

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 SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37	
a		a		a		a		a		a		a	
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	

Revenue Code Box that will distinguish the different units

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							
2							
3							
4							
5							
6							
7							
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19							
20							
21							
22							
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	
A		A	A	A	A	A	A	A	A	A	A	
B		B	B	B	B	B	B	B	B	B	B	
C		C	C	C	C	C	C	C	C	C	C	

69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
a		a		a		a		a	
b		b		b		b		b	
c		c		c		c		c	

UB-04 Form Number