Item	Description
74.	**Principal Procedure Code and Date**. Enter the appropriate ICD-10-CM PCS code identifying the primary medical or surgical procedure. In six-digit MMDDYY (Month, Day, Year) format, enter the date the surgery or delivery was performed. Enter the ICD-10-CM PCS code, without periods or spaces between the numbers. **Note:** The Medi-Cal claims processing system only scans the primary and secondary procedure codes entered in Boxes 74 and 74A. However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all procedure code fields (Boxes 74 thru 74E) so the claim is reimbursed at the appropriate level. Paper claims accommodate up to six procedure codes.
74A thru E.	**Other procedure codes and dates.** Enter the appropriate ICD-10-PCS code identifying the secondary medical or surgical procedure. Enter the ICD-10-PCS code, without periods or spaces between the numbers or characters. **Note:** For OB vaginal or cesarean delivery and transplants, enter the appropriate ICD-10-PCS code in either Box 74 or 74A thru E. Also see the “Note” in Item 74.
75.	**Unlabeled**. Not required by Medi-Cal.
76.	**Attending**. In the first box, enter the attending physician’s NPI. Do not use a group provider number. The attending physician’s first and last name are not required by Medi-Cal.
77.	**Operating.** In the first box, enter the operating physician’s NPI. Do not use a group provider number. The operating physician’s first and last name are not required by Medi-Cal.
78.	**Other (Use for admitting physician provider number).** In the first box, enter the admitting physician’s NPI. Do not use a group provider number. The admitting physician’s first and last name is not required by Medi-Cal.
79.	**Other**. Not required by Medi-Cal.

Table of Form Items Descriptions (continued)

Item	Description
80.	**Remarks**. Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the *Remarks* field (Box 80), attach the statement to the claim. An emergency certification statement is required for medical transportation providers. Please refer to the *Medical Transportation – Ground* and *Medical Transportation – Air* sections of the appropriate Part 2 provider manual for additional instructions.
‹‹81a.	**Code-Code**. Add taxonomy code with qualifier B3 (Healthcare Provider Taxonomy Code) to field 81CCa for billing providers.››
‹‹81b.	**Code-Code**. Add taxonomy code with qualifier B3 (Healthcare Provider Taxonomy Code) to field 81CCb for attending providers.››
‹‹81c thru d.	**Code-Code**. Not required by Medi-Cal.››

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	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.
*	Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section in this manual for more information.
¥	Documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason “11” without an attachment will either receive reimbursement at a reduced rate or a claim denial. Refer to “Reimbursement Reduced for Late Claims” in *the UB-04 Submission and Timeliness Instructions* section of this manual.