UB-04 Completion: Outpatient Services

Page updated: September 2020

The *UB-04* claim form is used to submit claims for outpatient services by institutional facilities (for example, outpatient departments, Rural Health Clinics and chronic dialysis centers). See *UB-04 Completion: Inpatient Services* in the Part 2 Inpatient Services Manual for billing instructions for services rendered to a registered hospital inpatient.

If the patient is treated as an outpatient in a hospital different from the one in which the patient is registered, the services must be billed by the treating hospital using the *UB-04* claim form with the appropriate facility type code (which is the first two digits in the *Type of Bill* field [Box 4]) for the outpatient facility.

Most claims for outpatient services can also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

For additional billing information, refer to *the UB-04 Special Billing Instructions for Outpatient Services, UB-04 Submission and Timeliness Instructions* and *UB-04 Tips for Billing: Outpatient Services* sections in this manual.

LEA Providers:

Timeliness limitations differ for Local Educational Agency (LEA) providers. LEA providers refer to the *Local Educational Agency (LEA) Billing and Reimbursement Overview* section.

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

Medi-Cal cannot process credits or adjustments on the *UB-04* form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Outpatient Services* sections in the appropriate Part 2 manual for information about claim adjustments.

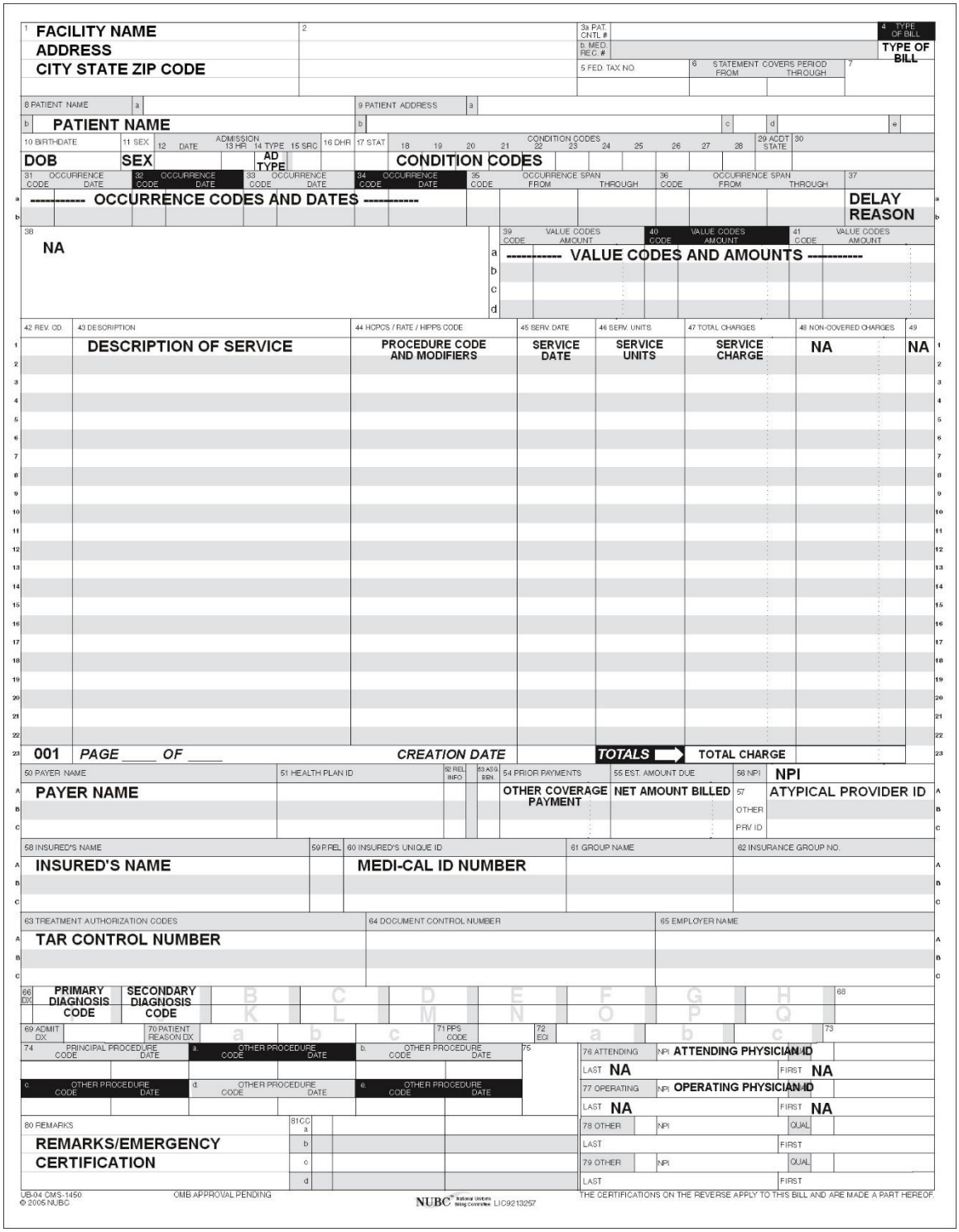


Figure 1: Medi-Cal Required Fields for Outpatient *UB-04* Claims

Explanation of Form Items

The following item numbers and descriptions correspond to the *UB-04* claim form 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 clinic or facility information).** Enter the clinic or facility name. Enter the address, without a comma between the city and state, and 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 box must match the billing provider's 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: Outpatient 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 RA for recipient clarification. The patient control number (Item 3) will appear on the RA.
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.* The type of bill code includes the two-digit facility type code and one-character claim frequency code. 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* 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:

Table of Facility Type Codes

Code	Facility Type
13	Hospital, Outpatient
14	Hospital, Laboratory Services Provided to Non-Patients
23	Skilled Nursing, Outpatient
32	Home Health Services Under a Plan of Treatment
‹‹33	Home Health, Outpatient››
34	Home Health Services, Not Under a Plan of Treatment
43	Religious Non-Medical Health Care Institutions, Outpatient Services
71	Clinic, Rural
72	Clinic, Hospital Based or Independent Renal Dialysis Center
73	Clinic, Freestanding
74	Clinic, Outpatient Rehabilitation Facility (ORF)
75	Clinic, Comprehensive Outpatient Rehabilitation Facility (CORF)
76	Clinic, Community Mental Health Center
77	Federally Qualified Health Center (FQHC)
78	Licensed Freestanding Emergency Medical Facility
79	Clinic, Other
81	Specialty Facility, Hospice (non-hospital based)
82	Specialty Facility, Hospice (hospital based)
83	Specialty Facility, Ambulatory Surgery Center
84	Specialty Facility, Freestanding Birthing Center
85	Specialty Facility, Critical Access Hospital
87	Specialty Facility, Freestanding Non-Residential Opioid Treatment Program
89	Specialty Facility, Other

Notes: Only one facility type may be billed on each claim. Outpatient services not logically compatible with the facility type identified on the claim must be billed on a separate claim.

For subacute services, specify the appropriate Place of Service and use modifier U2.

Table of Form Items Descriptions (Continued)

Item	Description
4.	**Type of bill (continued).** Clinics and outpatient hospitals use one of the following codes as the first two digits of the three-character type of bill code:

Table of Facility Type Codes by Provider Type

Provider Type	Facility Type
Chronic Dialysis Clinic	72
Community Hospital, Outpatient	13
Community Mental Health Clinic	76
Employer/Employee Clinic	79
Exempt from Licensure Clinic	79
Free Clinic	79
Home Health Agency	32, 34
Local Educational Agency	89
‹‹Medi-Cal Waiver Program (MCWP) Agency››	13, 32, 34 79
Multispecialty Clinic	79
Rehab Clinic	74
Rehab Clinic (Comprehensive)	75
Rural Health Clinic	71
Surgical Clinic	73, 79

Table of Form Items Descriptions (Continued)

Item	Description
5.	**Federal tax number**. Not required by Medi-Cal.
6.	**Statement covers period (From-Through)**. Not required by Medi-Cal.
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.

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.)

Table of Form Items Descriptions (Continued)

Item	Description
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.	**Admission date**. Not required by Medi-Cal.
13.	**Admission hour**. Not required by Medi-Cal.
14.	**Admission type**. ‹‹Not required by Medi-Cal.››
15.	**Admission source**. Not required by Medi-Cal.
16.	**Discharge hour**. Not required by Medi-Cal.
17.	**Status**. Not required by Medi-Cal.
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 other coverage and is identified separately. Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance 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. Please refer to the *Medical Transportation – Ground* and *Medical Transportation – Air* sections of the appropriate Part 2 provider manual for additional instructions. Outside Laboratory: Enter code "82" if this claim includes charges for laboratory work performed by a licensed laboratory. "Outside" laboratory (facility type "89") refers to a laboratory not affiliated with the billing provider. State in the *Remarks* field (Box 80) that a specimen was sent to an unaffiliated laboratory. Family Planning/CHDP: 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)/Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

‹‹Table of Condition Codes and Descriptions››

Code	Description
A1	EPSDT/CHDP
A4	Family Planning
AI	Sterilization/Sterilization *Consent* Form (PM 330) must be attached if code "AI" is entered See *Family Planning and Sterilization* sections in the appropriate Part 2 manual for further information.

‹‹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. The Medicare status codes are:

‹‹Table of Medicare Status Codes and Descriptions››

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.

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

Item	Description
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.

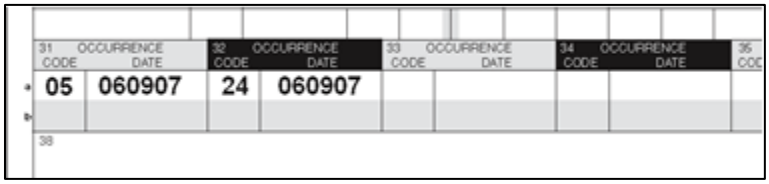


Figure 2. Occurrence Codes Example.

‹‹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 the following 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:

‹‹Table of Occurrence Codes and Descriptions››

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
35 thru 36A thru B.	**Occurrence span codes and dates**. Not required by Medi-Cal.
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-months-from-the-month-of-service billing limit.

‹‹Table of Documentation Descriptions››

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[1]
11	Other (theft, sabotage)	Attachment[1]
15	Natural disaster	Attachment

Also refer to the *UB-04 Submission and Timeliness Instructions* section for additional information about codes and documentation requirements.

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

Item	Description
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. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u> 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 Outpatient Services* section in this manual.

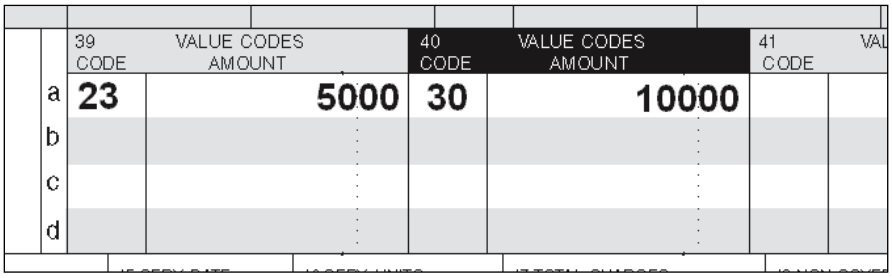


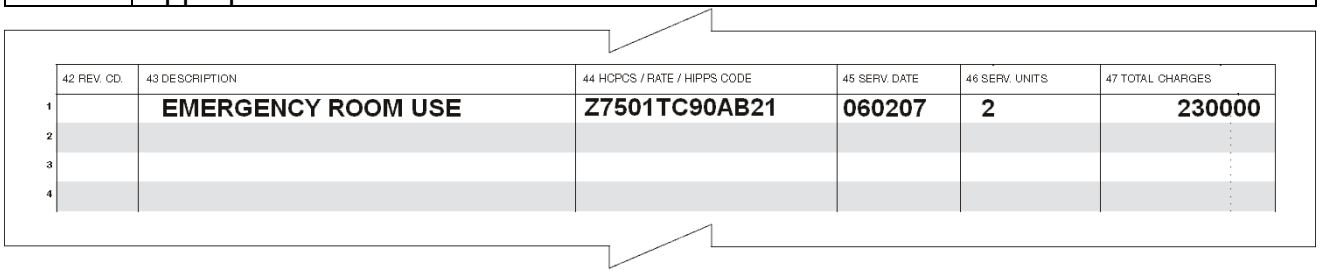
Figure 3: Value Codes Example.

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

Item	Description
39 thru 41A thru D.	**Value codes and amount**. Patient's Share of Cost (continued).
42.	**Revenue code**. Revenue codes are required (for instance, for organ procurement) for select outpatient billing. Specific instructions are included in select provider manual sections. Total Charges: Enter "001" on line 23, and enter the total amount on line 23, field 47.
43.	**Description**. This field will help you separate and identify the descriptions of each service. The description must identify the particular service code indicated in the *HCPCS/Rate/HIPPS Code* field (Box 44). For more information, refer to the CPT® code book. This field is optional except when billing for physician-administered drugs. **Entering the National Drug Code (NDC) for Physician-Administered Drugs**: Enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). Directly following the last digit of the NDC (no space), enter the two-character unit of measure qualifier followed by the numeric quantity. Refer to the *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* section in this manual for more information. **Notes**: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial. 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**. Enter the applicable procedure or drug code (CPT or HCPCS) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claim for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the *TAR and Non-Benefit List: Codes (10000 – 99999)* sections in the appropriate Part 2 manual. Up to four modifiers may be entered on outpatient *UB-04* claims. All modifiers must be billed immediately following the HCPCS code in the *HCPCS/Rate* field (Box 44) with no spaces. (*See Figure 4.)* **Note**: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier following the HCPCS code. Section 340B drugs may be billed on the same claim as non-340B drugs. For a listing of modifier codes, refer to the *Modifiers: Approved List* section in the appropriate Part 2 manual.



	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		EMERGENCY ROOM USE	Z7501TC90AB21	060207	2	230000
2						
3						
4						

Figure 4: Codes and Modifiers Example for *UB-04* Claim.

Medicare/Medi-Cal Recipients

If billing for services to a recipient with both Medicare and Medi-Cal, refer to the *Medicare Non-Covered Services* sections in the appropriate Part 2 Outpatient Services manual to check the list of Medicare non-covered services codes. Only those services listed in a *Medicare Non-Covered Services* section may be billed directly to Medi-Cal. All others must be billed to Medicare first.

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

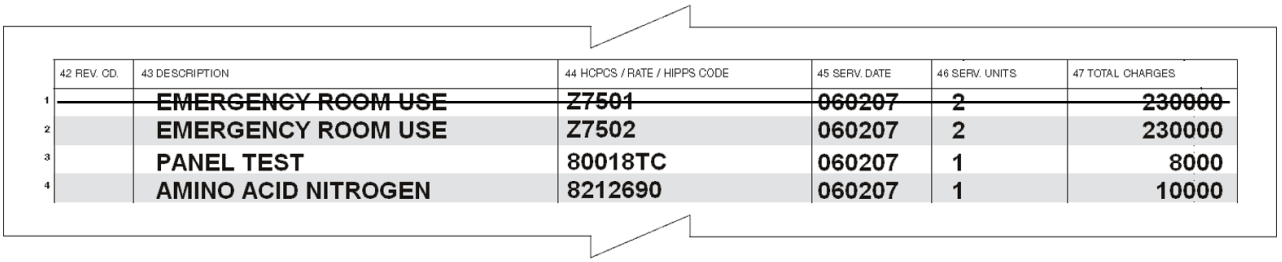
Item	Description
45.	**Service date**. Enter the date the service was rendered in six-digit, MMDDYY (Month, Day, Year) format, for example, June 24, 2020 = 062420.

‘From-Through’ Billing

For “From-Through” billing instructions, refer to the *UB-04 Special Billing Instructions for Outpatient Services* section in this manual.

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

Item	Description
46.	Service units. Enter the actual number of times a single procedure or item was provided for the date of service. 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). If an item is a taxable medical supply, include the applicable state and county sales tax. **Note**: Medi-Cal cannot process credits or adjustments on the *UB-04* form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Outpatient Services* sections in the appropriate Part 2 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 5. 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		~~EMERGENCY ROOM USE~~	~~Z7501~~	~~060207~~	~~2~~	~~230000~~
2		EMERGENCY ROOM USE	Z7502	060207	2	230000
3		PANEL TEST	80018TC	060207	1	8000
4		AMINO ACID NITROGEN	8212690	060207	1	10000

Figure 5: Line Deletion Example for *UB-04* Claim.

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

Item	Description
50A thru C.	**Payer name**. Enter “O/P MEDI-CAL” to indicate the type of claim and payer. Use capital letters only. Refer to *Figure 6.* 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. When billing other insurance, the other insurance is entered on Line A of Box 50, with the amount paid by Other Coverage on Line A of Box 54 (*Prior Payments*). All information related to the Medi-Cal billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line. 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, the insurance carrier must be billed prior to billing Medi-Cal.

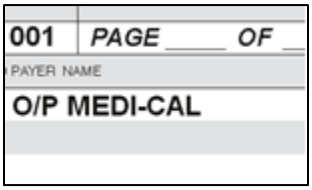


Figure 6: Payer Name Example for *UB-04* Claim.

‹‹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 payments (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 ($), positive (+) or negative (-) sign. Leave blank if not applicable. **Note:** For instructions about completing this field for Medicare/Medi-Cal crossover recipients, refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section in this manual.
55A thru C.	**Estimated amount due (Net amount billed)**. In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign ($).

‹‹Table of Total Charges››

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

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

Item	Description
56.	**NPI**. Enter the National Provider Identifier (NPI).
57A thru C.	**Other (billing) provider ID (Used by atypical providers only)**. Enter the Medi-Cal provider number, corresponding to information on lines A, B or C. **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. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.
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. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.
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. **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. **Note**: TAR and non-TAR procedures should not be combined on the same claim.

‹‹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.
67A.	**Unlabeled (Use for secondary diagnosis code)**. If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. **Note**: Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 67B thru Q and 68 will not be used for claims processing.
67B thru Q.	**Unlabeled**. Not required by Medi-Cal.
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.
74A thru E.	**Other procedure code and date**. Not required by Medi-Cal.
75.	**Unlabeled**. Not required by Medi-Cal.

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

Item	Description
76.	**Attending**. In the first box, enter the provider number of the referring or prescribing physician. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. The referring or prescribing physician's first and last names are not required by Medi-Cal. **Note**: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.
77.	**Operating**. In the first box, enter the provider number of the facility in which the recipient resides or of the physician actually providing services. Only one rendering provider number may be entered per claim form. Do not use a group provider number or state license number. The rendering physician's first and last names are 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. 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 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: Outpatient Services* section in the appropriate Part 2 manual for more information.
1	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.