

**TrailBlazer Health Enterprises®  
UB-04 Rural Health Clinic  
Billing Examples**

# On-Site Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN FROM THROUGH CODE		36 OCCURRENCE SPAN FROM THROUGH CODE		37 OCCURRENCE SPAN FROM THROUGH CODE		38 OCCURRENCE SPAN FROM THROUGH CODE	
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42 VALUE CODES CODE AMOUNT	
43 REV. CD. <b>0521</b>		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 55		48 NON-COVERED CHARGES 45					
23 <b>0001</b>		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 55 45	
50 PAYER NAME <b>Medicare</b>		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME <b>Beneficiary Last, First Name</b>		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		X		A		B	
C		D		E		F	
G		H		I		J	
K		L		M		N	
O		P		Q		R	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE		b OTHER PROCEDURE CODE DATE		75 ATTENDING NPI XXXXXXXXXXX	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST Last Name FIRST First Name	
80 REMARKS		81 CC a		b		76 OPERATING NPI XXXXXXXXXXX	
c		d		LAST FIRST		77 OTHER NPI XXXXXXXXXXX	
78 OTHER NPI XXXXXXXXXXX		LAST FIRST		79 OTHER NPI XXXXXXXXXXX		LAST FIRST	

# Off-Site Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. #		<b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY		7	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code		e Country Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX		14 TYPE 15 SRC XX	
16 DHR XX		17 STAT XX		18 CONDITION CODES XX		19 THROUGH XX		20 THROUGH XX	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN FROM THROUGH	
36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT	
41 VALUE CODES CODE AMOUNT		42 REV. CD. <b>0528</b>		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 65		48 NON-COVERED CHARGES 50		49		50	
23 <b>0001</b>		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		65 50	
50 PAYER NAME <b>Medicare</b>		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID		58 INSURED'S NAME <b>Beneficiary Last, First Name</b>		59 P.REL. XX	
60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME		62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME		66 DX 9		67		68		69 ADMIT DX A B C D E F G H I J K L M N O P Q	
70 PATIENT REASON DX a b c		71 PPS CODE		72 ECI a b c		73		74 PRINCIPAL PROCEDURE CODE DATE	
75 OTHER PROCEDURE CODE DATE		76 ATTENDING LAST First Name NPI XXXXXXXXXXX		77 OPERATING LAST First Name NPI		78 OTHER LAST First Name NPI		79 OTHER LAST First Name NPI	
80 REMARKS		81 CC a b c d		82		83		84	

# Home Visit Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN FROM THROUGH CODE		36 OCCURRENCE SPAN FROM THROUGH CODE		37 OCCURRENCE SPAN FROM THROUGH CODE		38 OCCURRENCE SPAN FROM THROUGH CODE	
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42 VALUE CODES CODE AMOUNT	
43 REV. CD. <b>0522</b>		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 65		48 NON-COVERED CHARGES 50		49		50	
23 <b>0001</b>		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 65 50	
50 PAYER NAME <b>Medicare</b>		51 HEALTH PLAN ID		52 REL. INFO X		53 ASG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME <b>Beneficiary Last, First Name</b>		59 P. REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		X		A		B	
C		D		E		F	
G		H		I		J	
K		L		M		N	
O		P		Q		68	
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		c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE	
76 ATTENDING LAST <b>Last Name</b> FIRST <b>First Name</b>		NPI <b>XXXXXXXXXX</b>		QUAL		77 OPERATING LAST FIRST	
78 OTHER LAST FIRST		NPI		QUAL		79 OTHER LAST FIRST	
80 REMARKS		81 CC a		b		c	
d		82		83		84	



# SNF Non-Covered Stay Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
e Country Code							
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC 16 DHR 17 STAT 18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE 30	
31 OCCURRENCE CODE DATE 32 OCCURRENCE CODE DATE 33 OCCURRENCE CODE DATE 34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN FROM THROUGH 36 OCCURRENCE SPAN FROM THROUGH 37							
38		39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d	
42 REV. CD. <b>0525</b>		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS <b>1</b>		47 TOTAL CHARGES <b>85 50</b>		48 NON-COVERED CHARGES		49	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23							
<b>0001</b>		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → <b>85 50</b>	
50 PAYER NAME <b>Medicare</b>		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME <b>Beneficiary Last, First Name</b>		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX <b>9</b>		X		A		B	
C		D		E		F	
G		H		I		J	
K		L		M		N	
O		P		Q		68	
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	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		76 ATTENDING NPI XXXXXXXXXXX	
77 OPERATING NPI		LAST Last Name		FIRST First Name		QUAL	
78 OTHER NPI		LAST		FIRST		QUAL	
79 OTHER NPI		LAST		FIRST		QUAL	
80 REMARKS		81 CC a b c d					

# Psychiatric Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. #		<b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY		7	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code		e Country Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX		14 TYPE 15 SRC XX	
16 DHR XX		17 STAT XX		18 CONDITION CODES XX		19 THROUGH XX		20 THROUGH XX	
21 THROUGH XX		22 THROUGH XX		23 THROUGH XX		24 THROUGH XX		25 THROUGH XX	
26 THROUGH XX		27 THROUGH XX		28 THROUGH XX		29 ACDT STATE XX		30	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN FROM THROUGH CODE	
36 OCCURRENCE SPAN FROM THROUGH CODE		37 OCCURRENCE SPAN FROM THROUGH CODE		38		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT	
41 VALUE CODES CODE AMOUNT		42 REV. CD. 090X		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 120		48 NON-COVERED CHARGES 75		49		50	
51		52		53		54		55	
56		57		58		59		60	
61		62		63		64		65	
66		67		68		69		70	
71		72		73		74		75	
76		77		78		79		80	
81		82		83		84		85	
86		87		88		89		90	
91		92		93		94		95	
96		97		98		99		100	

# Two Visits (Same Day) Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 VALUE CODES CODE AMOUNT a b c d	
42 REV. CD. <b>052X</b>		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS <b>2</b>		47 TOTAL CHARGES <b>168</b>		48 NON-COVERED CHARGES <b>75</b>		49	
23 <b>0001</b>		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → <b>168 75</b>	
50 PAYER NAME <b>Medicare</b>		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME <b>Beneficiary Last, First Name</b>		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX <b>9</b>		X		XXXXX X		B C D E F G H	
69 ADMIT DX		70 PATIENT REASON DX a b c		71 PPS CODE		72 ECI a b c	
74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE		b OTHER PROCEDURE CODE DATE		75 ATTENDING NPI XXXXXXXXXXX	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST Last Name FIRST First Name	
80 REMARKS <b>First diagnosis was for (define condition).</b>		81 CC a		b		76 OPERATING NPI XXXXXXXXXXX	
<b>Second diagnosis was for (define condition).</b>		c		d		LAST Last Name FIRST First Name	
<b>Two visits, same day, not related.</b>		78 OTHER NPI		79 OTHER NPI		LAST Last Name FIRST First Name	

# Medicare Secondary Payer (MSP) Conditional Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
				5 FED. TAX NO. SubID XX-XXXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
8 PATIENT NAME		9 PATIENT ADDRESS		Street Address or Post Office Box			
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
0521				MMDYY		1	
120		00					
23		0001		PAGE 1 OF 1		CREATION DATE MMDYY TOTALS 120 00	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
"C" Primary Insurance		XXXXXXXXXX		X		XXXXXXXXXX	
Medicare							
58 INSURED'S NAME		59 P.REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.							
Beneficiary Last, First Name		XX		XXXXXXXXXX		Insurance Name	
Beneficiary Last, First Name		XX		XXXXXXXXXX		Insurance Group Number	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
				Employer Name			
66 DX		67		68		69	
XXXXX X		A B C D E F G H		I J K L M N O P Q			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73							
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 ATTENDING NPI		77 OPERATING NPI	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90 REMARKS		91 CC		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
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50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
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82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92			

# MSP Liability Conditional Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
e Country Code							
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC XX		16 DHR XX		17 STAT XX		18 CONDITION CODES XX	
19 20 21 22 23 24 25 26 27 28		29 ACDT STATE XX		30			
31 OCCURRENCE CODE DATE MMDDYY		32 OCCURRENCE CODE DATE MMDDYY		33 OCCURRENCE CODE DATE MMDDYY		34 OCCURRENCE CODE DATE MMDDYY	
35 OCCURRENCE SPAN FROM THROUGH MMDDYY		36 OCCURRENCE SPAN FROM THROUGH MMDDYY		37			
38		39 VALUE CODES CODE AMOUNT a XX 00 00 b c d		40 VALUE CODES CODE AMOUNT 00 00		41 VALUE CODES CODE AMOUNT	
42 REV. CD 0521		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 120 00		48 NON-COVERED CHARGES		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 120 00	
50 PAYER NAME "C" Primary Insurance Medicare		51 HEALTH PLAN ID XXXXXXXXXXXX		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name Beneficiary Last, First Name		59 P.REL. XX XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX XXXXXXXXXXXX		61 GROUP NAME Insurance Name	
62 INSURANCE GROUP NO. Insurance Group Number		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Employer Name	
66 DX 9		X A J		B K		C L	
D M		E N		F O		G P	
H Q		68					
69 ADMIT DX 70 PATIENT REASON DX a b c		71 PPS CODE a b c		72 ECI a b c		73	
74 PRINCIPAL PROCEDURE CODE DATE a OTHER PROCEDURE CODE DATE b OTHER PROCEDURE CODE DATE c OTHER PROCEDURE CODE DATE d OTHER PROCEDURE CODE DATE e OTHER PROCEDURE CODE DATE		75		76 ATTENDING NPI XXXXXXXXXXXX LAST Last Name FIRST First Name		QUAL	
77 OPERATING NPI LAST FIRST		78 OTHER NPI LAST FIRST		79 OTHER NPI LAST FIRST		QUAL	
80 REMARKS Forgoing lien; please pay conditionally.		81 CC a b c d					

# MSP Primary Paid Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a XX 25 b c d		40 VALUE CODES CODE AMOUNT a 00 b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 0521	
43 DESCRIPTION PAGE 1 OF 1		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 120		48 NON-COVERED CHARGES 00		49		50 PAYER NAME "X" Primary Insurance Medicare	
51 HEALTH PLAN ID XXXXXXXXXXXX		52 REL INFO X		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE 120		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID		58 INSURED'S NAME Beneficiary Last, First Name Beneficiary Last, First Name	
59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME Insurance Name		62 INSURANCE GROUP NO. Insurance Group Number	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Employer Name		66 DX 9	
67 A B C D E F G H I J K L M N O P Q		68		69 ADMIT DX 70 PATIENT REASON DX a b c		71 PPS CODE 72 ECI a b c	
73		74 PRINCIPAL PROCEDURE CODE DATE 75 OTHER PROCEDURE CODE DATE		76 ATTENDING NPI XXXXXXXXXXXX LAST Last Name FIRST First Name		77 OPERATING NPI LAST FIRST	
78 OTHER NPI LAST FIRST		79 OTHER NPI LAST FIRST		80 REMARKS Primary paid \$25.		81 CC a b c d	

# Initial Preventive Physical Examination (IPPE) and Clinic Visit (Same Day) Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
e Country Code							
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC 16 DHR 17 STAT 18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE 30	
31 OCCURRENCE CODE DATE 32 OCCURRENCE CODE DATE 33 OCCURRENCE CODE DATE 34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN CODE FROM THROUGH 36 OCCURRENCE SPAN CODE FROM THROUGH 37							
38		39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d	
42 REV. CD. 052X		43 DESCRIPTION Clinic Visit		44 HCPCS / RATE / HIPPS CODE G0402		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 75.00		48 NON-COVERED CHARGES 50.25		49	
2001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 125.25	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX 9		X		XXXXX X		B C D E F G H	
I J K L M N O P Q						68	
69 ADMIT DX b		70 PATIENT REASON DX c		71 PPS CODE a		72 ECI b c	
73							
74 PRINCIPAL PROCEDURE CODE DATE a		OTHER PROCEDURE CODE DATE b		OTHER PROCEDURE CODE DATE c		75 ATTENDING NPI XXXXXXXXXXX	
76 LAST Last Name		77 FIRST First Name		78 QUAL		79	
80 OTHER PROCEDURE CODE DATE d		OTHER PROCEDURE CODE DATE e		OTHER PROCEDURE CODE DATE f		81 OTHER NPI QUAL	
82 LAST First		83 FIRST		84 QUAL		85	
86 OTHER NPI QUAL		87 LAST First		88 FIRST		89 QUAL	
90 OTHER NPI QUAL		91 LAST First		92 FIRST		93 QUAL	
94 OTHER NPI QUAL		95 LAST First		96 FIRST		97 QUAL	
98 OTHER NPI QUAL		99 LAST First		100 FIRST		101 QUAL	
102 OTHER NPI QUAL		103 LAST First		104 FIRST		105 QUAL	
106 OTHER NPI QUAL		107 LAST First		108 FIRST		109 QUAL	
110 OTHER NPI QUAL		111 LAST First		112 FIRST		113 QUAL	
114 OTHER NPI QUAL		115 LAST First		116 FIRST		117 QUAL	
118 OTHER NPI QUAL		119 LAST First		120 FIRST		121 QUAL	
122 OTHER NPI QUAL		123 LAST First		124 FIRST		125 QUAL	
126 OTHER NPI QUAL		127 LAST First		128 FIRST		129 QUAL	
130 OTHER NPI QUAL		131 LAST First		132 FIRST		133 QUAL	
134 OTHER NPI QUAL		135 LAST First		136 FIRST		137 QUAL	
138 OTHER NPI QUAL		139 LAST First		140 FIRST		141 QUAL	
142 OTHER NPI QUAL		143 LAST First		144 FIRST		145 QUAL	
146 OTHER NPI QUAL		147 LAST First		148 FIRST		149 QUAL	
150 OTHER NPI QUAL		151 LAST First		152 FIRST		153 QUAL	
154 OTHER NPI QUAL		155 LAST First		156 FIRST		157 QUAL	
158 OTHER NPI QUAL		159 LAST First		160 FIRST		161 QUAL	
162 OTHER NPI QUAL		163 LAST First		164 FIRST		165 QUAL	
166 OTHER NPI QUAL		167 LAST First		168 FIRST		169 QUAL	
170 OTHER NPI QUAL		171 LAST First		172 FIRST		173 QUAL	
174 OTHER NPI QUAL		175 LAST First		176 FIRST		177 QUAL	
178 OTHER NPI QUAL		179 LAST First		180 FIRST		181 QUAL	
182 OTHER NPI QUAL		183 LAST First		184 FIRST		185 QUAL	
186 OTHER NPI QUAL		187 LAST First		188 FIRST		189 QUAL	
190 OTHER NPI QUAL		191 LAST First		192 FIRST		193 QUAL	
194 OTHER NPI QUAL		195 LAST First		196 FIRST		197 QUAL	
198 OTHER NPI QUAL		199 LAST First		200 FIRST		201 QUAL	
202 OTHER NPI QUAL		203 LAST First		204 FIRST		205 QUAL	
206 OTHER NPI QUAL		207 LAST First		208 FIRST		209 QUAL	
210 OTHER NPI QUAL		211 LAST First		212 FIRST		213 QUAL	
214 OTHER NPI QUAL		215 LAST First		216 FIRST		217 QUAL	
218 OTHER NPI QUAL		219 LAST First		220 FIRST		221 QUAL	
222 OTHER NPI QUAL		223 LAST First		224 FIRST		225 QUAL	
226 OTHER NPI QUAL		227 LAST First		228 FIRST		229 QUAL	
230 OTHER NPI QUAL		231 LAST First		232 FIRST		233 QUAL	
234 OTHER NPI QUAL		235 LAST First		236 FIRST		237 QUAL	
238 OTHER NPI QUAL		239 LAST First		240 FIRST		241 QUAL	
242 OTHER NPI QUAL		243 LAST First		244 FIRST		245 QUAL	
246 OTHER NPI QUAL		247 LAST First		248 FIRST		249 QUAL	
250 OTHER NPI QUAL		251 LAST First		252 FIRST		253 QUAL	
254 OTHER NPI QUAL		255 LAST First		256 FIRST		257 QUAL	
258 OTHER NPI QUAL		259 LAST First		260 FIRST		261 QUAL	
262 OTHER NPI QUAL		263 LAST First		264 FIRST		265 QUAL	
266 OTHER NPI QUAL		267 LAST First		268 FIRST		269 QUAL	
270 OTHER NPI QUAL		271 LAST First		272 FIRST		273 QUAL	
274 OTHER NPI QUAL		275 LAST First		276 FIRST		277 QUAL	
278 OTHER NPI QUAL		279 LAST First		280 FIRST		281 QUAL	
282 OTHER NPI QUAL		283 LAST First		284 FIRST		285 QUAL	
286 OTHER NPI QUAL		287 LAST First		288 FIRST		289 QUAL	
290 OTHER NPI QUAL		291 LAST First		292 FIRST		293 QUAL	
294 OTHER NPI QUAL		295 LAST First		296 FIRST		297 QUAL	
298 OTHER NPI QUAL		299 LAST First		300 FIRST		301 QUAL	
302 OTHER NPI QUAL		303 LAST First		304 FIRST		305 QUAL	
306 OTHER NPI QUAL		307 LAST First		308 FIRST		309 QUAL	
310 OTHER NPI QUAL		311 LAST First		312 FIRST		313 QUAL	
314 OTHER NPI QUAL		315 LAST First		316 FIRST		317 QUAL	
318 OTHER NPI QUAL		319 LAST First		320 FIRST		321 QUAL	
322 OTHER NPI QUAL		323 LAST First		324 FIRST		325 QUAL	
326 OTHER NPI QUAL		327 LAST First		328 FIRST		329 QUAL	
330 OTHER NPI QUAL		331 LAST First		332 FIRST		333 QUAL	
334 OTHER NPI QUAL		335 LAST First		336 FIRST		337 QUAL	
338 OTHER NPI QUAL		339 LAST First		340 FIRST		341 QUAL	
342 OTHER NPI QUAL		343 LAST First		344 FIRST		345 QUAL	
346 OTHER NPI QUAL		347 LAST First		348 FIRST		349 QUAL	
350 OTHER NPI QUAL		351 LAST First		352 FIRST		353 QUAL	
354 OTHER NPI QUAL		355 LAST First		356 FIRST		357 QUAL	
358 OTHER NPI QUAL		359 LAST First		360 FIRST		361 QUAL	
362 OTHER NPI QUAL		363 LAST First		364 FIRST		365 QUAL	
366 OTHER NPI QUAL		367 LAST First		368 FIRST		369 QUAL	
370 OTHER NPI QUAL		371 LAST First		372 FIRST		373 QUAL	
374 OTHER NPI QUAL		375 LAST First		376 FIRST		377 QUAL	
378 OTHER NPI QUAL		379 LAST First		380 FIRST		381 QUAL	
382 OTHER NPI QUAL		383 LAST First		384 FIRST		385 QUAL	
386 OTHER NPI QUAL		387 LAST First		388 FIRST		389 QUAL	
390 OTHER NPI QUAL		391 LAST First		392 FIRST		393 QUAL	
394 OTHER NPI QUAL		395 LAST First		396 FIRST		397 QUAL	
398 OTHER NPI QUAL		399 LAST First		400 FIRST		401 QUAL	
402 OTHER NPI QUAL		403 LAST First		404 FIRST		405 QUAL	
406 OTHER NPI QUAL		407 LAST First		408 FIRST		409 QUAL	
410 OTHER NPI QUAL		411 LAST First		412 FIRST		413 QUAL	
414 OTHER NPI QUAL		415 LAST First		416 FIRST		417 QUAL	
418 OTHER NPI QUAL		419 LAST First		420 FIRST		421 QUAL	
422 OTHER NPI QUAL		423 LAST First		424 FIRST		425 QUAL	
426 OTHER NPI QUAL		427 LAST First		428 FIRST		429 QUAL	
430 OTHER NPI QUAL		431 LAST First		432 FIRST		433 QUAL	
434 OTHER NPI QUAL		435 LAST First		436 FIRST		437 QUAL	
438 OTHER NPI QUAL		439 LAST First		440 FIRST		441 QUAL	
442 OTHER NPI QUAL		443 LAST First		444 FIRST		445 QUAL	
446 OTHER NPI QUAL		447 LAST First		448 FIRST		449 QUAL	
450 OTHER NPI QUAL		451 LAST First		452 FIRST		453 QUAL	
454 OTHER NPI QUAL		455 LAST First		456 FIRST		457 QUAL	
458 OTHER NPI QUAL		459 LAST First		460 FIRST		461 QUAL	
462 OTHER NPI QUAL		463 LAST First		464 FIRST		465 QUAL	
466 OTHER NPI QUAL		467 LAST First		468 FIRST		469 QUAL	
470 OTHER NPI QUAL		471 LAST First		472 FIRST		473 QUAL	
474 OTHER NPI QUAL		475 LAST First		476 FIRST		477 QUAL	
478 OTHER NPI QUAL		479 LAST First		480 FIRST		481 QUAL	
482 OTHER NPI QUAL		483 LAST First		484 FIRST		485 QUAL	
486 OTHER NPI QUAL		487 LAST First		488 FIRST		489 QUAL	
490 OTHER NPI QUAL		491 LAST First		492 FIRST		493 QUAL	
494 OTHER NPI QUAL		495 LAST First		496 FIRST		497 QUAL	
498 OTHER NPI QUAL		499 LAST First		500 FIRST		501 QUAL	
502 OTHER NPI QUAL		503 LAST First		504 FIRST		505 QUAL	
506 OTHER NPI QUAL		507 LAST First		508 FIRST		509 QUAL	
510 OTHER NPI QUAL		511 LAST First		512 FIRST		513 QUAL	
514 OTHER NPI QUAL		515 LAST First					



# Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) and Clinic Visit (Same Day) Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY					
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
e Country Code							
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
14 TYPE 15 SRC X		16 DHR X		17 STAT XX		18 CONDITION CODES XX	
19 20 21 22 23 24 25 26 27 28		29 ACDT STATE XX		30			
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37			
38		39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d	
42 REV. CD. 052X		43 DESCRIPTION Clinic Visit		44 HCPCS / RATE / HIPPS CODE G0389		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 75.00		48 NON-COVERED CHARGES 50.25		49	
20 21 22 23		20 21 22 23		20 21 22 23		20 21 22 23	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49		24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49		24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49		24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49	
50 PAYER NAME Medicare		51 HEALTH PLAN ID X		52 REL INFO X		53 ASG BEN X	
54 PRIOR PAYMENTS X		55 EST. AMOUNT DUE 125.25		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID XXXXXXXXXXXX	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME XXXXXXXXXXXX	
62 INSURANCE GROUP NO. XXXXXXXXXXXX		63 TREATMENT AUTHORIZATION CODES XXXXX X XXXXX X		64 DOCUMENT CONTROL NUMBER B C D E F G H		65 EMPLOYER NAME I J K L M N O P Q	
66 DX 9		67 a b c		68 a b c		69 a b c	
70 PATIENT REASON DX b		71 PPS CODE c		72 ECI a b c		73	
74 PRINCIPAL PROCEDURE CODE DATE X		75 OTHER PROCEDURE CODE DATE X		76 ATTENDING NPI XXXXXXXXXXXX		77 OPERATING NPI XXXXXXXXXXXX	
78 OTHER NPI XXXXXXXXXXXX		79 OTHER NPI XXXXXXXXXXXX		80 REMARKS a b c d		81 CC a b c d	

# Ultrasound Screening for AAA Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN FROM THROUGH CODE		36 OCCURRENCE SPAN FROM THROUGH CODE		37 OCCURRENCE SPAN FROM THROUGH CODE		38	
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42 REV. CD. 052X	
43 DESCRIPTION AAA		44 HCPCS / RATE / HIPPS CODE G0389		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 50: 25		48 NON-COVERED CHARGES		49		50: 25	
0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		50: 25	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI XXXXXXXXXXX		57 OTHER PRV ID	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		X		A		B	
C		D		E		F	
G		H		I		J	
K		L		M		N	
O		P		Q		68	
69 ADMIT DX		70 PATIENT REASON DX		b		c	
71 PPS CODE		72 ECI		a		b	
73		c		74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE	
76 ATTENDING LAST Last Name FIRST First Name		NPI XXXXXXXXXXX		QUAL		77 OPERATING LAST FIRST	
78 OTHER LAST FIRST		NPI		QUAL		79 OTHER LAST FIRST	
80 REMARKS		81 CC a		b		c	
d		82		83		84	

# Telehealth Originating Site Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN FROM THROUGH CODE		36 OCCURRENCE SPAN FROM THROUGH CODE		37 OCCURRENCE SPAN FROM THROUGH CODE		38	
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42 REV. CD. <b>0780</b>	
43 DESCRIPTION <b>Originating Site</b>		44 HCPCS / RATE / HIPPS CODE <b>Q3014</b>		45 SERV. DATE MMDDYY		46 SERV. UNITS <b>1</b>	
47 TOTAL CHARGES <b>30</b>		48 NON-COVERED CHARGES <b>00</b>		49		50 PAYER NAME <b>Medicare</b>	
51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE <b>30</b>		56 NPI XXXXXXXXXXX		57 OTHER PRV ID		58 INSURED'S NAME <b>Beneficiary Last, First Name</b>	
59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXX		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66 DX 9	
67		68		69 ADMIT DX b		70 PATIENT REASON DX c	
71 PPS CODE a		72 ECI b		73		74 PRINCIPAL PROCEDURE CODE DATE	
75		76 ATTENDING LAST <b>Last Name</b> FIRST <b>First Name</b>		77 OPERATING LAST FIRST		78 OTHER LAST FIRST	
79 OTHER LAST FIRST		80 REMARKS		81 CC a		82	
83		84		85		86	

# Telehealth Originating Site and Clinic Visit Billing Example

<b>Provider Name</b> Street Address City, State, ZIP Code Telephone; Fax; Country Code		<b>Pay-to Name</b> Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # <b>Required</b> <b>Recommended</b>		4 TYPE OF BILL <b>0711</b>	
8 PATIENT NAME a		9 PATIENT ADDRESS a Street Address or Post Office Box		5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY	
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code	
10 BIRTHDATE MMDDCCYY X		11 SEX X		12 DATE XX		13 HR XX	
31 OCCURRENCE CODE DATE X		32 OCCURRENCE CODE DATE X		33 OCCURRENCE CODE DATE X		34 OCCURRENCE CODE DATE X	
35 OCCURRENCE SPAN FROM THROUGH X		36 OCCURRENCE SPAN FROM THROUGH X		37 OCCURRENCE SPAN FROM THROUGH X		38 OCCURRENCE SPAN FROM THROUGH X	
39 VALUE CODES CODE AMOUNT a b c d		40 VALUE CODES CODE AMOUNT a b c d		41 VALUE CODES CODE AMOUNT a b c d		42 REV. CD. 052X 0780	
43 DESCRIPTION Clinic Visit Originating Site		44 HCPCS / RATE / HIPPS CODE Q3014		45 SERV. DATE MMDDYY MMDDYY		46 SERV. UNITS 1 1	
47 TOTAL CHARGES 75:00 30:00		48 NON-COVERED CHARGES 00 00		49 00 00		23 105:00	
50 PAYER NAME Medicare		51 HEALTH PLAN ID X		52 REL INFO X		53 ASG BEN X	
54 PRIOR PAYMENTS X		55 EST. AMOUNT DUE XXXXXXXXX		56 NPI XXXXXXXXX		57 OTHER PRV ID XXXXXXXXX	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXX		61 GROUP NAME XXXXXXXXX	
62 INSURANCE GROUP NO. XXXXXXXXX		63 TREATMENT AUTHORIZATION CODES XXXXX X XXXXX X		64 DOCUMENT CONTROL NUMBER B C D E F G H I J K L M N O P Q		65 EMPLOYER NAME XXXXX X XXXXX X	
66 DX 9		67 I J K L M N O P Q		68 R S T U V W X Y Z		69 ADMIT DX b c	
70 PATIENT REASON DX b c		71 PPS CODE a b c		72 ECI a b c		73 a b c	
74 PRINCIPAL PROCEDURE CODE DATE a		75 OTHER PROCEDURE CODE DATE b		76 ATTENDING NPI XXXXXXXXX		77 OPERATING NPI XXXXXXXXX	
78 OTHER NPI XXXXXXXXX		79 OTHER NPI XXXXXXXXX		80 REMARKS a b c d		81 CC a b c d	