

## 3.1 Claim Billing

### 3.1.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using Provider Electronic Solutions (PES) software (provided by Electronic Data Systems (EDS) at no cost) or other Health Insurance Portability and Accountability Act (HIPAA) compliant vendor software.

- To submit electronic claims, use the HIPAA 837 Institutional transaction
- To submit claims on paper, use original red UB-04 claim forms available from local form suppliers

All claims must be received within one (1) year of the date of service.

### 3.1.2 Electronic Claims

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See *Section 2, General Billing Information* for more information on electronic billing.

#### 3.1.2.1 Guidelines for Electronic Claims

##### Provider Number

In compliance with HIPAA and the National Provider Identifier (NPI) initiative, Idaho Medicaid requires the submission of the NPI number on electronic 837 claim transactions. Idaho Medicaid recommends providers obtain an NPI for each individual Medicaid provider number. Electronic claims will not be denied if the electronic 837 Institutional transaction is submitted with the Idaho proprietary Medicaid provider number. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the 837 claim transaction.

##### Detail Lines

Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

##### Surgical Procedure Codes – ICD-9-CM Volume 3

Idaho Medicaid allows twenty-five (25) surgical procedure codes on an electronic HIPAA 837 Institutional claim.

##### Four Modifiers

On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code, up to four (4) modifiers are allowed. (On a paper claim, only two (2) modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

##### Type of Bill (TOB) Codes

Idaho Medicaid rejects all electronic transactions with type of bill (TOB) codes ending in a value of six (6). Electronic HIPAA 837 Institutional claims

with valid TOB codes, not covered by Idaho Medicaid, are rejected before processing.

**Condition Codes**

Idaho Medicaid allows twenty-four (24) condition codes on an electronic HIPAA 837 Institutional claim.

**Value, Occurrence, and Occurrence Span Codes**

Idaho Medicaid allows twenty-four (24) value, twenty-four (24) occurrence, and twenty-four (24) occurrence span codes on the electronic HIPAA 837 Institutional claim.

**Diagnosis Codes**

Idaho Medicaid allows twenty-seven (27) diagnosis codes on the electronic HIPAA 837 Institutional claim.

**Ambulance Services**

Idaho requires the following information when submitting an electronic HIPAA 837 Institutional claim for ambulance services.

- Transport code
- Transport reason code
- Transport distance
- Condition code
- Round trip purpose - when the transport code is equal to X for round trip

**National Drug Code (NDC) Information with HCPCS and CPT Codes**

A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

**Electronic Crossovers**

Idaho Medicaid allows providers to submit electronic crossover claims for institutional services.

### 3.1.3 Guidelines for Paper Claim Forms

#### 3.1.3.1 How to Complete the Paper Claim Form

These instructions support the completion for the UB-04 Institutional billing claim form only. The following will speed claim processing:

- Provider numbers submitted on the paper UB-04 Institutional claim form must be the 9-digit Idaho Medicaid billing provider number; paper claims submitted with only the NPI will be returned to the provider; claims submitted with both the NPI and the Medicaid provider number will be processed using the Medicaid provider number only
- Complete all required areas of the UB-04 Institutional claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning
- Keep claim form clean, use correction tape to cover errors

- A maximum of twenty-two (22) line items per claim can be accepted; if the number of services performed exceeds twenty-two (22) lines, prepare a new claim form and complete the required data elements; total each claim separately
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span
- Do not use staples or paperclips for attachments, stack them behind the claim
- Do not fold the claim form(s), mail flat in a large envelope (recommend 9 x 12)

See *Section 3.1.3.3, Completing Specific Fields on a Paper Claim Form* for instructions on completing specific fields.

### **3.1.3.2 Where to Mail the Paper Claim Form**

Send completed claim forms to:

EDS  
P.O. Box 23  
Boise, ID 83707

**3.1.3.3 Completing Specific Fields on a Paper Claim Form**

Refer to Section 3.1.3.4, *Sample Claim Form*, to see a sample UB-04 Institutional claim with all fields numbered. Provider questions regarding institutional policy and coverage requirements are referred to the *Rules Governing the Medical Assistance Program*.

The following numbered items correspond to the UB-04 Institutional claim form. Consult the 'Use' column to determine if information in any particular field is required and refer to the 'Description' column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled Field	Required	<p>Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA).</p> <p><b>Note:</b> If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.</p>
3a	PAT. CNTL #	Desired	<p>The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.</p>
3b	MED REC #	Desired	<p>Medical/Health Record Number: The number assigned to the participant's medical/health record.</p>
4	TYPE OF BILL	Required	<p>Type of Bill: Enter the 3-digit code from the <i>UB-04 manual</i>. Adjustment 'type of bill codes' are not appropriate when submitting services on paper claim forms for Idaho Medicaid billings.</p> <p>See Section 3.1.4, <i>Type of Bill Codes</i>.</p>
6	STATEMENT COVERS PERIOD	Required	<p>Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY</p> <p><b>Administratively Necessary (AND):</b> The From date is the month, day, and year the participant was discharged from inpatient acute level of care.</p> <p><b>Outpatient Claims:</b> Outpatient claims must indicate the specific dates in Field 45 to eliminate duplicate appearing services.</p> <p><b>Late or Additional Charges:</b>  <b>Inpatient</b> claims - see Field 42 for information.  <b>Outpatient</b> claims - see Field 45 for information.</p> <p><b>Accommodation Charges:</b> Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a participant is discharged under normal circumstances. Although there is no reimbursement for the discharge day; that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation.</p> <p><b>Extended Hospitalization:</b> If a participant requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code 30 in Field 17. This code tells the system that the participant is still a patient and to reimburse the hospital for the last day on the claim.</p> <p>Example: Claims for three (3) sequential interim bills</p>

Field	Field Name	Use	Description																
			would have the following sequential date and patient status format: <b>Patient Days</b> <table border="1"> <thead> <tr> <th>Claim</th> <th>From / To Date</th> <th>Status</th> <th>Billed</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>01/15-01/31/04</td> <td>30</td> <td>17</td> </tr> <tr> <td>2</td> <td>02/01-02/15/04</td> <td>30</td> <td>15</td> </tr> <tr> <td>3</td> <td>02/16-02/24/04</td> <td>01</td> <td>8</td> </tr> </tbody> </table> <b>Note:</b> If patient status <b>30</b> is not used, the accommodation rate formula will not balance and the system will deny the claim.	Claim	From / To Date	Status	Billed	1	01/15-01/31/04	30	17	2	02/01-02/15/04	30	15	3	02/16-02/24/04	01	8
Claim	From / To Date	Status	Billed																
1	01/15-01/31/04	30	17																
2	02/01-02/15/04	30	15																
3	02/16-02/24/04	01	8																
8a	PATIENT NAME - ID	Required	Enter the participant's 7-digit Medicaid identification number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero (0) in the eighth (8 <sup>th</sup> ) through the eleventh (11 <sup>th</sup> ) positions. Example: 0234567 can be entered as 02345670000.																
8b	PATIENT NAME	Required	Patient Name: Enter the participant's name exactly as it is spelled on the participant's Medicaid ID card. Be sure to enter the last name first, followed by the first name, and middle initial.																
12	ADMISSION DATE	Required, Inpatient, Hospice, Nursing Home	Enter the month, day, and year the participant entered the facility. (This date will be the same on all submitted claims and will not necessarily be the same as the date found in Field 6. Enter as MMDDYY or MMDDCCYY																
13	ADMISSION HOUR	Required, Inpatient, Outpatient, Hospice, Nursing Home	Enter the 2-digit hour the participant was admitted for inpatient or outpatient care in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims.																
14	ADMISSION TYPE	Required, Inpatient	Admission Type: Use the priority admission codes in the <i>UB-04 manual</i> . Only codes 1, 2, 3, and 4 are allowed by Medicaid. Required for inpatient claims.																
15	ADMISSION SRC	Required, Inpatient	Admission Source: Use the 1-digit source of admission codes 1 through 8 in the <i>UB-04 manual</i> . Medicaid does not accept code 9.  Required for inpatient claims. Not Required for outpatient claims.																
16	DHR	Required, Inpatient	Discharge Hour: Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m.  Required for inpatient claims. Desired for outpatient claims.																
17	STAT	Required, Inpatient	Patient Status: Use one of the codes listed in <i>Section 3.1.5, Patient Status Codes</i> , to indicate patient status. Required for inpatient claims. Not Required for outpatient claims.																

Field	Field Name	Use	Description
18-28	CONDITION CODES	Desired	Use the codes listed in the NUBC billing manual.
31-34	OCCURRENCE CODE/DATE	Desired	Use one (1) of the codes listed in the NUBC billing manual and enter the date of the occurrence.
35-36	OCCURRENCE SPAN	Desired	Use the date span related to the 'Occurrence Code' entered in the preceding field.
39-41	VALUE CODES AMOUNT	Required, AN Days	Value Codes and Amounts: See <i>Section 3.5, Billing Procedures</i> , for directions on how to bill AND. <b>Covered Days: Required for inpatient claims only</b> <b>80</b> – Covered Days <b>81</b> – Co-Insurance days (Cross over claims only) <b>82</b> – Lifetime Reserve Days (Cross over claims only)
42	REV. CD.	Required, Inpatient	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. <b>Revenue code 001</b> is no longer to be used for the total charges; the total charges are to be entered in the designated box on line 23. <b>Inpatient claims (late, additional, or denied charges):</b> 1. Late or additional charges where the revenue code was not on the original claim: Bill on a new claim for only the late or additional charges with the accommodation rate and revenue code. Note in the Field <b>80</b> , 'Billing for late charges'. 2. Late or additional charges where the revenue code was paid on the original claim: Submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: Bill the denied line with the accommodation rate and revenue code on a new claim. Note in the Field <b>80</b> , 'Billing for denied lines'. <b>Outpatient claims (late, additional, or denied charges):</b> For instructions for outpatients billing, refer to Field <b>45</b> .
44	HCPCS/RATE/HIPPS CODE	Required, If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with <sup>CPT</sup> or <sup>HCPCS</sup> notation in <i>Section 3.5.5, Revenue Codes</i> and <i>Section 3.7.3, Ancillary Revenue Codes</i> . If the code requires a modifier, put one (1) space between the code and modifier. Example: PET scans require a HCPCS code and the <b>TC</b> modifier (i.e. G0222 TC). <b>Note:</b> HIPPS codes are not billable to Idaho Medicaid.

Field	Field Name	Use	Description
45	SERV. DATE	Required Outpatient	<p>Service Dates: Required for all outpatient services. Enter the specific date of service for all charges or the claims will be denied.</p> <p><b>Outpatient claims (late, additional, or denied charges):</b></p> <ol style="list-style-type: none"> <li>1. Late or additional charges outside the date span in Field 6: bill on a new claim form. Note in the Field 80, 'Billing for late charges'.</li> <li>2. Late or additional charges within the date span in Field 6 with the same revenue codes and the same specific date: submit on an adjustment request form.</li> <li>3. Late or additional charges within the date span in Field 6 with different revenue codes: bill on a new claim form. Note in the Field 80, 'Billing for late charges'</li> <li>4. Resubmit all denied charges on a new claim.</li> </ol>
46	SERV. UNITS	Required	<p>Units of Service: Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered.</p> <p>Example: Accommodation Code = Number of days the level of service was rendered.</p> <p><b>Note:</b> It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a participant in the hospital receives three (3) different levels of care, each must be billed on a separate line.</p> <p>Example:                      Level I = \$100 x 3 units of service                      Level II = \$150 x 2 units of service                      Level III = \$200 x 1 unit of service</p>
47	TOTAL CHARGES	Required	<p>Total charges: Bill total covered charges only.</p> <p>Ancillary Charges Formula:</p> $\frac{\text{Revenue Code Fee} \times \text{Units of Service}}{\text{Total Charges}}$ <p>Accommodation Rate Formula:</p> $\frac{\text{Daily Rate} \times \text{Units of Service}}{\text{Total Charges}}$
<p>In Fields 50 through 62, each field has three (3) lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one (1) other payer in addition to Medicaid, enter all primary payer data on line A and all Medicaid data on line B. If there are two (2) other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer data on line B, and all Medicaid data on line C.</p>			
50 A	PAYER NAME	Not Required	<p>Payer A: If Medicaid is the only payer, enter 'Idaho Medicaid' in Field 50A.</p> <p>If there is one (1) other payer in addition to Medicaid, enter the name of the group or plan in Field 50A and enter 'Idaho Medicaid' in Field 50B.</p>
50 B	PAYER NAME	Not Required	<p>Payer B: If there are two (2) other payers in addition to Medicaid, enter the names of the group or plan in Fields 50A and 50B and enter 'Idaho Medicaid' in Field 50C.</p>
50 C	PAYER NAME	Not Required	<p>Payer C: If there are two (2) other payers in addition to Medicaid, enter 'Idaho Medicaid' in Field 50C.</p>

Field	Field Name	Use	Description
<b>51 A-C</b>	HEALTH PLAN ID	Not Required	<p>Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in Field <b>50 A-C</b>.</p> <p>Example: In Field <b>50A</b>, Medicare is entered as the Payer. In Field <b>51A</b>, enter the identification number used by Medicare for the provider.</p> <p>Example: In Field <b>50B</b>, Healthy Home Insurance Company is entered as the Payer. In Field <b>51B</b> enter the identification number used by Healthy Home Insurance Company for the provider.</p>
<b>54</b>	PRIOR PAYMENTS	Required, If Applicable	<p>Prior Payments - Payers and Participant:</p> <p>Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.</p>
<b>55</b>	EST. AMOUNT DUE	Not Required	Estimated Amount Due: Total charges due (total from Field <b>47</b> ) minus prior payments (total from Field <b>54</b> ).
<b>57 A-C</b>	OTHER (BILLING) PRV ID	Required	<p>Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in Field <b>50 A-C</b>.</p> <p>Example: In Field <b>50A</b>, Medicare is entered as the Payer. In Field <b>57A</b>, enter the identification number used by Medicare for the provider.</p> <p>Example: In Field <b>50B</b>, Healthy Home Insurance Company is entered as the Payer. In Field <b>57B</b> enter the identification number used by Healthy Home Insurance Company for the provider.</p>
<b>58</b>	INSURED'S NAME	Desired	<p>Insured's Name: If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's Medicaid ID card. Be sure to enter the last name first, followed by the first name, and middle initial.</p> <p>Enter the participant Medicaid data in the same line used to enter the Medicaid provider data.</p> <p>Example: Medicaid provider information is entered in <b>50A</b>, and then the Medicaid participant data must be entered in <b>58A</b>.</p>
<b>59</b>	P. REL	Desired	Patient's Relationship to Insured: See the <i>UB-04 Manual</i> for the 2-digit relationship codes.
<b>60</b>	INSURED'S UNIQUE ID	Not Required	<p>Participant Identification Number: Enter the 7-digit Medicaid ID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero (0) in the eighth (8<sup>th</sup>) through the eleventh (11<sup>th</sup>) positions.</p> <p>Example: 0234567 can be entered as 02345670000.</p> <p>Enter the identification number used by other payers on the appropriate line(s).</p>
<b>61</b>	GROUP NAME	Not Required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.



Field	Field Name	Use	Description
62	INSURANCE GROUP NO.	Not Required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORIZATION CODES	Required, If Applicable	Treatment Authorization Codes: Prior authorization (PA) number for AND, or retrospective reviews or PA number for ambulance run by EMS.
67	DX A-Q	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do not use E diagnosis codes.
68-73	OTHER DX	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do <b>not</b> use E diagnosis codes.
69	ADMIT DX	Required	Admitting Diagnosis Code: Required for inpatient. Desired for outpatient claims. Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the <i>Qualis Health Handbook</i> .
72	ECI	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS-1500 claim form for professional claims.)
74	PRINCIPAL PROCEDURE CODE/DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used.
74 a-e	OTHER PROCEDURE CODE/DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical, diagnostic or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
76	ATTENDING	Required	Attending Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (4 <sup>th</sup> ) (last) box after '76 Attending'. Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.

<p><b>78-79</b></p>	<p>OTHER</p>	<p>Required, Healthy Connect- ion</p>	<p>Other Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (4<sup>th</sup>) (last) box of <b>78</b> or <b>79</b> 'Other'. Required for Healthy Connections participants referred to the hospital by the primary care provider. Enter the primary care provider's 9-digit numerical referral number in Field <b>78</b> or <b>79</b>. Do not include the letters 'HC' before the number. If Field <b>78</b> is blank the information in Field <b>79</b> will populate the referral number field.</p> <table border="1" data-bbox="695 512 1317 638"> <tr> <td>78 OTHER</td> <td>NPI</td> <td>QUAL</td> <td>802222200</td> </tr> <tr> <td colspan="2">LAST</td> <td colspan="2">FIRST</td> </tr> <tr> <td>79 OTHER</td> <td>NPI</td> <td>QUAL</td> <td>803333300</td> </tr> <tr> <td colspan="2">LAST</td> <td colspan="2">FIRST</td> </tr> </table>	78 OTHER	NPI	QUAL	802222200	LAST		FIRST		79 OTHER	NPI	QUAL	803333300	LAST		FIRST	
78 OTHER	NPI	QUAL	802222200																
LAST		FIRST																	
79 OTHER	NPI	QUAL	803333300																
LAST		FIRST																	
<p><b>80</b></p>	<p>REMARKS</p>	<p>Not Required</p>	<p>Remarks: Enter information when applicable. For participants who have only Medicare Part A, enter 'Participant has Part A only'. Other information to be entered may include: proof of timely billing ICN, third party injury information, or no third party liability coverage.</p>																

### **3.1.3.4 *Sample Paper Claim Form***

1		2		3a PAT. CNTL #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	

8 PATIENT NAME			9 PATIENT ADDRESS		
a			a		

10 BIRTHDATE		11 SEX	12 DATE			ADMISSION 13 HR 14 TYPE 15 SRC			16 DHR		17 STAT		18 19 20 21				CONDITION CODES 22 23 24 25 26 27 28				29 ACDT STATE	30
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31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37	
a		a		a		a		a		a		a		a	
b		b		b		b		b		b		b		b	

38				39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a				a		a		a	
b				b		b		b	
c				c		c		c	
d				d		d		d	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23

PAGE \_\_\_\_ OF \_\_\_\_ CREATION DATE TOTALS

50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI
A		A		A	A	A		A		A
B		B		B	B	B		B		B
C		C		C	C	C		C		C

58 INSURED'S NAME			59 P.REL	60 INSURED'S UNIQUE ID			61 GROUP NAME		62 INSURANCE GROUP NO.	
A			A	A			A		A	
B			B	B			B		B	
C			C	C			C		C	

63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			
A				A				A			
B				B				B			
C				C				C			

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX		a	b	c	71 PPS CODE	72 ECI	a	b	c	73
74 PRINCIPAL PROCEDURE CODE	DATE	a.	OTHER PROCEDURE CODE	DATE	b.	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL	
									LAST		FIRST
c.	OTHER PROCEDURE CODE	DATE	d.	OTHER PROCEDURE CODE	DATE	e.	OTHER PROCEDURE CODE	DATE	76 OPERATING NPI	QUAL	
									LAST		FIRST

80 REMARKS			81CC a		76 OTHER NPI	QUAL	
			b		LAST		FIRST
			c		77 OTHER NPI	QUAL	
			d		LAST		FIRST