

Washington Apple Health (Medicaid)

Paper Claim Billing Resource

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this resource

This resource provides general information that applies to most Apple Health providers. This guide is a resource for the process of billing and submitting claims to the Washington Health Care Authority (HCA).

Effective October 1, 2016, HCA will accept only electronic claims for Apple Health (Medicaid) services, except under limited circumstances.

Paper Claims Submission Practices Changing

All Apple Health (Medicaid) providers (excluding Tribal billing offices): Effective October 1, 2016, the Health Care Authority (HCA) only accepts electronic claims for Apple Health (Medicaid) services, except under very limited circumstances.

Providers may seek approval to submit paper claims if they are in a temporary or long-term situation outside of their control that prevents submission of claims electronically. Examples of these unusual circumstances may include but are not limited to:

- HCA notifies provider in writing that paper claims will be accepted due to ProviderOne System issues preventing acceptance of electronic claims.
- The provider can demonstrate that the information needed for adjudication of an Apple Health (Medicaid) claim cannot be submitted electronically using the claim formats required under the ProviderOne Billing and Resource Guide.
- The provider is experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted.
- Providers that have not submitted any electronic claims within the past state fiscal year (July 1, 2015 to June 30, 2016).

Providers who wish to ask for an exemption from submitting claims electronically may do so using the [Request a Waiver form](#). For more information see the [ProviderOne Billing and Resource Guide webpage](#) on the agency's website.

If you need further information regarding this notice, please contact: HCA Customer Service Center at 1-800-562-3022.

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Introduction

This resource provides general information to help understand the processes for submitting paper claims to receive timely and accurate payments for covered services. This resource is to be used as a supplement to the ProviderOne Billing and Resource Guide.

Disclaimer

A contract, known as the Core Provider Agreement (CPA), governs the relationship between HCA and medical assistance providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, agency rules, regulations, program policies, provider alerts, and billing guides, including this resource. Providers must submit a claim in accordance with agency rules, policies, provider alerts, and billing guides in effect at the time they provided the service.

HCA does not assume responsibility for informing providers of national coding rules. ProviderOne will deny claims billed in conflict with national coding rules. Consult the appropriate coding resources.

Who should use this resource?

The following providers will find this resource helpful:

- Providers temporarily approved to submit paper.
- Tribal billing offices. HCA complies with 25 U.S. Code § 1621e(h) and will not deny a claim for benefits submitted by an Indian tribe or tribal organization based on the format in which the claim is submitted.

Providers who do not meet one of the criteria above must submit claims electronically. The agency will not process paper claims unless you have an approved waiver form for short-term temporary submission of paper claims.

For more information about seeking an exception to electronic billing, review the [Elimination of Paper Claims – Frequently Asked Questions \(FAQ\)](#).

This resource for paper claims assumes familiarity with standard medical billing practices and coding.

Helpful information

<p>Where can I find billing guides that explain program-specific billing guidelines, coverage, limitations, and fee schedules?</p>	<p>See the individual program-specific billing guides:</p> <ul style="list-style-type: none"> • Provider billing guides and fee schedules • Hospital reimbursement
<p>Who do I contact if I have questions on payments, denials, general questions regarding claims processing, or managed care plans?</p>	<p>The Medical Assistance Customer Service Center (MACSC) provider line is available Monday through Friday 7 a.m. – 4:30 p.m. daily (claims line open 8 a.m. to noon, closed noon to 1:30 p.m., and open 1:30 p.m. to 3:30 p.m.)</p> <p>The interactive voice recognition (IVR) phone system is available 24 hours a day, 7 days a week.</p> <ul style="list-style-type: none"> • Providers may contact MACSC at 1-800-562-3022; or • Email MACSC at Contact Us <p>Note: Providers may use HCA's toll-free lines for questions regarding its programs; however, HCA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HCA's programs (see Chapter182-502 WAC).</p>
<p>Where can I get information about becoming an Apple Health provider, submitting a change of address, submitting a change of ownership, or to ask questions about the status of an application?</p>	<p>See the Enroll as a Provider webpage.</p> <p>1-800-562-3022 ext. 16137</p>
<p>Where can I find information about HCA's current rule making activity?</p>	<p>See the agency's Rulemaking webpage.</p>
<p>Where do I find all Washington Administrative Codes?</p>	<p>See the Washington Administrative Code (WAC) webpage.</p>
<p>What is the Apple Health web address?</p>	<p>See the Washington Apple Health (Medicaid) webpage.</p>
<p>Where can I ask questions about private insurance or third party liability?</p>	<p>For private insurance claims, submit a Contact us email. Choose Medical Provider and use Private Commercial Insurance on the Select Topic dropdown.</p> <p>For casualty-related claims, see the Third Party Liability webpage, or call 1-800-562-3022.</p>

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<p>Where do I ask questions about non-emergency transportation services?</p>	<p>HCA provides access to non-emergency transportation services for clients who need help with transportation to and from their healthcare appointments.</p> <p>For more information, see the Transportation Services (Non-Emergency) webpage.</p> <p>E-mail: HCA Transportation</p>
<p>Where do I ask questions about Interpreter Services?</p>	<p>For spoken language access providers (LAP), register through UniversalLanguage . Visit the spoken language access provider webpage for more details.</p> <p>For sign language interpretation, visit the sign language interpretation webpage for more details.</p> <p>E-mail: HCA Interpreter Services</p>
<p>Where do I obtain HCA's forms?</p>	<p>See the agency's Forms and publications webpage.</p>
<p>Where can I find locations of local Community Services Offices (CSO)?</p>	<p>For more information, see the CSO webpage.</p>
<p>How do I find out where the local Home and Community Services (HCS) office is located?</p>	<p>For more information, see the HCS webpage.</p>
<p>How do I contact the local Behavioral Health Organization (BHO)?</p>	<p>For more information, see the BHO directory.</p>
<p>How do I find out what is included in the nursing facility per diem or general rate?</p>	<p>Contact Aging and Long Term Support Administration (AL TSA) or call at 1-800-422-3263.</p>
<p>Where can I find information about billing claims through ProviderOne Direct Data Entry?</p>	<p>See the ProviderOne Billing and Resource Guide webpage.</p>
<p>Where can I find information about billing HIPAA/EDI Claims?</p>	<p>See the HIPAA webpage.</p>

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<p>How do I request authorization?</p>	<p>Call 1-800-562-3022 using an extension listed below:</p> <ul style="list-style-type: none">• Durable medical equipment and supplies, prosthetics and orthotics, and oxygen: 15466• Dental: 15468• Pharmacy: 15483• Medical – surgical: 52018• All other medical services and enteral nutrition: 15471 <p>See the program-specific billing guides for information on requesting authorization.</p> <ul style="list-style-type: none">• Provider billing guides and fee schedules• Hospital reimbursement <p>For more assistance regarding authorization see the ProviderOne Billing and Resource Guide.</p> <p>Authorization forms can be sent by fax or mail:</p> <p>Fax 1-866-668-1214</p> <p>Attn: [enter one of the authorization areas above] AUTHORIZATION SERVICES OFFICE PO BOX 45535 OLYMPIA WA 98504-5535</p> <p>If you are mailing/faxing supporting documentation without the original authorization request form, a cover sheet is required. See the ProviderOne Billing and Resource Guide for more information on cover sheets.</p>
<p>Where can I access provider-training materials?</p>	<p>See the Provider Resources webpage.</p>

Section 1: Apple Health overview

What is Apple Health?

Medical Assistance is the general name for Washington Apple Health programs administered by the Health Care Authority (HCA).

Washington Apple Health includes Medicaid, mental health programs, chemical dependency and prevention treatment programs, the Children’s Health Insurance Program (CHIP), family planning programs, and other state-funded children’s healthcare programs. Medicaid is the federal entitlement program financed and operated jointly by the states and the federal government.

For further information about eligibility, benefit packages and coverage limits please see the [ProviderOne Billing and Resource Guide](#).

Section 2: Submitting paper claims

Guidelines/instructions for paper claim submission

In order for the Optical Character Reader (OCR) feature of the scanner to read a paper claim, the blank claim form must be a commercially produced form with either Sinclair Valentine J6983 or OCR Red Paper using these scannable red inks. These inks cannot be duplicated by a computer printer.

The following guidelines must be met to eliminate denials of a paper claim:

- Do not use red ink pens, highlighters, “post-it notes,” stickers, correction fluid, or tape anywhere on the claim form or backup documentation. The scanner cannot read red ink and a yellow highlighter could turn into a dark square covering the highlighted information during the scanning process.
- Use standard typewritten fonts that are 10 C.P.I. (characters per inch).
 - ✓ Do not mix character fonts on the same claim form
 - ✓ Do not use italics or script
- Use black printer ribbon, ink-jet, or laser printer cartridges.
 - ✓ Make sure ink is not faded or too light
 - ✓ Use of Dot Matrix printers may compromise the print quality
- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

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- For multiple page claims, please designate the page number on each page in the lower right hand corner. Enter this information (e.g. 1 of 5, 2 of 5, 3 of 5, etc.) in the white space at the very bottom of the claim form. This will help multiple page claims from being separated. The total dollar amount needs to be listed **on the last claim form** for all combined pages.
- If the client has Medicare, complete the claim form as if billing for a non-Medicare client and attach the Explanation of Medicare Benefits (EOMB).
- If the client has commercial private insurance, enter the private insurance payment on the claim form and attach the private insurance Explanation of Benefits (EOB). Do not include any other payment on the claim.

If you have an approved waiver to continue billing paper claims, the mailing address is noted on your approval letter where these claims should be submitted to.

If you are a tribal biller, please visit the [Tribal Affairs resources webpage](#) for the appropriate address to submit paper claims.

Note: The agency will not accept hand written or copied claim forms.

Section 3: Claim notes

Examples of claim notes and indicators

The following are examples of claim notes and indicators:

- SCI=B for baby on mom's ID (**can only be used the first 60 days of baby's life**)
 - For multiple births use the following:
 - SCI=BA for twin/triplet A
 - SCI=BB for twin/triplet B
 - SCI=BC for triplet C
- SCI=F for enteral nutrition – client not eligible for WIC
- SCI=I for Involuntary Treatment Act (ITA)
- SCI=V for voluntary (psych) treatment

Note: When using Special Claims Indicator (SCI) entries, everything following the "=" symbol will be read as part of your indicator, so do not enter any additional data after that or ProviderOne will not recognize your entry. For program-specific claim notes see the program-specific billing guides.

Section 4: Claim forms

Completing the CMS-1500 claim form

The CMS-1500 claim form is a universal claim form and is the “approved” form that must be used when billing for professional services. Approved forms will say “Approved OMB-0938-1197 FORM 1500 (02-12)” on the bottom right hand corner. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the agency. Some field titles may not reflect their usage for a particular claim type. This form is not available through Washington Health Care Authority but should be available through your local office supplier.

Field	Name	Action
1a	ProviderOne Client ID	Enter the ProviderOne Client ID (example 123456789WA).
2	Patient’s Name	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. If billing for a baby on mom’s ID, enter the baby’s name here. If the baby is unnamed, use the mom’s last name and “baby” as the first name. Note: Be sure to insert commas separating sections of the name.
3	Patient’s Birthdate Patient’s Sex	Enter the client’s birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc. Enter the patient’s sex (gender). If billing baby on mom’s ID, enter the baby’s birth date instead. If billing baby on mom’s ID, enter the baby’s sex here.
4	Insured’s Name	When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA), enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word “Same” may be entered.
5	Patient’s Address	Enter the address of the client who received the services (the person whose name is in Field 2).
6	Patient Relationship to Insured	Check the appropriate box.
7	Insured’s Address	Enter the address of the insured.
9	Other Insured’s Name	If there is other (primary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a	Other Insured’s Policy or Group Number	Enter the other insured’s policy or group number.
9b	Other Insured’s Date of Birth and Gender	Check the appropriate box for the insured’s gender and enter the birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.

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Field	Name	Action
9d	Insurance Plan Name or Program Name	Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). Please note: Apple Health, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are inappropriate entries for this field.
10	Patient's Condition Related To	Check yes or no to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field 24. Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.).
11	Insured's Policy Group or FECA (Federal Employees Compensation Act) Number	Primary insurance, when applicable. This information applies to the insured person listed in Field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate the client has other insurance coverage and Medicaid is the payer of last resort.
11a	Insured's Date of Birth and Gender	Check the appropriate box when applicable for the insured's gender and enter the birthdate if different from field 3 in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
11c	Insurance Plan Name or Program Name	When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: This may or may not be associated with a group plan.)
11d	Is there another Health Benefit Plan?	Required if the client has other insurance. Indicate yes or no. If yes, you should have completed Fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check yes. If 11d is left blank, the claim may be processed and denied in error.
14	Date of Current Illness, Injury, or Pregnancy	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
15	If Patient Has Had Same or Similar Illness	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
16	Dates Patient Unable to Work in Current Occupation	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
17	Name of Referring Physician or Other Source	When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name (Last Name, First Name).
17b	ID Number of Ordering/Referring Physician	When applicable, enter the NPI number of the ordering/referring physician. The provider reported here must be enrolled as a Washington State Medicaid provider. When billing for services provided to PCCM clients: enter the National Provider Identifier (NPI) of the PCCM who referred the client for the service(s).
18	Hospitalization Dates Related to Current Services	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.

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Field	Name	Action
19	Reserved for Local Use	<p>This field is used for notes that require an Apple Health claims specialist to review a claim before payment is made. To make any of the following comments, enter "SCI=" and the corresponding letter on the list below:</p> <ul style="list-style-type: none"> • B – BABY ON MOMS CLIENT ID BA for twin/triplet A BB for twin/triplet B BC for triplet C • F – ENTERAL NUTRITION – CLIENT NOT ELIGIBLE FOR WIC • H – CHILDREN WITH SPECIAL HEALTHCARE NEEDS • I – INVOLUNTARY TREATMENT ACT (ITA)(Legal Status) • K – NOT RELATED TO TERMINAL ILLNESS (Hospice Client) • V – VOLUNTARY TREATMENT (Legal Status) <p>This is also the location to enter NDCs, if applicable. Indicate what line the NDC is for by putting "LN#" before the NDC.</p> <p>If the client is on a spenddown, enter "Spenddown" here and the \$ amount.</p> <p>When billing multiple PA or EPA numbers, enter the authorization number as follows: 19. Line 1: 870000XXX/ Line 2: 870000XXX</p> <p>Note: Baby on Mom's Client ID can only be used during the first 60 days of baby's life.</p>
20	Outside Lab?	If applicable, check the appropriate box and enter charges.
21	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code(s) in areas A-L, with A being primary.
22	Medicaid Resubmission	<p>When applicable. If this billing is being submitted beyond the 365 day timely filing deadline, enter the TCN that verifies that the claim was originally submitted within the time limit. (The TCN number is the claim number listed on the Remittance and Status Report.)</p> <p>Also enter TCN numbers in this field for adjusting or voiding claims. They must be in the following format:</p> <ul style="list-style-type: none"> • 7-101629600000340000 (replace/adjustment) • 8-101629600000340000 (void/cancel)
23	Prior Authorization Number	When applicable. If the service or hardware being billed requires authorization, enter the assigned number. For billing multiple authorization numbers, see Field 19.
24a	Date(s) of Service	Enter the "from" and "to" dates of service.

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Field	Name	Action
24b	Place of Service	Enter the appropriate two digit code. For example: 11- Office 31- Skilled Nursing Facility 32- Nursing Facility The agency requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Claims with inaccurate place of service designations will be denied.
24d	Procedures, Services or Supplies CPT/HCPCS	Enter the appropriate procedure code for the service(s) being billed. When appropriate enter a modifier(s).
24e	Diagnosis Pointer	Enter the diagnosis pointer by entering A-L to correspond to field 21. The first diagnosis should be the principal diagnosis. Follow additional digit requirements per ICD-10. Do not enter the actual diagnosis code in this field. Please do not enter a comma or any other punctuation in this field.
24f	Charges	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with the remittance amount.
24g	Days or Units	Enter the total number of days or units for each line. These figures must be whole units.
24i	ID Qualifier	Enter the taxonomy qualifier ZZ if required by Medicare or any other primary carrier. ProviderOne ignores this field but some carriers require it in order for field 24j to be forwarded to HCA.
24j	Rendering Provider ID# If applicable, reference (outside) laboratory	Enter the taxonomy code in the top half of the field for the rendering provider, if applicable. Enter the NPI for the rendering provider in the bottom half of the field. This information is only needed if it is different than fields 33a and 33b. For more information on taxonomy codes, please see the ProviderOne Billing and Resource Guide . The rendering provider must be enrolled as a Washington State Medicaid provider prior to start of treatment. Enter the NPI number of the reference (outside) laboratory here.

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Field	Name	Action
25	Federal Tax ID Number	Enter in the Federal Tax ID or Social Security number and indicate via the check boxes which number is being used.
26	Patient's Account Number	Not required (optional field for your internal purposes). Enter alpha and/or numeric characters only. For example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report (RA) under the heading Patient Account Number.
27	Accept Assignment?	Check the appropriate box.
28	Total Charge	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29	Amount Paid	If there is a private insurance payment, show the amount here and attach a copy of the private insurance EOB. If payment is received from a source other than insurance, specify the source in Field 10d. Do not use dollar signs or decimals in this field or enter prior Medicare, Medicare Advantage, or Medicaid payments here.
30	Rsvd for NUCC Use	Enter total charges minus any amount(s) in Field 29. Do not use dollar signs or decimals in this field.
32	Service Facility Location Information	<p>Enter the location address if different from Field 33</p> <ul style="list-style-type: none"> • Enter the location NPI • Enter the location Taxonomy. For more information on taxonomy codes, please see the ProviderOne Billing and Resource Guide. <p>This field is required for Sleep Centers, Birthing Facilities, and Centers of Excellence when the location of service is different from the billing NPI's location.</p>
33	Physician's, Supplier's Billing Name, Address, Zip Code And Phone #	<p>Enter the provider's Name and Address on all claim forms.</p> <ul style="list-style-type: none"> • Enter the Billing Provider NPI • Enter the Billing Provider Taxonomy. For more information on taxonomy codes, please see the ProviderOne Billing and Resource Guide.

Completing the 2012 ADA Dental claim form

The 2012 ADA dental claim form is the only form approved by Washington Health Care Authority for dental billing. Approved forms will say "(c) 2012 American Dental Association" in the lower right-hand corner. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the agency. This form is not available through Washington Health Care Authority but should be available through your local office supplier.

Field	Name	Action
2	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field.
3	Company/Plan Name, Address, City, State, Zip Code	Enter the claims address for the Health Care Authority.
4	Other Dental or Medical Coverage	Check the appropriate box.
5	Name of Policyholder/Subscriber (Last, First, Middle Initial, Suffix)	If different from the patient, enter the name of the subscriber.
6	Date of Birth	Enter the subscriber's date of birth. Hyphens, dashes, etc. are not needed.
8	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the subscriber's SSN or other identifier assigned by the payer.
9	Plan/Group Number	If the client has third party coverage, enter the dental plan number of the subscriber.
10	Relationship to Primary Policyholder/Subscriber	Check the applicable box.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. Note: Be sure to insert commas separating sections of the name.
13	Date of Birth (MMDDCCYY)	Enter the client's date of birth. Hyphens, dashes, etc. are not needed.
14	Gender	Check the applicable box.
15	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the patient's ProviderOne Client ID (for example 123456789WA)
16	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
18	Relationship to Policyholder/Subscriber	Check the appropriate box.

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Field	Name	Action
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. Note: This field is not required if “self” is checked in box 18.
21	Date of Birth (MMDDCCYY)	Enter the client’s date of birth. Hyphens, dashes, etc. are not needed. Note: This field is not required if “self” is checked in box 18.
22	Gender	Check the appropriate box. Note: This field is not required if “self” is checked in box 18.
23	Patient ID/Account #	Not required (optional field for your internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. This number will be printed on the Remittance Advice (RA) under the heading Patient Account Number.
24	Procedure Date (MMDDCCYY)	Enter the eight-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 04012007). Hyphens, dashes, etc. are not needed.
25	Area of Oral Cavity	If the procedure code requires an arch or a quadrant designation, enter one of the following: 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number, letter(s): 1. 1 through 32 for permanent teeth 2. A through T for primary teeth 3. 51 through 82 or AS through TS for supernumerary teeth 4. Only one tooth number may be billed per line Do not fill in preceding zeros for tooth numbers (e.g. tooth 1).

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Field	Name	Action
28	Tooth Surface	<p>Enter the appropriate letter from the list below to indicate the tooth surface. Up to five surfaces may be listed in this column (separate with a comma):</p> <p style="text-align: center;"> B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal </p> <p>Note: Make entries in this field only if the procedure requires a tooth surface.</p>
29	Procedure Code	<p>Enter the appropriate current CDT procedure code that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.</p> <p>Note: The agency only covers procedure codes listed on our Fee Schedule that has a dollar amount indicated.</p>
30	Description	<p>Give a brief written description of the services rendered. When billing for general anesthesia or IV sedation, enter the actual beginning and ending time.</p>
31	Fee	<p>Enter your usual and customary fee (not the agency's maximum allowable rate) for each service rendered. If the Fee Schedule indicates to bill Acquisition Cost (AC), please bill your acquisition cost.</p>
31a	Other Fee(s)	<p>This field is not used by the agency.</p>
32	Total Fee	<p>Enter the total charges. Do not include decimal points or dollar signs.</p>
33	Missing Teeth Information	<p>Place an "X" on the appropriate missing teeth.</p>
35	Remarks	<p>Enter appropriate comments in this field</p> <ul style="list-style-type: none"> • To indicate a payment by a private insurance, enter "insurance payment" and the amount. Attach the private insurance EOB to the claim. • If processing a void, enter the TCN in this field preceded by an 8 (e.g. 8-123456789012345678). • If processing an adjustment or replacement, enter the TCN in this field preceded by a 7 (e.g. 7-123456789012345678). • If the claim is an adjustment and indicating an insurance payment, use the following format – 7-123456789012345678 - \$123.45. • Indicate the client's Spenddown amount - enter "Spenddown" and then the \$ amount.

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Field	Name	Action																												
38	Place of Treatment	<p>The agency defines the following places of service for paper claims when a place of treatment box is checked but no two-digit place of service is indicated:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Box checked</td> <td style="width: 50%;">Place of Service (POS)</td> </tr> <tr> <td>Office</td> <td>Dental office (POS 11)</td> </tr> <tr> <td>Hospital</td> <td>Outpatient hospital (POS 22)</td> </tr> <tr> <td>ECF</td> <td>Skilled nursing facility (POS 31)</td> </tr> <tr> <td>Other</td> <td>The agency will not allow “other” without a two-digit place of service indicated.</td> </tr> </table> <p>If the services rendered are not in one of the places of service indicated above, then the two-digit POS must be indicated in field 38.</p> <p>The agency considers the following places of service for dental claims (not all services are covered in all places of service):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Place of Service</td> <td style="width: 50%;">Two digit Indicator code</td> </tr> <tr> <td>Office</td> <td>11 - Dentist office</td> </tr> <tr> <td rowspan="3">Hospital</td> <td>21 - Inpatient hospital</td> </tr> <tr> <td>22 - Outpatient hospital</td> </tr> <tr> <td>23 - Hospital emergency room</td> </tr> <tr> <td></td> <td>31 - Skilled nursing facility</td> </tr> <tr> <td rowspan="5">Other</td> <td>54 - Intermediate care facility</td> </tr> <tr> <td>03 - School based services</td> </tr> <tr> <td>12 - Client’s residence</td> </tr> <tr> <td>24 - Professional Services in an Ambulatory Service Center</td> </tr> <tr> <td>50 - Federally Qualified Health Center</td> </tr> <tr> <td></td> <td>71 - State or public health clinic</td> </tr> </table> <p>The agency requires that the use of a valid two-digit place of service be indicated that accurately reflects the place of service. Inaccurate place of service designations result in claim denials.</p>	Box checked	Place of Service (POS)	Office	Dental office (POS 11)	Hospital	Outpatient hospital (POS 22)	ECF	Skilled nursing facility (POS 31)	Other	The agency will not allow “other” without a two-digit place of service indicated.	Place of Service	Two digit Indicator code	Office	11 - Dentist office	Hospital	21 - Inpatient hospital	22 - Outpatient hospital	23 - Hospital emergency room		31 - Skilled nursing facility	Other	54 - Intermediate care facility	03 - School based services	12 - Client’s residence	24 - Professional Services in an Ambulatory Service Center	50 - Federally Qualified Health Center		71 - State or public health clinic
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39	Enclosures	Indicate “Y” if you are attaching backup documents and “N” if not attaching backup documents. (Do not send X-rays when billing for services).																												
40	Is Treatment for Orthodontics?	Check the appropriate box.																												
41	Date Appliance Placed (MMDDCCYY)	This field must be completed for orthodontic treatment.																												
42	Months of Treatment Remaining	If applicable, enter the months of treatment remaining.																												
43	Replacement of Prosthesis?	Check appropriate box. If “yes,” enter the reason for replacement in field 35 (Remarks).																												

Paper Claim Billing Resource

Field	Name	Action
44	Date Prior Placement (MMDDCCYY)	Enter the appropriate date if “yes” is checked for field 43.
45	Treatment Resulting from	Check the appropriate box.
46	Date of Accident (MMDDCCYY)	If applicable, enter the date of accident.
47	Auto Accident State	Enter the two letter abbreviation for the state the accident occurred in, if applicable.
48	Name, Address, City, State, Zip Code	Enter the practice or business name and address as recorded with the agency. If a solo practice, enter the dentist name and business address as recorded with the agency.
49	NPI	Enter the National Provider Identifier (NPI). Providers are identified by this code and not by provider name. Omitting this number will result in claim denial The provider must be enrolled as a Medicaid contracted provider prior to start of treatment.
50	License Number	Enter the billing dentist’s license number.
51	SSN or TIN	Enter the billing dentist’s SSN or TIN.
52a	Additional Provider ID	Enter the taxonomy for the billing provider. For more information on taxonomy codes, please see the ProviderOne Billing and Resource Guide .
53	Treating Dentist and Treatment Location Information	Enter the treating dentist’s signature and date.
54	NPI	Enter the treating provider NPI if it is different from the billing provider NPI. The treating provider must be enrolled as a Medicaid contracted provider prior to start of treatment.
55	License Number	Enter the treating dentist’s license number.
56	Address, City, State, Zip Code	Enter the treating dentist’s address, city, state and zip code.
56a	Provider Specialty Code	Enter in the treating provider taxonomy if an NPI was entered in box 54.
58	Additional Provider ID	This field is not used by the agency.

Completing the UB-04 claim form

The following instructions explain how to complete the UB-04 claim form and the “approved” form must be used when billing. The form will say “Approved OMB No. 0938-0997” on the bottom left hand corner. The instructions should be used to supplement the information in the [National Uniform Billing Committee \(NUBC\)](#) official UB-04 Data Specifications Manual. For fields that are situational and for code usage details not covered below please refer to the NUBC Manual. This form is not available through the Washington Health Care Authority but should be available through your local office supplier.

Form Locator	Name	Action																				
1	Billing Provider Name	Line 1: Provider Name Line 2: Street Address or Post Office Box Line 3: City, State, and Zip Code plus 4 Line 4: Telephone (& Fax)																				
2	Pay-to Name and Address	Report only if different from form Locator 1.																				
3a	Patient Control Number	Enter patient’s unique (alpha and/or numeric) number assigned by the provider. This number will be printed on the Remittance and Status Report (RA) under the heading Patient Account Number.																				
3b	Medical/Health Record Number	Optional item. Enter alpha and/or numeric characters only. This entry is not returned on the RA.																				
4	Type of Bill	ProviderOne uses the Type of Bill for adjudication and pricing. The ProviderOne recommended TOBs are: <table border="0"> <thead> <tr> <th>Type of service</th> <th>Type of bill code</th> </tr> </thead> <tbody> <tr> <td>Hospice</td> <td>81X, 82X</td> </tr> <tr> <td>Home Health</td> <td>32X, 34X</td> </tr> <tr> <td>Kidney Center</td> <td>72X</td> </tr> <tr> <td>Inpatient Hospital</td> <td>11X</td> </tr> <tr> <td>Outpatient Hospital</td> <td>13X</td> </tr> <tr> <td>Nursing Home</td> <td>21X</td> </tr> <tr> <td>Swing Bed</td> <td>18X</td> </tr> <tr> <td>FQHC Crossover</td> <td>77X</td> </tr> <tr> <td>RHC Crossover</td> <td>71X</td> </tr> </tbody> </table>	Type of service	Type of bill code	Hospice	81X, 82X	Home Health	32X, 34X	Kidney Center	72X	Inpatient Hospital	11X	Outpatient Hospital	13X	Nursing Home	21X	Swing Bed	18X	FQHC Crossover	77X	RHC Crossover	71X
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5	Federal Tax Number	Enter the Federal tax identification number.																				
6	Statement Covers Period	Enter from and to dates of service (MMDDCCYY). Overlapping fiscal/calendar years do not require split billing.																				
8a	Patient Name/Identifier	Enter the patient’s ProviderOne Client ID (for example, 123456789WA).																				

Paper Claim Billing Resource

Form Locator	Name	Action																																																				
8b	Patient Name/Identifier	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. If billing for a baby on mom’s ID enter the baby’s name here. If the baby is un-named use the mom’s last name and “baby” as the first name. Note: Be sure to insert commas separating sections of the name.																																																				
9	Patient Address	Enter the address of the client who received the services.																																																				
10	Birthdate	Enter in the patient’s date of birth in the following format: MMDDCCYY. (Example: 05102003 for May 10, 2003.) If billing baby on mom’s ID enter the baby’s birth date instead.																																																				
11	Sex	Indicate if the patient is male (M) or female (F). If billing baby on mom’s ID enter the baby’s sex here.																																																				
12	Admission Date	Indicate the start date of admission.																																																				
13	Admission Hour	Enter the code for the hour of admission converted to 24 hour time as shown below: <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">CODE</th> <th style="text-align: center;">TIME AM</th> <th style="text-align: center;">CODE</th> <th style="text-align: center;">TIME PM</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">00</td> <td style="text-align: center;">12:00-12:59 (Midnight)</td> <td style="text-align: center;">12</td> <td style="text-align: center;">12:00-12:59 (Noon)</td> </tr> <tr> <td style="text-align: center;">01</td> <td style="text-align: center;">01:00-01:59</td> <td style="text-align: center;">13</td> <td style="text-align: center;">01:00-01:59</td> </tr> <tr> <td style="text-align: center;">02</td> <td style="text-align: center;">02:00-02:59</td> <td style="text-align: center;">14</td> <td style="text-align: center;">02:00-02:59</td> </tr> <tr> <td style="text-align: center;">03</td> <td style="text-align: center;">03:00-03:59</td> <td style="text-align: center;">15</td> <td style="text-align: center;">03:00-03:59</td> </tr> <tr> <td style="text-align: center;">04</td> <td style="text-align: center;">04:00-04:59</td> <td style="text-align: center;">16</td> <td style="text-align: center;">04:00-04:59</td> </tr> <tr> <td style="text-align: center;">05</td> <td style="text-align: center;">05:00-05:59</td> <td style="text-align: center;">17</td> <td style="text-align: center;">05:00-05:59</td> </tr> <tr> <td style="text-align: center;">06</td> <td style="text-align: center;">06:00-06:59</td> <td style="text-align: center;">18</td> <td style="text-align: center;">06:00-06:59</td> </tr> <tr> <td style="text-align: center;">07</td> <td style="text-align: center;">07:00-07:59</td> <td style="text-align: center;">19</td> <td style="text-align: center;">07:00-07:59</td> </tr> <tr> <td style="text-align: center;">08</td> <td style="text-align: center;">08:00-08:59</td> <td style="text-align: center;">20</td> <td style="text-align: center;">08:00-08:59</td> </tr> <tr> <td style="text-align: center;">09</td> <td style="text-align: center;">09:00-09:59</td> <td style="text-align: center;">21</td> <td style="text-align: center;">09:00-09:59</td> </tr> <tr> <td style="text-align: center;">10</td> <td style="text-align: center;">10:00-10:59</td> <td style="text-align: center;">22</td> <td style="text-align: center;">10:00-10:59</td> </tr> <tr> <td style="text-align: center;">11</td> <td style="text-align: center;">11:00-11:59</td> <td style="text-align: center;">23</td> <td style="text-align: center;">11:00-11:59</td> </tr> </tbody> </table> <p>Refer to the NUBC manual for more information.</p>	CODE	TIME AM	CODE	TIME PM	00	12:00-12:59 (Midnight)	12	12:00-12:59 (Noon)	01	01:00-01:59	13	01:00-01:59	02	02:00-02:59	14	02:00-02:59	03	03:00-03:59	15	03:00-03:59	04	04:00-04:59	16	04:00-04:59	05	05:00-05:59	17	05:00-05:59	06	06:00-06:59	18	06:00-06:59	07	07:00-07:59	19	07:00-07:59	08	08:00-08:59	20	08:00-08:59	09	09:00-09:59	21	09:00-09:59	10	10:00-10:59	22	10:00-10:59	11	11:00-11:59	23	11:00-11:59
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14	Priority(Type) of Visit	Required when patient is being admitted to the hospital for inpatient services. Refer to the NUBC manual for more information.																																																				
15	Admission Source	Indicate the source of referral for admission or visit. Refer to the NUBC manual for more information.																																																				
16	Discharge Hour	Enter the hour of discharge. Refer to the 24-hour time as shown in the coding table for Form Locator 13 and the NUBC manual for more information.																																																				
17	Status	Enter the code indicating patient status as of the discharge date. Refer to the NUBC manual for more information.																																																				

Paper Claim Billing Resource

Form Locator	Name	Action
18-28	Condition Codes	<p>Refer to the NUBC manual for Codes other than below:</p> <p>Washington State assigned Condition Codes</p> <p>Trauma - Qualified Trauma cases are identified by the following codes:</p> <p>TP Indicates a pediatric client (through age 14 only) with an Injury Severity Score (ISS) in the range of 9-12</p> <p>TT Indicates a transferred client with an ISS that is less than 13 for adults or less than 9 for pediatric clients</p> <p>TV Indicates an ISS in the range of 13 to 15</p> <p>TW Indicates an ISS in the range of 16 to 24</p> <p>TX Indicates an ISS in the range of 25 to 34</p> <p>TY Indicates an ISS in the range of 35 to 44</p> <p>TZ Indicates an ISS of 45 or greater</p>
29	Accident State	If applicable, enter the state in which the accident occurred. (Example: OR, CA, etc.)
31-34	Occurrence Code and Dates	Refer to the NUBC manual for more information. Not required on a Hospice, Kidney Center, Home Health or SNF claims.
35-36	Occurrence Span Codes and Dates	Refer to the NUBC manual for more information.
38	Responsible Party name and address	Enter the information for the claim addressee.

Paper Claim Billing Resource

Form Locator	Name	Action
39-41	Value codes and Amounts	<p>Refer to the NUBC manual for codes other than below:</p> <p>Value Code 66: For EMER patient liability on Inpatient Hospital claims, then enter the Patient Participation Amount.</p> <p>Value Code 66: For Spenddown on Institutional Hospital claims then enter the Patient Participation Amount.</p> <p>Value Code 24: Enter this code in the code field with the Patient Class immediately following in the amount field. See the Nursing Facilities Billing Guide for valid Patient Class codes. (e.g., 20.00=class code 20).</p> <p>Value Code 31: Enter this code in the code field with the Patient Participation amount for the entire month immediately following in the amount field for Nursing Home claims.</p> <p>Value Code 31: For Hospice claims indicating the Skilled Nursing Facility room and board charge, enter this code in the code field only once per claim and if there is more than one patient participation amount, sum the amounts and enter only one value amount.</p> <p>Value Code 54: Enter this code in the code field with the newborn birth weight in grams in the amount field (no decimals). Right justify the weight in grams to the left of the dollars/cents delimiter. If your billing software requires the decimal in the Value Code field, enter the weight in grams followed by “.00” (e.g. 2499.00).</p>
42	Revenue Code	<p>Revenue Codes must be valid for the Type of Bill or facility. For example, revenue code usage for Hospice may differ from a hospital.</p> <ol style="list-style-type: none"> a. For Hospice, Home Health, Kidney Center and Nursing Home billing, see the individual Billing Guides. b. For Inpatient and Outpatient Hospital services, see the Apple Health Revenue Code Grid. c. On the final page of your claim, form locator 42, line 23 will require revenue code 0001 with your claim total in form locator 47, line 23.

Paper Claim Billing Resource

Form Locator	Name	Action
43	Description	<p>Enter a written description of the related revenue categories included on the bill.</p> <p>The agency is collecting NDC information on Centers for Medicare and Medicaid Services designated, physician administered drugs in the outpatient hospital setting and for Kidney Centers (revenue Codes 0634-0637 drugs with procedures).</p> <p>See the Physician-Related Services /Health Care Professional Services Billing Guide for the description of the NDC reporting format criteria.</p> <p>When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug for the specified detail line. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.</p> <p>Refer to the NUBC manual for more information.</p>
44	HCPCS/CPT/RATE Codes	<p>When applicable, enter the HCPCS/CPT/RATE codes.</p> <p>Outpatient HCPCS – see the Apple Health Revenue Code Grid for Revenue code/HCPCS combination requirements.</p> <p>Inpatient rates – required when a room and board revenue code is reported.</p> <p>Modifiers are entered in this field, when applicable, and attached to the qualifying code line.</p>
45	Service Date	Required on outpatient hospital, kidney center, hospice, nursing home, and home health claims. On each line, enter the date of service.
46	Service Units	Enter the units of service for each revenue code. Please do not use decimal points (e.g. 1 unit = 1).
47	Total Charges	<p>Enter the total charge for each revenue code or procedure code entry.</p> <p>Line 23: This entry must be the sum of the individual charges.</p>
48	Non-Covered Charges	<p>Enter the amount required by contract with the agency.</p> <p>Enter charges for non-covered services performed during the stay or charges paid by another payer (Medicare) when all services must be reported on the inpatient claims.</p>

Paper Claim Billing Resource

Form Locator	Name	Action
50 a-c	Payer Name	Enter Washington Medicaid for the Medicaid payer identification. Enter the name of the third party payer if applicable: 50a–Primary payer 50b–Secondary payer 50c–Tertiary payer
51	Health Plan ID	For Apple Health Medicaid, leave blank. Enter the health plan identification number (if known) in 51 a, b, c depending on whether the insurance is primary, secondary, or tertiary.
52 a-c	Release of Information Certification Indicator Required	Indicate whether the patient or patient’s legal representative has signed a statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried on the claim. I = Informed Consent to Release Medical Information. (Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.) Y = Yes, provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. Refer to the NUBC manual for more information.
53 a-c	Assignment of Benefits Certification Indicator Required	Not used by the agency.
54 a-c	Prior Payments	Enter the amount that has been received (if any) toward payment of the claim from another payer prior to billing the agency. 54a–Primary payment 54b–Secondary payment 54c–Tertiary payment
55	Estimate Amount Due	The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	NPI	Enter the NPI for the billing provider.
57 a-c	Other Billing Provider ID	A unique identification number assigned to the provider submitting the bill by the health plan. Not Required. The agency does not assign or require a unique identification number other than the NPI.

Paper Claim Billing Resource

Form Locator	Name	Action
58 a-c	Insured's Name	<p>Enter the insured's last name, first name, and middle initial exactly as it appears on the client services card or other proof of eligibility.</p> <p>Note: Be sure to insert commas separating sections of the name.</p> <p>If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried.</p> <p>Carry through the payer line scheme reported in Form Locator 50 A-C.</p> <p>Refer to the NUBC manual for more information.</p>
59 a-c	Patient's Relationship to Insured	<p>Enter 18 when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this field.</p>
60 a-c	Insured's Unique ID	<p>Enter all of the insured's unique identification numbers assigned by any payer organizations.</p> <p>Carry through the payer line scheme reported in Form Locator 50 A-C.</p> <p>Enter the ProviderOne Client ID exactly as it appears on the ProviderOne Services card or other proof of eligibility (example: 123456789WA).</p> <p>Refer to the NUBC manual for more information.</p>
61 a-c	Group Name	<p>Refer to the NUBC manual for more information.</p>
62 a-c	Insurance Group Number	<p>Refer to the NUBC manual for more information.</p>
63 a-c	Treatment Authorization Codes	<p>Enter the Prior Authorization (PA) number issued by the agency or Expedited Authorization Number (EPA) located in the appropriate program-specific billing guides for the billed service if required.</p> <p>Carry through the payer line scheme reported in Form Locator 50 A-C.</p> <p>If the claim meets the qualifications for Medical Inpatient Detoxification (MID) use the following EPA numbers. Please see the Inpatient Hospital Services Billing Guide for additional information.</p> <ul style="list-style-type: none"> • Acute alcohol detoxification use 870000433 • Acute drug detoxification use 870000435 <p>Claims for MID services without one of the above EPA numbers will be denied.</p>

Paper Claim Billing Resource

Form Locator	Name	Action
64 a-c	Document Control Number	<p>When applicable. If the submission date for the claim is over the 365-day time limit, enter the TCN that verifies that the claim was originally submitted within the time limit. (The TCN number is the claim number listed on the Remittance Advice.)</p> <p>Also enter TCN numbers in this field for adjusting or voiding claims. They must be in the following format:</p> <ul style="list-style-type: none"> • 7-101629600000340000 (replace/adjustment) • 8-101629600000340000 (void/cancel)
65 a-c	Employer Name	<p>If applicable, enter the employer name of the insured.</p> <p>Carry through the payer line scheme reported in Form Locator 50 a-c.</p>
66	Diagnosis and Procedure Code Qualifier	<p>Required. Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported:</p> <p>9 – Ninth Revision 0 – Tenth Revision</p>
67	Principal Diagnosis Code	<p>Principal Diagnosis Code (the condition established after study to be chiefly responsible for causing the use of facility services). Required:</p> <ul style="list-style-type: none"> • Present on Admission (POA) Indicator - see NUBC manual for usage guidelines. • Please see the Inpatient Hospital Services Billing Guide for additional information.
67a-q	Other Diagnosis Codes	<p>Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service or affect the length of stay.</p> <ul style="list-style-type: none"> • For preterm infants, include the appropriate birth weight code (765.11 to 765.19). • POA Indicator for applicable secondary diagnosis. • Refer to the NUBC manual for more information.
69	Admitting Diagnosis Code	<p>Enter the presenting symptom (diagnosis) and the reason for the patient's visit.</p> <p>Refer to the NUBC manual for more information.</p>
70a-c	Patient's Reason for Visit	Refer to the NUBC manual for more information.
72a-c	External Cause of Injury	Refer to the NUBC manual for more information.
74	Other Procedure Codes and Date	<p>Inpatient: Enter the code identifying the principal ICD surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format.</p> <p>Refer to the NUBC manual for more information.</p>

Paper Claim Billing Resource

Form Locator	Name	Action
74a-e	Other Procedure Codes and Date	<p>Inpatient: Enter the codes identifying all other significant procedures performed during the billing period covered by the claim and the dates on which the procedures were performed. Do not use decimal points.</p> <p>Refer to the NUBC manual for more information.</p>
76	Attending Provider Name and Identifiers	<p>Enter the NPI number for the attending physician (the physician primarily responsible for the care of the patient) or the resident physician. The NPI number of the Advanced Registered Nurse Practitioners (ARNPs) may also be reported in this form locator if they were primarily responsible for services in the hospital setting.</p> <p>Report in this form locator the NPI number of the physician ordering lab tests or X-ray services.</p> <p>Note: All providers reported here must be enrolled as a Washington State Medicaid Provider.</p>
77	Operating Physician Name and Identifiers	<p>Required. Enter the NPI number for the operating physician when a surgical procedure code is listed on the claim.</p> <p>Note: All providers reported here must be enrolled as a Washington State Medicaid Provider.</p>
78-79	Other Provider (Individual) Name and Identifiers	<p>Enter the NPI number of other treating providers or the referring provider. Enter the NPI number for a Primary Care Case Management (PCCM), or Skilled Nursing Facility (SNF).</p> <p>Note: All providers reported here must be enrolled as a Washington State Medicaid Provider.</p>
80	Remarks	<p>Enter any notes that would help in processing a claim for payment.</p> <p>Possible comments include:</p> <ul style="list-style-type: none"> • SCI=B – Baby on Moms ID <ul style="list-style-type: none"> ○ SCI=BA for twin/triplet A ○ SCI=BB for twin/triplet B ○ SCI=BC for triplet C • SCI=I – Involuntary Treatment Act (ITA) • SCI=V – Voluntary Treatment <p>Note: Baby on Mom’s Client ID can only be used during the first 60 days of baby’s life.</p> <p>Refer to the NUBC manual for more information.</p>

Paper Claim Billing Resource

Form Locator	Name	Action
81 a-d	Code-Code	<p>The billing provider's NPI entered in Form Locator 56 is mapped to a taxonomy code(s) that is needed to identify the provider in the ProviderOne claims processing system. The provider must enter qualifier code B3 and the reported taxonomy code in this Form Locator that corresponds to the service billed on the claim. For more information on taxonomy codes, please see the ProviderOne Billing and Resource Guide.</p> <p>For any other code qualifiers, please refer to the NUBC manual for more information.</p>