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## Dialysis Examples: UB-04

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The examples in this section are to assist providers in billing for dialysis services on the *UB-04* claim. Refer to the dialysis 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 and the [UB-04 Special Billing Instructions for Outpatients](#) section for additional *UB-04* claim completion information, including “from-through” billing. 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.

## **Monthly Dialysis Fee (“From-Through” Format)**

*Figure 1. Monthly dialysis fee (“from-through” format).*

*This is a sample only. Please adapt to your billing situation.*

In this example, services at an independent renal dialysis center are billed in the “from-through” format in the *Service Date* field (Box 45).

Enter the two-digit facility type code “72” (clinic - hospital-based or independent renal dialysis center) and one-character claim frequency code “1” as “721” in the *Type of Bill* field (Box 4).

Enter an explanation of the service rendered (maintenance dialysis with lab) in the *Description* field (Box 43). Enter the first date the recipient was seen for training (this is the “from” date) in the *Service Date* field (Box 45). The from date, October 1, 2015, is entered in six-digit format as 100115. No other information is entered on this claim line.

Enter the specific days the services were rendered (10/4, 8, 12, 15, 19, 22, 26 and 29) in the *Description* field (Box 43) and the corresponding HCPCS code for the services (Z6004) in the *HCPCS/Rate* field (Box 44). Enter the “through” date of service, October 29, 2015, which is the end date of training, in the *Service Date* field (Box 45) as 102915.

**Note:** The professional fee for this service is billed separately on a *CMS-1500* claim form.

The number of services (8) rendered is entered in the *Service Units* field (Box 46). Enter the usual and customary charges in the *Total Charges* field (Box 47, line 23).

Enter “O/P Medi-Cal” to indicate the type of claim and payer in the *Payer Name* field (Box 50). The Chronic Dialysis Center’s NPI is placed in the *NPI* field (Box 56).

Enter an appropriate ICD-10-CM code 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 referring or prescribing provider number is entered in the *Attending* field (Box 76). The rendering provider number is entered in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3 UNIT CONT. #		4 TYPE OF BILL 721	
9 PATIENT NAME DOE, JANE		9 PATIENT ADDRESS					
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION NO. 14 TYPE	
15 SRC		16 DMR		17 STAT		18 19 20 21	
22		23		24		25	
26		27		28		29 ACCT 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 / HPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
001		PAGE OF		CREATION DATE		TOTALS 110400	
50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 PRIOR PAYMENTS		53 EST. AMOUNT DUE 110400	
54		55		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 PPEL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76 ATTENDING NPI 2345678901		77 QUAL	
78		79		76 ATTENDING LAST		77 QUAL	
80		81		77 OPERATING NPI 1234567890		78 QUAL	
82		83		77 OPERATING LAST		78 QUAL	
84		85		78 OTHER NPI		79 QUAL	
86		87		78 OTHER LAST		79 QUAL	
88		89		79 OTHER NPI		80 QUAL	
90		91		79 OTHER LAST		80 QUAL	

Figure 1: Monthly Dialysis Fee (“From-Through” Format).

## **Home Dialysis (“From-Through” Format)**

Report HCPCS codes S9335 or S9339 on a single monthly claim by using the “from-through” billing method on the *UB-04* or the CMS-1500 forms. “From-through” billing may be used to report consecutive or non-consecutive dates of service.

On the *UB-04* form, enter the home dialysis procedure description in the *Description* field (Box 43, line 1). List the individual dates of service rendered within that calendar month in the *Description* field (Box 43, line 2). Enter either code ‘S9335’ or ‘S9339’ in the HCPCS field (Box 44, line 2). Enter the first and last days of the month as the ‘from’ and ‘through’ dates in the *Service Date* field (Box 45, lines 1 and 2, respectively). Enter the total sum of service units rendered within that calendar month in the *Service Units* field (Box 46, line 2) (one per diem unit of S9335 or S9339 equals one day or date of service). Multiply the number of units by the maximum allowable amount per unit in the *Total Charges* field (Box 47, line 2).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2		3a PAT. CNTRL. # b. MED. REC. #		4 TYPE OF BILL 721															
8 PATIENT NAME a DOE, JANE			9 PATIENT ADDRESS b																	
10 BIRTH DATE 08241980	11 SEX F	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT YO	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37 THROUGH	38 CODE	39 OCCURRENCE SPAN FROM	40 THROUGH	41 CODE	42 THROUGH	43	44	45	46	47	48	49	50	51
38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59	60	61	62
1	HOME THERAPY, HEMODIALYSIS; 10/4, 8, 12, 15, 19, 22, 26, 29	S9335	100421 102921	8	110400															
23	001 PAGE OF	CREATION DATE	TOTALS	110400																
50 PAYER NAME O/P MEDI-CAL	51 HEALTH PLAN ID	52 BILL INFO	53 ASST BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 110400	56 NPI	57 OTHER PRV ID	58	59	60	61	62	63	64	65	66	67	68	69	70
58 INSURED'S NAME	59 PREL	60 INSURED'S UNIQUE ID 90000000A95001	61 GROUP NAME	62 INSURANCE GROUP NO.	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83
86 DX D1D1D1D 0	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
69 ADMIT DX	70 PATIENT REASON DX	71 HIPPS CODE	72 ECI	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OTHER PROCEDURE DATE	78 ATTENDING NPI 2345678901	79 QUAL	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94
77 OTHER PROCEDURE DATE	78 OTHER PROCEDURE DATE	79 OTHER PROCEDURE DATE	80 OTHER PROCEDURE DATE	81 OPERATING NPI 1234567890	82 QUAL	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97
80 REMARKS	81 CC a	82	83	84 OTHER NPI	85 QUAL	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
81 CC b	82	83	84 OTHER NPI	85 QUAL	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101
81 CC c	82	83	84 OTHER NPI	85 QUAL	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101
81 CC d	82	83	84 OTHER NPI	85 QUAL	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101

Figure 2: Home Dialysis (“From-Through” Format)

## **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.