Health Partners

Hospital Billing Requirements for UB-92 Form

FIELD#	FIELD DESCRIPTION	INPATIENT	OUTPATIENT
1	Provider name, address and telephone	R	R
2	Unlabeled field--patient's Social Security number	R	R
3	Patient control number	R	R
4	Type of bill	R	R
5	Federal tax ID number	R	R
6	Statement coverage period	R	R
7	Covered days	R	N/A
8	Non-covered days	C	N/A
9	Co-insurance days	C	N/A
10	Lifetime reserve days	C	N/A
11	Unlabeled	Optional	N/A
12	Patient name	R	R
13	Patient address	R	R
14	Date of birth	R	R
15	Sex	R	R
16	Marital status	R	R
17	Admission date/date of service	R	R
18	Admission hour	R	R
19	Type of admission	R	C
20	Source of admission	R	R
21	Discharge hour	R	C
22	Patient status	R	R
23	Medical/health record number	R	R
24-30	Condition codes	R	R
31	DRG—If required for reimbursement agreement	C	Optional
32-35	Occurrence codes and dates	C	C
36	Occurrence span code and dates	C	C
38	Responsible party's name and address	R	R
39-41	Value codes and amounts	C	C
42	Revenue code	R	R
43	Revenue description	R	R
44	CPT/HCPCS codes/rates	C	R
45	Service date	N/A	R
46	Units of service	R	R
47	Total charges by revenue code category	R	R
48	Non-covered charges	Optional	Optional
49	Unlabeled	Optional	Optional
50	Payer identification	R	R
51	**HP location (site) number**	**R**	**R**
52	Release of information certification indicator	R	R
53	Assignment of benefits certification indicator	R	R
54	Prior payments—payer and patient	C	C
55	Estimated amount due	R	R
56	Line 4-5 ambulance code	C	C
58	Insured's name	R	R
59	Patient's relationship to insured	R	R
60	Health Partners ID number	R	R

R=Required
C=Conditional

Health Partners

Hospital Billing Requirements for UB-92 Form (cont.)

FIELD#	FIELD DESCRIPTION	INPATIENT	OUTPATIENT
61	Insured's group name, if applicable	C	C
62	Insurance group number	C	C
63	Treatment authorization code	R	R
64	Employment status code	R	R
65	Employer name	C	C
66	Employer location	C	C
67	Principal diagnosis code (ICD-9)	R	R
68	Other diagnosis codes	C	C
76	Admitting diagnosis code	R	N/A
77	External cause of injury code	C	C
78	Unlabeled	Optional	Optional
79	Procedure coding method	C	C
80	Principal procedure codes and dates	C	C
81	Other procedure codes and dates	C	C
82	**Attending physician medical license number**	**R**	**R**
83	Other physician	C	C
84	Remarks	Optional	Optional
85	Provider representative signature	R	R
86	Date bill submitted	R	R

R=Required
C=Conditional