

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

On-Site Billing Example

Provider Name		Pay-to Name		Ba PAT. CNTL #		Required		4 TYPE OF BILL	
Street Address		Street Address or Post Office Box		b. MED. REC. #		Recommended		0711	
City, State, ZIP Code		City, State, ZIP Code		5 FED. TAX NO. SubID		6 STATEMENT COVERS PERIOD FROM THROUGH		7	
Telephone; Fax; Country Code				XX-XXXXXXX		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		e Country Code	
10 BIRTHDATE		11 SEX		ADMISSION DATE		13 HR		14 TYPE 15 SRC	
MMDDCCYY X		XX		16 DHR		17 STAT		CONDITION CODES	
31 OCCURRENCE CODE		32 OCCURRENCE CODE		33 OCCURRENCE CODE		34 OCCURRENCE CODE		35 OCCURRENCE SPAN FROM THROUGH	
DATE		DATE		DATE		DATE		36 OCCURRENCE SPAN FROM THROUGH	
a		b		c		d		e	
38		39 VALUE CODES CODE		40 VALUE CODES AMOUNT		41 VALUE CODES CODE		41 VALUE CODES AMOUNT	
a		b		c		d		e	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
0521						MMDDYY		1	
2		3		4		5		6	
7		8		9		10		11	
12		13		14		15		16	
17		18		19		20		21	
22		23		24		25		26	
27		28		29		30		31	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51	
55		45							
23 0001		PAGE 1 OF 1		CREATION DATE		MMDDYY		TOTALS → 55 45	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
A Medicare				X					
B		C		D		E		F	
56 NPI		57 OTHER PRV ID		58 INSURED'S NAME		59 P.REL.		60 INSURED'S UNIQUE ID	
XXXXXXXXXX				A Beneficiary Last, First Name		XX		XXXXXXXXXX	
B		C		D		E		F	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		68	
A		B		C		D		E	
66 DX		A		B		C		D	
9		J		K		L		M	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
a		b		c		a		b	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		75		76 ATTENDING NPI	
DATE		DATE		DATE		DATE		XXXXXXXXXX	
c OTHER PROCEDURE CODE		d OTHER PROCEDURE CODE		e OTHER PROCEDURE CODE		LAST		Last Name	
DATE		DATE		DATE		FIRST		First Name	
80 REMARKS		81 CC a		82 OTHER NPI		LAST		QUAL	
		b		79 OTHER NPI		FIRST			
		c		LAST		FIRST			
		d		LAST		FIRST			

Off-Site Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		32 OCCURRENCE CODE DATE XX		33 OCCURRENCE CODE DATE XX		34 OCCURRENCE CODE DATE XX	
35 OCCURRENCE SPAN FROM THROUGH XX		36 OCCURRENCE SPAN FROM THROUGH XX		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. 0528		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE MMDDYY		45 SERV. DATE 1	
46 SERV. UNITS 65		47 TOTAL CHARGES 50		48 NON-COVERED CHARGES		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 65 50	
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	
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		75 OTHER PROCEDURE CODE DATE b		76 ATTENDING NPI XXXXXXXXXXX	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
80 REMARKS		81 CC a b c d		82		83	

Skilled Nursing Facility (SNF) Covered Stay Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		12 DATE XX		13 HR XX	
14 TYPE 15 SRC XX		16 DHR XX		17 STAT XX		18 CONDITION CODES XX	
19 ACDT STATE		20 STATE		21 STATE		22 STATE	
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. 0524		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 85		48 NON-COVERED CHARGES 50					
49							
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		A X		B A		C B	
D C		E D		F E		G F	
H G		I H		J I		K J	
L K		M L		N M		O N	
P O		Q P		R Q		S R	
69 ADMIT DX		70 PATIENT REASON DX a		71 PPS CODE b		72 ECI 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		81 CC a		76 OPERATING NPI		LAST Last Name FIRST First Name	
b		c		77 OTHER NPI		LAST Last Name FIRST First Name	
d		78 OTHER NPI		79 OTHER NPI		LAST Last Name FIRST First Name	

SNF Non-Covered Stay Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX	
19 XX		20 XX		21 XX		22 XX	
23 XX		24 XX		25 XX		26 XX	
27 XX		28 XX		29 ACDT STATE		30 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 XX			
38 a b c d		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
42 REV. CD. 0525		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 85 50		48 NON-COVERED CHARGES		49	
50 PAYER NAME Medicare		51 HEALTH PLAN ID		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		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		67 X		68 A B C D E F G H		69 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		a OTHER PROCEDURE CODE DATE		b OTHER PROCEDURE CODE DATE		75 ATTENDING NPI XXXXXXXXXXXX	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST Last Name	
76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE		b OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI XXXXXXXXXXXX		76 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73		74 PRINCIPAL PROCEDURE CODE DATE		a OTHER PROCEDURE CODE DATE	
75 ATTENDING NPI							

Two Visits (Same Day) Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		16 DHR XX		17 STAT XX		18 CONDITION CODES XX	
31 OCCURRENCE CODE DATE XX		32 OCCURRENCE CODE DATE XX		33 OCCURRENCE CODE DATE XX		34 OCCURRENCE CODE DATE XX	
35 OCCURRENCE SPAN FROM THROUGH XX		36 OCCURRENCE SPAN FROM THROUGH XX		37 OCCURRENCE SPAN FROM THROUGH XX		38 VALUE CODES CODE AMOUNT XX	
42 REV. CD. 090X		43 DESCRIPTION 090X		44 HCPCS / RATE / HIPPS CODE 090X		45 SERV. DATE MMDDYY	
46 SERV. UNITS 2		47 TOTAL CHARGES 168		48 NON-COVERED CHARGES 75		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS 168 75	
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 X		56 NPI XXXXXXXXXXXX		57 OTHER PRV ID X	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME X	
62 INSURANCE GROUP NO. X		63 TREATMENT AUTHORIZATION CODES X		64 DOCUMENT CONTROL NUMBER X		65 EMPLOYER NAME X	
66 DX 9		X		X		B	
C		D		E		F	
G		H		I		J	
K		L		M		N	
O		P		Q		R	
69 ADMIT DX 9		70 PATIENT REASON DX a		71 PPS CODE b		72 ECI c	
74 PRINCIPAL PROCEDURE CODE DATE 9		OTHER PROCEDURE CODE DATE a		OTHER PROCEDURE CODE DATE b		75 ATTENDING NPI XXXXXXXXXXXX	
OTHER PROCEDURE CODE DATE c		OTHER PROCEDURE CODE DATE d		OTHER PROCEDURE CODE DATE e		LAST Last Name FIRST First Name	
80 REMARKS First diagnosis was for (define condition). Second diagnosis was for (define condition). Two visits, same day, not related.		81 CC a		b		76 OPERATING NPI XXXXXXXXXXXX	
c		d		77 OTHER NPI XXXXXXXXXXXX		LAST Last Name FIRST First Name	
78 OTHER NPI XXXXXXXXXXXX		79 OTHER NPI XXXXXXXXXXXX		LAST Last Name FIRST First Name		QUAL	

Medicare Secondary Payer (MSP) Conditional Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		12 DATE XX		13 HR XX	
14 TYPE 15 SRC XX		16 DHR XX		17 STAT XX		18 CONDITION CODES XX	
19 ACDT XX		20 STATE XX		21 THROUGH XX		22 THROUGH XX	
23 OCCURRENCE CODE MMDDYY		24 OCCURRENCE DATE MMDDYY		25 OCCURRENCE CODE MMDDYY		26 OCCURRENCE DATE MMDDYY	
27 OCCURRENCE CODE MMDDYY		28 OCCURRENCE DATE MMDDYY		29 OCCURRENCE CODE MMDDYY		30 OCCURRENCE DATE MMDDYY	
31 OCCURRENCE CODE MMDDYY		32 OCCURRENCE DATE MMDDYY		33 OCCURRENCE CODE MMDDYY		34 OCCURRENCE DATE MMDDYY	
35 OCCURRENCE CODE MMDDYY		36 OCCURRENCE DATE MMDDYY		37 OCCURRENCE CODE MMDDYY		38 OCCURRENCE DATE MMDDYY	
39 VALUE CODES CODE AMOUNT a XX 00 00		40 VALUE CODES CODE AMOUNT b		41 VALUE CODES CODE AMOUNT c		42 VALUE CODES CODE AMOUNT d	
43 REV. CD. 0521		44 DESCRIPTION		45 HCPCS / RATE / HIPPS CODE		46 SERV. DATE MMDDYY	
47 SERV. UNITS 1		48 TOTAL CHARGES 120 00		49 NON-COVERED CHARGES		50	
51 PAGE 1 OF 1		52 CREATION DATE MMDDYY		53 TOTALS 120 00		54	
55 PAYER NAME "C" Primary Insurance Medicare		56 HEALTH PLAN ID XXXXXXXXXXXX		57 REL. INFO X		58 ASG BEN	
59 PRIOR PAYMENTS		60 EST. AMOUNT DUE		61 NPI XXXXXXXXXXXX		62 OTHER PRV ID	
63 INSURED'S NAME Beneficiary Last, First Name Beneficiary Last, First Name		64 P. REL. XX XX		65 INSURED'S UNIQUE ID XXXXXXXXXXXX XXXXXXXXXXXX		66 GROUP NAME Insurance Name	
67 INSURANCE GROUP NO.		68 INSURANCE GROUP NO.		69 TREATMENT AUTHORIZATION CODES		70 DOCUMENT CONTROL NUMBER	
71 EMPLOYER NAME		72 EMPLOYER NAME		73 EMPLOYER NAME		74 EMPLOYER NAME	
75 DX 9		76 DX X		77 DX A		78 DX B	
79 DX C		80 DX D		81 DX E		82 DX F	
83 DX G		84 DX H		85 DX I		86 DX J	
87 DX K		88 DX L		89 DX M		90 DX N	
91 DX O		92 DX P		93 DX Q		94 DX R	
95 ADMIT DX 70		96 PATIENT REASON DX a		97 PATIENT REASON DX b		98 PATIENT REASON DX c	
99 PPS CODE 71		100 PPS CODE 72		101 PPS CODE 73		102 PPS CODE 74	
103 PRINCIPAL PROCEDURE CODE DATE		104 OTHER PROCEDURE CODE DATE		105 OTHER PROCEDURE CODE DATE		106 OTHER PROCEDURE CODE DATE	
107 OTHER PROCEDURE CODE DATE		108 OTHER PROCEDURE CODE DATE		109 OTHER PROCEDURE CODE DATE		110 OTHER PROCEDURE CODE DATE	
111 REMARKS Enter comment on why primary insurance did not pay. Use occurrence code 24 and date of denial.		112 CC a		113 CC b		114 CC c	
115 OTHER NPI 78		116 OTHER NPI 79		117 OTHER NPI 80		118 OTHER NPI 81	
119 OTHER NPI 82		120 OTHER NPI 83		121 OTHER NPI 84		122 OTHER NPI 85	

MSP Primary Paid Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		Ba PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXXX		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 XX		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 a XX 25 b c d		40 VALUE CODES CODE AMOUNT 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		48 NON-COVERED CHARGES 00		49	
23 0001		PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS → 120 00	
50 PAYER NAME A "X" Primary Insurance B Medicare C		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 A Beneficiary Last, First Name B Beneficiary Last, First Name C		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		61 GROUP NAME Insurance Name	
62 INSURANCE GROUP NO. XXXXXXXXXXXX		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Employer Name	
66 DX 9		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 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 XXXXXXXXXXXX	
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST Last Name FIRST First Name	
80 REMARKS Primary paid \$25.		81 CC a b c d		76 OPERATING NPI		LAST FIRST	
				77 OTHER NPI		LAST FIRST	
				78 OTHER NPI		LAST FIRST	
				79 OTHER NPI		LAST FIRST	

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

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		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 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	
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	
23 0001		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		X		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	
73		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	
76 ATTENDING NPI XXXXXXXXXXX		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
80 REMARKS		81 CC a		b		c	
d		LAST		FIRST		QUAL	

IPPE Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY		7			
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 XX		12 DATE XX		13 HR XX	
14 TYPE 15 SRC XX		16 DHR XX		17 STAT XX		18 CONDITION CODES XX	
19 XX		20 XX		21 XX		22 XX	
23 XX		24 XX		25 XX		26 XX	
27 XX		28 XX		29 ACDT STATE XX		30 XX	
31 OCCURRENCE CODE DATE XX		32 OCCURRENCE CODE DATE XX		33 OCCURRENCE CODE DATE XX		34 OCCURRENCE CODE DATE XX	
35 OCCURRENCE SPAN FROM THROUGH XX		36 OCCURRENCE SPAN FROM THROUGH XX		37 XX			
38 XX		39 VALUE CODES CODE AMOUNT XX		40 VALUE CODES CODE AMOUNT XX		41 VALUE CODES CODE AMOUNT XX	
42 REV. CD. 052X		43 DESCRIPTION IPPE		44 HCPCS / RATE / HIPPS CODE G0402		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 50 25		48 NON-COVERED CHARGES 25		49	
23 0001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS →		50 25	
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 XXXXXXXXXX		56 NPI XXXXXXXXXX		57 OTHER PRV ID X	
58 INSURED'S NAME Beneficiary Last, First Name		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXX		61 GROUP NAME X	
62 INSURANCE GROUP NO. X		63 TREATMENT AUTHORIZATION CODES X		64 DOCUMENT CONTROL NUMBER X		65 EMPLOYER NAME X	
66 DX 9		A X		B A		C B	
D C		E D		F E		G F	
H G		I H		J I		K J	
L K		M L		N M		O N	
P O		Q P		R Q		S R	
69 ADMIT DX X		70 PATIENT REASON DX b		71 PPS CODE c		72 ECI a	
73 c		74 PRINCIPAL PROCEDURE CODE DATE X		75 OTHER PROCEDURE CODE DATE X		76 ATTENDING NPI XXXXXXXXXX	
77 OPERATING NPI X		78 OTHER NPI X		79 OTHER NPI X		QUAL X	
80 REMARKS a		b		c		d	

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

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 XX		12 DATE XX		13 HR XX	
14 TYPE 15 SRC XX		16 DHR XX		17 STAT XX		18 XX	
19 XX		20 XX		21 XX		22 XX	
23 XX		24 XX		25 XX		26 XX	
27 XX		28 XX		29 ACDT STATE XX		30 XX	
31 OCCURRENCE CODE DATE XX		32 OCCURRENCE CODE DATE XX		33 OCCURRENCE CODE DATE XX		34 OCCURRENCE CODE DATE XX	
35 OCCURRENCE SPAN FROM THROUGH XX		36 OCCURRENCE SPAN FROM THROUGH XX		37 XX		38 XX	
39 VALUE CODES CODE AMOUNT XX		40 VALUE CODES CODE AMOUNT XX		41 VALUE CODES CODE AMOUNT XX		42 XX	
43 REV. CD. 052X		44 HCPCS / RATE / HIPPS CODE Clinic Visit AAA		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 75: 00		48 NON-COVERED CHARGES 50: 25		49 XX		50 XX	
51 XX		52 XX		53 XX		54 XX	
55 XX		56 XX		57 XX		58 XX	
59 XX		60 XX		61 XX		62 XX	
63 TREATMENT AUTHORIZATION CODES XX		64 DOCUMENT CONTROL NUMBER XX		65 EMPLOYER NAME XX		66 XX	
67 XX		68 XX		69 XX		70 XX	
71 XX		72 XX		73 XX		74 XX	
75 XX		76 XX		77 XX		78 XX	
79 XX		80 XX		81 XX		82 XX	
83 XX		84 XX		85 XX		86 XX	
87 XX		88 XX		89 XX		90 XX	
91 XX		92 XX		93 XX		94 XX	
95 XX		96 XX		97 XX		98 XX	
99 XX		100 XX		101 XX		102 XX	

Ultrasound Screening for AAA Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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	
23 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		71 PPS CODE		72 ECI	
73		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		81 CC a		76 OPERATING NPI		LAST Last Name FIRST First Name	
b		c		77 OTHER NPI		LAST Last Name FIRST First Name	
d		78 OTHER NPI		79 OTHER NPI		LAST Last Name FIRST First Name	

Telehealth Originating Site Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
5 FED. TAX NO. SubID XX-XXXXXXX		6 STATEMENT COVERS PERIOD FROM THROUGH MMDDYY MMDDYY		7			
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	
19		20		21		22	
23		24		25		26	
27		28		29 ACDT STATE 30		31	
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. 0780		43 DESCRIPTION Originating Site		44 HCPCS / RATE / HIPPS CODE Q3014		45 SERV. DATE MMDDYY	
46 SERV. UNITS 1		47 TOTAL CHARGES 30 00		48 NON-COVERED CHARGES		49	
20001 PAGE 1 OF 1		CREATION DATE MMDDYY		TOTALS 30 00			
50 PAYER NAME Medicare		51 HEALTH PLAN ID		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		59 P.REL. XX		60 INSURED'S UNIQUE ID XXXXXXXXXXXX		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 b c		70 PATIENT REASON DX 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 77 OPERATING NPI LAST FIRST 78 OTHER NPI LAST FIRST 79 OTHER NPI LAST FIRST	
80 REMARKS		81 CC a b c d		82		83	

Telehealth Originating Site and Clinic Visit Billing Example

Provider Name Street Address City, State, ZIP Code Telephone; Fax; Country Code		Pay-to Name Street Address or Post Office Box City, State, ZIP Code		3a PAT. CNTL # b. MED. REC. # Required Recommended		4 TYPE OF BILL 0711	
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 Clinic Visit		44 HCPCS / RATE / HIPPS CODE Q3014		45 SERV. DATE MMDDYY		46 SERV. UNITS 1	
47 TOTAL CHARGES 75.00		48 NON-COVERED CHARGES 30.00		49		50 PAYER NAME Medicare	
51 HEALTH PLAN ID		52 REL INFO X		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE 105.00		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	
67		68		69 ADMIT DX b		70 PATIENT REASON DX c	
71 PPS CODE		72 ECI a		73		74 PRINCIPAL PROCEDURE CODE DATE	
75		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	