UB-04 Completion: Long Term Care Services

Page updated: February 2025

The *UB-04* claim form is used to submit claims for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) services.

‹‹Most claims for these services may also be submitted through ASC X12N 837 v5010 claim (837). For 837 and registration information, refer to the *ASC X12N 837* section in the Part 1 manual or call the Telephone Service Center (TSC) at 1-800-541-5555.››

For additional billing information, refer to the following sections of this manual:

- *UB-04 Completion: LTC Services Billing Example*
- *UB-04 Submission and Timeliness Instructions*
- *UB-04 Tips for Billing: LTC Services*

For crossover billing information, refer to the *Medicare/Medi-Cal Crossover Claims: Long Term Care* and *Medicare/Medi-Cal Crossover Claims: Long Term Care 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 LTC Services* sections in this manual for information about claim adjustments.

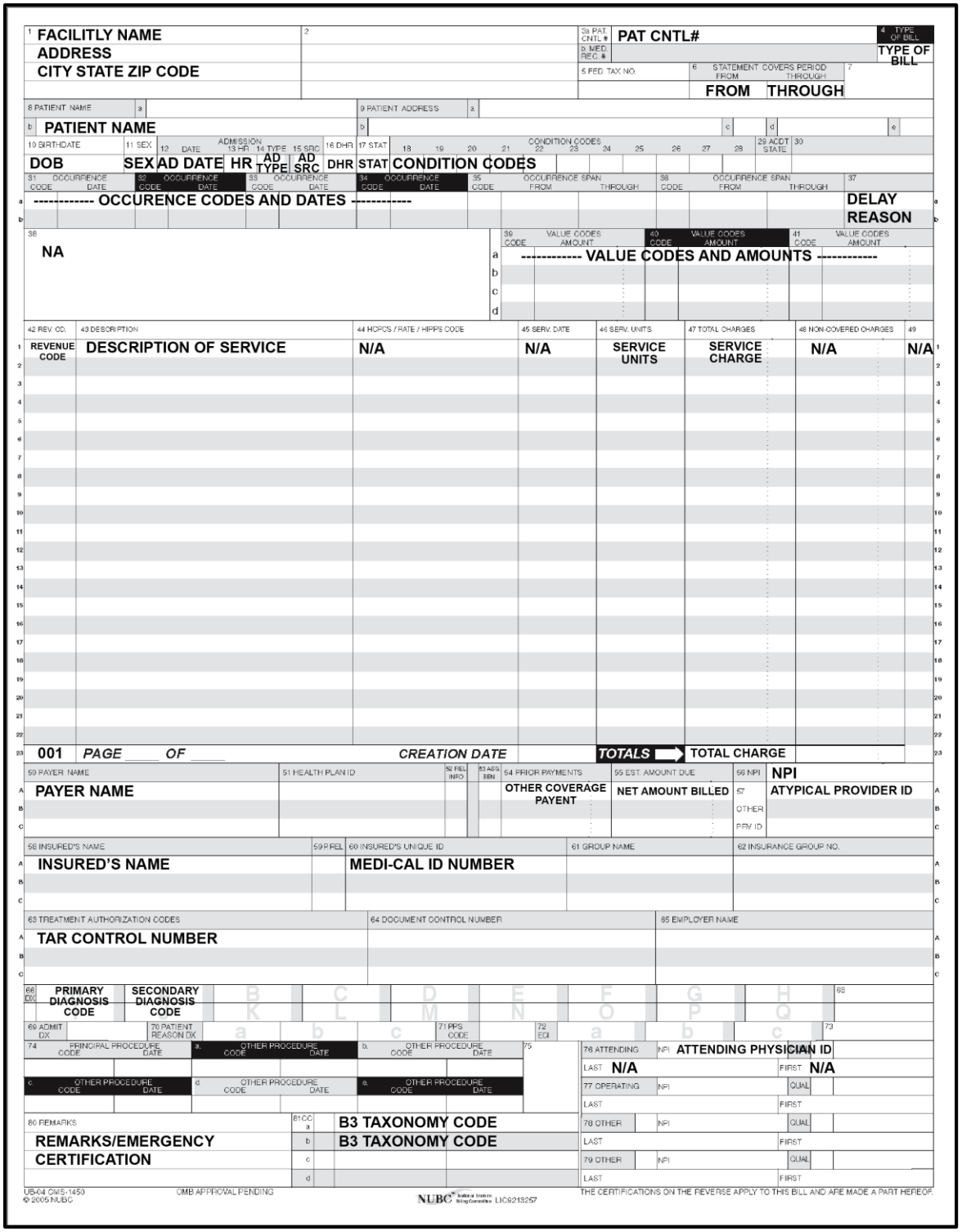

Figure 1. *UB-04* Claim Form

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *UB-04* claim form on the previous page for completing Medi-Cal claims and Medi-Cal Part A coinsurance and Part B crossover claims. All items must be completed unless otherwise noted. Note that only one month's service can be billed on each claim form.

All instructions are applicable to both paper and 837 claims except where noted. For general paper claim and 837 billing instructions, review the *Forms: Legibility and Completion Standards* section in this manual and the *ASC X12N 837* section in the Part 1 manual. For further instructions regarding completion of the UB-04 claim for LTC services, refer to the *UB-04 Completion: Services* section in the appropriate Part 2 manual.

Required Claim Form Items

Note: A quick reference of required claim form items for Medi-Cal per diem billing, Medicare Part A coinsurance and Part B deductible residual amount billing appears at the end of this section (see "LTC Medi-Cal Per Diem, Medicare Part A, & Medicare Part B Variance Table").

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.

Required Claim Form Items Table

Item	Medi-Cal Claim Description
1	**Unlabeled** (Use for hospital information). Enter the hospital name. ‹‹Enter the 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. ››

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
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: Long Term Care 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 LTC Facility Type Code Descriptions (Item 4)

Code	Facility Type
18	Hospital – Swing Beds
21	Skilled Nursing – Inpatient (including Medicare Part A)
22	Skilled Nursing – Inpatient (Medicare Part B only)
23	Skilled Nursing – Outpatient
28	Skilled Nursing – Swing Beds
65	Intermediate Care –Level I
66	Intermediate Care – Level II

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim 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. Bill only up to one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2023, is written 040523. **Note:** When a patient is discharged, the thru date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.
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.
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 equals 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101.
11	**Sex.** Use the capital letter "M" for male, or "F" for female.
12 thru 13	**Admission Date and Hour**. In a six-digit format, enter the date of admission to the facility. 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. equals 15) **Note:** Although providers can enter this data, the claims processing system shall utilize the Admit Date from the Treatment Authorization Request (TAR).

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
14	**Admission Type.** Enter the numeric code indicating the necessity for admission to the facility: • Emergency – 1 • Urgent – 2 • Elective – 3 • Newborn – 4 • Information not available – 9 If the delivery was outside the facility, 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 facility: 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 facility]), 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

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim 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. equals 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." The patient status code must agree with the revenue code and value code/amount combination (that is, if the status code indicates leave days, the revenue code and value code/amount combination must also indicate leave days). Refer to the Leave of Absence, Bed Hold, and Room and Board Provider Manual for detailed leave days billing instructions. **Note:** FI does not require a copy of Form MC-171 (*Notification of Patient Admission, Discharge, or Death*) to be attached to the *UB-04* claim form.

Table of Patient Status 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 Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
04	Discharged/transferred to a Facility that Provides Custodial or Supportive Care
05	Discharged/transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
09	Admitted as an Inpatient to this Hospital
20	Expired
21	Discharged/Transferred to Court/Law Enforcement
30	Still Patient

Table of Patient Status Code Descriptions (Item 17) (continued)

Code	Explanation
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 (Certified) Providing Hospice Level of Care
61	Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
62	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
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)
69	Discharged/transferred to a Designated Disaster Alternate Care Site
70	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim 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 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. Emergency Certification: Enter code “81” when billing for emergency services. 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 any service rendered under emergency conditions. These statements must be signed and dated by the provider and must be supported by a physician’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. 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 *Conditions Codes* fields (Boxes 18 thru 24) blank on the *UB-04* claim. The Medicare status codes are listed in the Table of Medicare Status Code Descriptions (Items 18 thru 24).

Table of Medicare Status 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

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim 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. 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. **Discharge Date**. In six-digit MMDDYY (Month, Day, Year) format, enter code “42” and the date of facility discharge when the date of discharge is different than the “Through” date in Box 6.

Table of Occurrence 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

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
35 thru 36a thru b	**Occurrence Span Codes and Dates.** Occurrent Span codes and dates are used to identify events that relate to the payment of the claim. Occurrence Span 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 Span codes “70” (Qualifying Stay For SNF) and “MR” (Disaster Related), enter “70” in Box 35a and “MR” in Box 36a. 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 35 thru 36. The claims processing system will ignore all codes not applicable to Medi-Cal. In addition, this field is required if the claim is for a Leave of Absence. Refer to the Leave of Absence, Bed Hold, and Room and Board Provider Manual for detailed leave days billing instructions. Applicable Medi-Cal codes are: Enter code “74” (Non-Covered Level of Care/Leave of Absence Dates) if the claim is for a Leave of Absence of any type. Enter code “M4” (Residential Level of Care) if the claim is for Leave of Absence to the patient’s home and the patient has not been discharged. In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service associated with the Occurrence Span codes.
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. Refer to the *UB-04 Submission and Timeliness Instructions* section in this manual for detailed information about codes and documentation requirements.

Table of Delay Reason Code Descriptions and 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

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
37b	**Unlabeled**. Not required by Medi-Cal.
38	**Unlabeled**. Not required by Medi-Cal.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
39 thru 41a thru d	**Value Codes and Amount**. **Patient's Share of Cost.** Value codes and amounts are used to relate amounts to data elements necessary to process the claim. 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 "24" (Medicaid Rate Code) and "23" (Accepted By Medi-Cal), enter "23" in Box 39a and "24" in Box 40a. Although the Medi-Cal claims processing system only recognizes select codes, providers may include codes and amounts billed to other payers in Boxes 39 thru 41. The claims processing system will ignore all codes not applicable to Medi-Cal. 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, refer to *the Share of Cost (SOC): UB-04 for Long Term Care* section in this manual. Enter "23" and the amount of the patient's Share of Cost for the service, if applicable. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi-Cal. A description of non-covered services is included in the *Share of Cost (SOC): UB-04 for Long Term Care* section of this manual. The SOC amount entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the DHS 6114 form, Item 15. (See the *Share of Cost [SOC]: UB-04 for Long Term Care section* in this manual for an example.)

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
39 thru 41a thru d	When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the Remarks field (Box 80). The SOC amount is deducted from the amount billed to Medi-Cal. The SOC amount entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the DHS 6114 form, Item 15. (See the *Share of Cost [SOC]: UB-04 for Long Term Care* section in this manual for an example.) When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the Remarks field (Box 80). The SOC amount is deducted from the amount billed to Medi-Cal. Enter "24" (Medicaid Rate Code) and the corresponding Designated State Level Medicaid Rate Code on the *Value Codes and Amount* fields associated with LTC services. The Designated State Level Medicaid Rate Code should be entered in the "cents" portion of the *Value Codes and Amount* field.
42	**Revenue Code**. Enter the appropriate revenue code. **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 code used in Box 42. **Note:** If there are multiple pages of the claim, enter the page numbers on line 23 in this field.
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.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
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). When billing for full Medi-Cal coverage, compute the 'Total Charges' by multiplying the number of days times the appropriate Medi-Cal daily rate for the revenue code and Designated State Level Medicaid Rate Code listed. **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 Long Term Care* 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), but only if they are associated with the other claim information entered (e.g. Statement Coverers Period, Status, etc.). It is also acceptable to skip lines. To delete a line, mark through the boxes. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.
50a thru c	**Payer name. Enter "LTC MEDI-CAL"** to indicate type of claim and payer. Use capital letters only. 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.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim 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 ($), positive (+) or negative (-) sign. Leave blank if not applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. **Note:** If the Medi-Cal eligibility verification system indicates a scope of coverage code "L" for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the *Other Health Coverage (OHC)* section in this manual.
55a thru c	**Estimated amount due (net amount billed).** In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign ($).

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
56	**NPI.** ‹‹Enter the enrolled National Provider Identifier (NPI) where the payment is issued.›› Be sure to include all ten characters of the number. Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that bill with anything other than an NPI will be denied. **Note to ASC X12N 837 v.5010 Claim (837) Users:** Anytime a provider number is changed, a new provider application/agreement form must be submitted to the EDI unit to allow continued 837 billing using the new provider number. For more information, refer to the *ASC X12N 837 Requirements and Procedures* section in the Part 1 manual.
57a thru c	Other (billing) provider ID (used by atypical providers only). Not required by Medi-Cal. **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.
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 number as it appears on the Medi-Cal Eligibility Confirmation Letter. **Note:** Medi-Cal does not accept Medicare ID numbers.
61a thru c	**Group Name.** Not required by Medi-Cal.
62a thru c	**Insurance Group Number**. Not required by Medi-Cal.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
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. Be sure the billed dates fall within the TAR authorized dates. **Note:** Providers who obtain electronic TARs (eTARs) must enter a 10-digit TAR Control Number (TCN) and add a zero at the end as the 11th digit. Providers with a nine-digit paper TAR must add two zeroes at the end to complete the 11-digit TCN.
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.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
67	**Unlabeled (Use for primary diagnosis code).** Enter the Primary ICD-10-CM diagnosis code (International Classification of Diseases – 10th Revision, Clinical Modification). 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. **Note**: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A.
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. **Note:** The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A.
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.
74	**Principal Procedure Code and Date**. Not required by Medi-Cal.

Required Claim Form Items Table (continued)

Item	Medi-Cal Claim Description
74a thru e	**Other procedure codes and dates**. Not required by Medi-Cal.
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. Be sure the attending physician's NPI is entered on a(n): • Admit claim • Initial Medi-Cal claim for a Medicare/Medi-Cal crossover patient • Claim when there is a change in the attending physician's provider number
77	**Operating.** Not required by Medi-Cal.
78	**Other.** Not required by Medi-Cal.
79	**Other.** Not required by Medi-Cal.
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.
‹‹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.››

LTC Medi-Cal Per Diem, Medicare Part A and Medicare Part B Differences

Although the *UB-04* shall be used to bill hard copy claims for Medi-Cal LTC services, hard copy claims for Medicare LTC services will also utilize the UB-04 claim form. All Claim Form Item field instructions listed above for Medi-Cal claims shall also apply to Medicare claims, where applicable. However, key differences are noted below and should be incorporated/applied when completing Medicare LTC claims.

For detailed crossover billing information, refer to the *Medicare/Medi-Cal Crossover Claims: LTC Services* and *Medicare/Medi-Cal Crossover Claims: LTC Services Billing Examples* sections in this manual.

Key Claim Form Items

LTC Medi-Cal Per Diem, Medicare Part A and Medicare Part B Variance Table

Note: When billing for Medicare/Medi-Cal crossover claims, follow the directions in either the Part A Coinsurance Claim Description or the Part B Crossover Claim Description column. When billing for straight Medi-Cal claims, follow the directions in the Medi-Cal Claim Description column. However, all other *UB-04* fields must be completed as instructed in this section and other applicable sections in this manual.

Crossover Claim Requirements Table

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
4	**Type Of Bill**. Enter the appropriate three-character Type Of Bill code as specified in the 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 NUBC *UB-04* Data Specifications Manual facility type codes commonly used by Medi-Cal. Use one of the following codes as the first two digits of the three-character Type Of Bill code: 18, 21, 22, 23, 28, 65, 66	Enter only Type Of Bill 18, 21, or 28, as applicable, for a Part A claims.	Enter only Type Of Bill 22 or 23, as applicable, for Part B claims.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
6	**Statement Covers Period** (From–Through). In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. Bill only up to one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2023, is written 040523. **Note:** When a patient is discharged, the thru date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.	Same as Medi-Cal **Note:** Dates of service reflect only those dates covered by coinsurance. No TAR required.	Only up to a one-month period may be billed on a single claim. If the Part B Medi-Cal Crossover service involves only one day, enter the same date in both the FROM and THROUGH boxes. If the services were performed over a range of dates in the same month, the FROM date is the first service date and the THROUGH date is the last service date as appears on the Medicare form.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
31 thru 34 a 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. 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 if the accident or injury was non-employment related: 01, 02, 03, 05, 06. **Discharge Date**. In six-digit MMDDYY (Month, Day, Year) format, enter code “42” and the date of facility discharge when the date of discharge is different than the “Through” date in Box 6.	Enter Occurrence Code 50 Attach a copy of the Medicare EOMB/RA.	Enter Occurrence Code 50. Attach a copy of the Medicare EOMB/RA.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
37a	Unlabeled (Use for delay reason codes). Enter one of the following delay reason codes and include the required documentation, if there is an exception to the six-month from the month of service billing limit: 1, 3, 4, 5, 6, 7, 10, 11, 15. Refer to the *UB-04 Submission and Timeliness Instructions* section in this manual for detailed information about codes and documentation requirements.	Enter delay reason code number 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare EOMB/RA.	Enter delay reason code number 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare EOMB/RA.
39 thru 41 a thru d	**Value Codes and Amount**. **Patient's Share of Cost.** Value codes and amounts are used to relate amounts to data elements necessary to process the claim. 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 "24" (Medicaid Rate Code) and "23" (Accepted By Medi-Cal), enter "23" in Box 39a and "24" in Box 40a.	Same as Medi-Cal For billing Deductible, Coinsurance and SOC, refer to the *Medicare/ Medi-Cal Crossover Claims: Long Term Care Billing Examples* section in this manual.	Leave Blank For billing Deductible, Coinsurance and SOC, refer to the Medicare/Medi-*Cal Crossover Claims: Long Term Care Billing Examples section* in this manual.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
39 thru 41a thru d	Although the Medi-Cal claims processing system only recognizes select codes, providers may include codes and amounts billed to other payers in Boxes 39 thru 41. The claims processing system will ignore all codes not applicable to Medi-Cal. 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, refer to *the Share of Cost (SOC): UB-04 for Long Term Care* section in this manual. Enter “23” and the amount of the patient’s Share of Cost for the service, if applicable. The recipient’s net SOC liability is the amount billed to the recipient. The recipient’s net SOC liability is determined by subtracting from the recipient’s original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient’s SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items “not covered” by Medi-Cal. A description of non-covered services is included in the *Share of Cost (SOC): UB-04 for Long Term Care* section of this manual.	Refer to above.	Refer to above.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
39 thru 41 a thru d	The SOC amount entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the *DHS 6114* form, *Item 15*. (See the *Share of Cost [SOC]: UB-04 for Long Term Care* section in this manual for an example.) When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the *Remarks* field [Box 80]. The SOC amount is deducted from the amount billed to Medi-Cal. Enter "24" (Medicaid Rate Code) and the corresponding Designated State Level Medicaid Rate Code on the *Value Codes and Amount* fields associated with LTC services. The Designated State Level Medicaid Rate Code should be entered in the "cents" portion of the *Value Codes and Amount* field.	Refer to above.	Refer to above.
42	**Revenue Code**. Enter the appropriate revenue code. **Total Charges:** Enter "001" on line 23, and enter the total amount on line 23, field 47.	Same as Medi-Cal	Leave Blank

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
43	**Description.** Enter the description of the revenue code used in Box 42. **Note:** If there are multiple pages of the claim, enter the page numbers on line 23 in this field.	Same as Medi-Cal	Leave Blank
46	**Service Units** (Accommodation Days). Enter the number of days of care by revenue code.	Same as Medi-Cal	Leave Blank
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). When billing for full Medi-Cal coverage, compute the 'Total Charges' by multiplying the number of days times the appropriate Medi-Cal daily rate for the revenue code and Designated State Level Medicaid Rate Code listed. **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 Long Term Care* 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).	Multiply the per diem rate allowed by Medicare, times the total coinsurance days being billed and enter the total.	Enter the amount allowed by Medicare for these services directly from the Medicare EOMB/RA.

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
50a thru c	**Payer name. Enter "LTC MEDI-CAL"** to indicate type of claim and payer. Use capital letters only. 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.	The payers must be listed in the following order of payment: Other Health Coverage (if applicable) except Medicare Supplemental Insurance, Medicare, Medicare Supplemental Insurance (if applicable), Medi-Cal. Refer to *Medicare/ Medi-Cal Crossover Claims: Long Term Care* for further details.	The payers must be listed in the following order of payment: Other Health Coverage (if applicable) except Medicare Supplemental Insurance, Medicare, Medicare Supplemental Insurance (if applicable), Medi-Cal. Refer to *Medicare/ Medi-Cal Crossover Claims: Long Term Care f*or further details.
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. Other Health Coverage (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.	On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount.	On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount plus any contract adjustment amount (from EOMB/RA).

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim 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 ($).	Enter the amount billed to Medi-Cal (coinsurance) as shown on the EOMB/RA from the Medicare intermediary, less any patient's Share of Cost applied to this billing line.	Same as Part A coinsurance. Enter the portions to be billed to Medi-Cal (coinsurance plus any Medicare deductible as shown on EOMB/RA from the Medicare intermediary, minus any patient's Share of Cost.
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. Be sure the billed dates fall within the TAR authorized dates. **Note:** Providers who obtain electronic TARs (eTARs) must enter a 10-digit TAR Control Number (TCN) and add a zero at the end as the 11th digit. Providers with a nine-digit paper TAR must add two zeroes at the end to complete the 11-digit TCN.	Leave Blank	Leave Blank

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
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. Be sure the billed dates fall within the TAR authorized dates. **Note**: Providers who obtain electronic TARs (eTARs) must enter a 10-digit TAR Control Number (TCN) and add a zero at the end as the 11th digit. Providers with a nine-digit paper TAR must add two zeroes at the end to complete the 11-digit TCN.	Leave Blank	Leave Blank
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.	Same as Medi-Cal	Leave Blank

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
67	Unlabeled (Use for primary diagnosis code). Enter the Primary ICD-10-CM diagnosis code (*International Classification of Diseases – 10th Revision, Clinical Modification*). 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. **Note:** The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67a.	Same as Medi-Cal	Leave Blank

Crossover Claim Requirements Table (continued)

Claim Form Item	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
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. **Note:** The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67a.	Same as Medi-Cal	Leave Blank
77	**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. Be sure the attending physician's NPI is entered on a(n): • Admit claim • Initial Medi-Cal claim for a Medicare/Medi-Cal crossover patient • Claim when there is a change in the attending physician's provider number	Same as Medi-Cal	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.

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.