

Key: "R" – Required in filing claim

"NR" – Not Required, not used

"S" – Situational, only used if appropriate specific to claim

- 1. Billing Provider Name, Address and Telephone Number R**
The name and service location of the provider submitting the claim REQUIRED to be a physical address (PO Boxes are not allowed)
- 2. Billing Provider Designated Pay-to Address S**
The address that the provider submitting the bill intends payment to be sent (if different from Field 1)
- 3a. Patient Control Number NR**
Patient's unique number assigned by the provider
- 3b. Medical/Health Record Number S**
The number assigned to the patient's medical/health record by the Provider
- 4. Type of Bill R**
A code indicating the specific type of bill (TOB). The first digit is A leading zero. The fourth digit defines the frequency of the bill for the institutional and electronic professional claim
- 5. Federal Tax Number R**
The number assigned to the provider by the federal government for tax reporting purposes
- 6. Statement Covers Period (From-Through) R**
The beginning and ending service dates of the period included on this bill (MMDDYY)
- 7. Reserved for Assignment by the NUBC NR**
- 8a. Patient Identifier S**
Patient Identifier as assigned by the Payer
- 8b. Patient Last Name/Patient First Name R**
Last Name, First Name and Middle initial of the patient
- 9a. Patient Street Address R**
The mailing address of the patient
- 9b. City R**
The mailing address of the patient
- 9c. State R**
The mailing address of the patient
- 9d. Zip Code R**
The mailing address of the patient
- 9e. County Code NR**
The mailing address of the patient
- 10. Patient Birth Date R**
The Date of Birth of the patient (MMDDYYYY)
- 11. Patient Sex R**
The sex of the patient as recorded at admission, outpatient service, or start of care
- 12. Admission/Start of Care Date S**
The start date for this episode of care. Is REQUIRED when Box 4 is designated 'Inpatient' or 012x, 022x, 032x, 081x, 082x. For other (home health) services, it is the date the episode of care began (MMDDYY)
- 13. Admission Hour S**
The code referring to the hour during which the patient was admitted for inpatient care
- 14. Priority (Type) of Admission or Visit R**
A code indicating the priority of this admission/visit
- 15. Point of Origin for Admission or Visit (Admission Source) S**
A code indicating the point of patient origin for this admission or visit. This field is REQUIRED accept when Box 4 = 014x
- 16. Discharge Hour S**
Code indicating the discharge hour of the patient from inpatient care
- 17. Patient Discharge Status R**
A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6, Statement Covers Period
- 18. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 19. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 20. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 21. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 22. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 23. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 24. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 25. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 26. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 27. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 28. Condition Code S**
A code(s) used to identify conditions or events relating to this bill that may affect processing
- 29. Accident State S**
The accident state field contains the two digit state abbreviation where the accident occurred. REQUIRED when field 31-34 = '02'
- 30. Reserved for Assignment by the NUBC NR**
- 31. Occurrence Code and Date S**
The code and date defining a significant event to this bill that may affect payer processing. Date is REQUIRED if Occurrence Code is present
- 32. Occurrence Code and Date S**
The code and date defining a significant event to this bill that may affect payer processing. Date is REQUIRED if Occurrence Code is present
- 33. Occurrence Code and Date S**
The code and date defining a significant event to this bill that may affect payer processing. Date is REQUIRED if Occurrence Code is present

- 34. Occurrence Code and Date** S
The code and date defining a significant event to this bill that may affect payer processing. Date is REQUIRED if Occurrence Code is present
- 35. Occurrence Span Code and Dates (From-Through)** S
A Code and the related dates that identify an event that relates to the payment of this claim. Occurrence Span Code is REQUIRED when Date is present
- 36. Occurrence Span Code and Dates (From-Through)** S
A Code and the related dates that identify an event that relates to the payment of this claim. Occurrence Span Code is REQUIRED when Date is present
- 37. Reserved for Assignment by the NUBC** NR
- 38. Responsible Party Name & Address (Claim Addressee)** NR
The name and address of the party to whom the bill is being submitted
- 39. Value Code and Amounts** S
A Code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Code is REQUIRED if Amount is present
- 40. Value Code and Amounts** S
A Code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Code is REQUIRED if Amount is present
- 41. Value Code and Amounts** S
A Code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Code is REQUIRED if Amount is present
- 42. Revenue Code** R
Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements
- 43. Revenue Description/IDE Number/Medicaid Drug Rebate** NR
The standard abbreviated description of the related revenue code categories included in this bill
- 44. HCPCS/Accommodation Rates/HIPPS Rate Codes** S
1. HCPCS- The Healthcare Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills.
 2. Accommodation Rates- These are rates for inpatient bills. (NOT USED FOR 5010)
 3. HIPPS Rate Codes- Health Insurance Prospective Payment System rate codes present specific sets of patient characteristics on which payment determinations are made under several prospective payment systems.
REQUIRED when Revenue Code = 0022, 0023, 0024
- 45. Service Date(Lines 1-22)** S
The date (MMDDYY) the outpatient service was provided. (Applies to Lines 1-22; Line 23 refers to the creation date (MMDDYY) of the bill)
- 46. Service Units** R
A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.
- 47. Total Charges** R
Total charges for the primary payer pertaining to the related Revenue code for the current billing period as entered in the Statement covers period. Total charges includes both covered and non-covered charges. Must be numeric and not negative
- 48. Non-Covered Charges** S
To reflect the non- covered charges for the destination payer as it pertains to the related revenue code
- 49. Reserved for Assignment by the NUBC** NR
- 50a. Payer Name** R
Name of the health plan that the provider might expect some payment for the bill.
- 50b. Payer Name** NR
Name of the health plan that the provider might expect some payment for the bill.
- 50c. Payer Name** NR
Name of the health plan that the provider might expect some payment for the bill.
- 51a. Health Plan Identification Number** R
The number used by the health plan to identify itself
- 51b. Health Plan Identification Number** NR
The number used by the health plan to identify itself
- 51c. Health Plan Identification Number** NR
The number used by the health plan to identify itself
- 52. Release of Information Certification Indicator** R
Code indicates whether the provider has on file a signed statement (from patient or the patient's legal representative) permitting the provider to release data to another organization
- 53. Assignment of Benefits Certification Indicator** R
Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider
- 54. Prior Payments - Payer** S
The amount the provider has received (to date) by the health plan toward payment of this bill
- 55. Estimate Amount Due – Payer** NR
The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments)
- 56. National Provider Identifier – Billing Provider** R
The unique identification number assigned to the provider submitting the bill
- 57a. Other (Billing) Provider Identifier** NR
A unique identification number assigned to the provider submitting the bill by the health plan
- 57b. Other (Billing) Provider Identifier** NR
A unique identification number assigned to the provider submitting the bill by the health plan
- 57c. Other (Billing) Provider Identifier** NR
A unique identification number assigned to the provider submitting the bill by the health plan
- 58a. Insured's Name** R
The name of the individual under whose name the insurance benefit is carried
- 58b. Insured's Name** S
The name of the individual under whose name the insurance benefit is carried
- 58c. Insured's Name** S
The name of the individual under whose name the insurance benefit is carried
- 59a. Patient's Relationship to the Insured** R
Code indicating the relationship of the patient to the identified insured
- 59b. Patient's Relationship to the Insured** S
Code indicating the relationship of the patient to the identified insured

59c. Patient's Relationship to the Insured S

Code indicating the relationship of the patient to the identified insured

60. Insured's Unique Identifier R

The Unique number assigned by the health plan to the insured

61. Insured's Group Name NR

The group or plan name through which the insurance is provided to the insured

62. Insured's Group Number NR

The identification number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered

63. Authorization Code/Referral Number S

An identifier that designates that services on this bill have been authorized by the payer or indicates that a referral is involved

64. Document Control Number (DCN) NR

The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control

65. Employer Name (of the Insured) NR

The name of the employer that provides health coverage for the insured individual identified in Field 58

66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) R

The qualifier that denotes the version of International Classification of Diseases (ICD) reported

67. Principal Diagnosis Code and Present on Admission Indicator R

The ICD-9, 10-CM codes describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for occasioning the admission of the patient for care)

67 A- Q. (Shaded) Other Diagnosis Codes and Present on**Admission Indicator** NR

The ICD-9,10- CM diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. The principal diagnosis code can include any valid ICD code that meets the definition for use as a principal diagnosis.

68. Reserved for Assignment by the NUBC NR**69. Admitting Diagnosis Code** S

The ICD diagnosis code describing the patient's diagnosis at the time of admission. REQUIRED when claim involves inpatient admission

70. Patient's Reason for Visit S

The ICD-CM diagnosis codes describing the patient's reason for visit at the time of outpatient. REQUIRED when outpatient

71. Prospective Payment System (PPS) Code S

The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer

72 A - C. External Cause of Injury (ECI) Code and Present on**Admission Indicator** NR

The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect

73. Reserved for Assignment by the NUBC NR**74. Principal Procedure Code and Date** S

The ICD code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. REQUIRED when inpatient and Revenue Code = 0360 – 0369 or if Date is present

74 A – E. Other Procedure Codes and Dates NR

The ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Report those that are the most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis

75. Reserved for Assignment by the NUBC NR**76. Attending Provider Name and NPI** S

REQUIRED if either name or identification number is present. The Attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim

77. Operating Physician Name and NPI S

REQUIRED if either name or identification number is present. The individual with the primary responsibility for performing the surgical procedure(s) is present

78. Other Provider (Individual) Names and NPI NR

The name and ID number of the individual corresponding to the Provider Type category indicated in this section of the claim

79. Other Provider (Individual) Names and NPI NR

The name and ID number of the individual corresponding to the Provider Type category indicated in this section of the claim

80. Remarks Field NR

Area to capture additional information necessary to adjudicate the claim

81. Code – Code Field NR

To report additional codes related to the form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.