

OFFICE OF HEALTH STATISTICS

Tennessee Department of Health

**Ambulatory Surgical
Treatment Center
Data System User
Manual**

**CMS-1500 and UB-04
Reporting**

2013

Ambulatory Surgical Treatment Center

Data System User Manual

STATE OF TENNESSEE

Department of Health
Division of Policy, Planning & Assessment
Office of Health Statistics
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SECTION I

Introduction

Introduction to CMS-1500 and UB-04 Reporting

Traditionally surgeries were performed in hospitals as inpatient procedures. But in past years, a new trend arose. Concerns about rising hospital costs have led to an increasing proportion of surgeries being performed on an outpatient basis.

With the shift to outpatient surgery a second trend arose. Numerous outpatient surgery centers were built independent of hospitals. These centers, called ambulatory surgical treatment centers, specialize in performing outpatient surgeries. They do not offer the full range of services provided by a hospital. An increasing proportion of surgeries are now being performed in these centers. The Department of Health have been collecting information from UB-04 billing claims on all outpatient surgeries performed in Tennessee hospitals since 1995 and started collecting from Ambulatory Surgical Treatment Centers (ASTC) in 2007.

T. C. A. 68-1-119 requires each licensed ambulatory surgical treatment center (ASTC) in the state to report its claims data to the Tennessee Department of Health. Administrative rule 1200-7-4 was promulgated by the Department to carry out this legislative mandate. This data is to be reported quarterly in the appropriate format via third party entities approved by the Department. Personal identifiers are to be kept confidential. Penalties are prescribed for failure to report.

Patient Record Data Systems (PRDS), part of the Division of Health Statistics, has been charged by the Department to carry out this project. Each ASTC will transmit its records to the vendor it has selected. Each vendor will send the records it has received from its ambulatory surgical treatment centers to PRDS.

Both CMS-1500 claims data and UB-04 claims data will be collected. Each type of claim data should be reported according to its layout in this manual.

Several applications are foreseen for the ASTC data depending on the needs of the end-user. Measures of resource use are valuable for health planning and certificate of need evaluations. These look at the volume of activity for treating various health conditions and for performing various procedures.

Public health users would likewise be interested in these measures of resource use by diagnoses and procedures. Also they would want to look at the data to help gain better assessments of the incidence and prevalence of various diseases and health-related conditions. They also are concerned with charges to help assess the costs of health care, both in total and for specific problems.

Business users will be interested in the volume of activity in various locations and in various health care segments. They will also be interested in relative charges in the highly competitive health care market.

Besides the use of the ASTC data alone, it can be used in conjunction with hospital and ODC data. This can be done either to compare these sources of similar services or to combine them to get a more complete picture of the total usage of health care in Tennessee

SECTION II

Reporting Requirements

General Reporting Requirements

Each facility will select a vendor certified by the Tennessee Department of Health to process the ASTC data. Each facility will have one contact person responsible for its data compilation and submission. The three certified vendors are:

Practice Resource Network, Inc.
2 Maryland Farms, Suite 133
Brentwood, TN 37027
615-661-8929 ext. 115

Contact: Carole Roussel

Tennessee Hospital Association
5201 Virginia Way
Brentwood, TN 37027
615-401-7453

Contact: Sarah Cooley

System13, Inc.
1648 State Farm Boulevard
Charlottesville, VA 22911
434-977-0000 ext. 210

Contact: Tom Phelps, Director, Health Information Division

The Field Descriptions and the Layout give detailed information on how to fill out each field in the ASTC data record sent to the Department. The Reporting Instructions give some general information and help interpret them. Vendors should follow them to create the data file. The purpose of this chapter is to give instructions on when, where, and how to report data files.

This layout is also the established standard for reporting to the vendors. However, if another layout is acceptable to the center and its' vendor, it is acceptable to the Department if all reporting requirements are met.

The data reported to the Tennessee Department of Health should be that required by the payer to whom the claim is submitted. Medicare, TennCare, private and other insurers vary somewhat in their required usage of the CMS-1500 or UB-04 forms. **Follow their instructions in submitting claims and put the same information in the data record submitted to the Department. The instructions given in this Manual are primarily given to standardize the format of the electronic record, not to specify field content, except for fields added for use by the Department.** (Of course, data fields not required by the Department and not submitted to the payer can be omitted.)

General Reporting Requirements (continued)

The national standard for the usage of the CMS-1500 form is the manual produced by the American Medical Association's National Uniform Claims Committee. The national standard for the usage of the UB-04 forms is established by the American Hospital Association's National Uniform Billing Committee.

Each record sent by the vendor to the Department is the electronic representation of one CMS-1500 or UB-04 form. Records are fixed format. A group of electronic records transmitted together constitute a file. All the records for a quarter for all facilities reporting through a vendor should be combined into two separate files, one of CMS-1500 records and the second of UB-04 records.

Sixty days after the close of a quarter each facility is required to have its data submission for that quarter to its vendor. The data will be sent in the format agreed upon by the ASTC and its vendor. Optionally, paper forms may be submitted for which the vendor is responsible to key. All cases seen in the facility for that quarter should be reported to the Department. The facilities are responsible to submit to their vendor all information needed to create the data records required by the Department. Facilities should follow the instructions of their vendor in submitting their claims records.

Each vendor will compile the data from each of its reporting facilities and submit all such data to the state **one hundred twenty days** after the close of the quarter. It shall also report to the state any facility that has failed to report its data and any deficiencies found in any facility's data.

The vendor is responsible to check that the submission for each facility that has contracted with it is correct and complete. The vendor also adds the state ID number for each facility for which it is reporting, its own ID number, and the unique record number for each record. These should be in the field locations and formats specified to the vendor by the Department.

The vendor is also responsible to create the vendor-generated fields. These may be created from raw data values or reported directly by the centers.

Each vendor shall have one person responsible as the primary contact person for the state. For each quarter the vendors will submit to the state, in addition to the data, an updated list of the facilities that have contracted with them, the facilities' contact persons, and the status of the data for each facility.

Special Reporting Requirements

- Newborn claims should generate a separate record from that of the mother, even for normal well newborns. The appropriate codes are admission type “4”, admission source “1”, “4” or “9” and the appropriate primary diagnosis code UB-04 claims.
- For any bill of two or more pages, vendors submit a separate electronic record for each page. The total charge for the bill should be on the last record for the bill.
- All data submitted should be final data for a particular reporting period. Interim bills should be held until they can be combined and submitted as a final bill.
- Procedures performed within 72 hours prior to admission should be included as part of the record. Those performed earlier should be submitted as a separate record.
- Charity/free discharges are required to be reported. Physician ID numbers are required for the physicians involved in the management of the patient’s medical care.
- Satellite centers licensed under a parent center must file separate CMS-1500 or UB-04 claims data from the parent center. The claims data for a parent and its satellite should be submitted to the vendor as instructed by the vendor.

Data Editing and Quality Control

The vendor will review and edit data submitted to the Department. If errors or inconsistencies are identified when CMS-1500 or UB-04 data are edited, the vendor will report the errors to the appropriate center in writing. The center will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the center.

Default Values

Default values have been defined for some of the required fields that have proven to be problematic. The use of default values will prevent errors from being flagged when a required data item is unavailable or unknown. Default values for a field, if present, are given in the Data Dictionary for CMS-1500 in Section III.2 and for UB-04 in Section IV.2.

Required Fields

CMS-1500

The following fields are required to be reported for all CMS-1500 records:

- Patient's Birth Date
- Patient's Sex
- Patient's Address (State)
- Patient's Address (Zip-Code)
- Dates of Service (Through Date)
- Diagnosis
- Total \$ Charges
- Patient's Social Security Number
- Patient's Race/Ethnicity

UB-04

The following fields are required to be reported for all UB-04 records:

- Statement Covers Period
- Patient's Address (State)
- Patient's Address (Zip-Code)
- Patient's Date of Birth
- Patient's Sex
- Revenue Codes
- Total \$ Charges (By Revenue Code Category)
- Principal Diagnosis Code
- Patient's Social Security Number
- Patient's Race/Ethnicity

These “required fields” are those that we expect to be reported for all claims. Other fields are to be reported if they are reported to the payers.

Vendor Generated Fields

In addition the vendor will generate the Record ID (Field Numbers 1-8), the Payer Classification Codes and the person initial fields (CMS-1500: field numbers 131 – 136, UB-04: field numbers 248 – 255) for each record. The Ambulatory Surgical Treatment Centers must report sufficient information to the vendors to allow the generation of these codes. Optionally, the centers may elect to generate the codes.

Vendor Reporting Instructions

The Field Descriptions and the Layout give detailed information on how to fill out each field in the ASTC data record. The vendor should follow these instructions on how to create the data file. The purpose of this chapter is to explain the meaning of some of the instructions in the Field Descriptions and the Layout and to give some general instructions on creating the records.

As a general rule the data reported to the Tennessee Department of Health should be that required by the payer to whom the claim is submitted. Medicare, TennCare, private and other insurers vary somewhat in their required usage of the CMS-1500 or UB-04 form. The facilities should **follow the instructions of the insurer in submitting claims and put the same information in the data record submitted to the Department. The instructions given in this Manual are primarily given to standardize the format of the electronic record, not to specify field content, except for fields added for use by the Department.**

General

Each record is the electronic representation of one CMS-1500 or UB-04 form. It is a fixed format record, i.e. each field begins and ends in the same position in each and every record. All records, based on the same form, are the same length. Each record should end with a carriage return character and a line feed character. A group of electronic records transmitted together constitute a file. All the records for a quarter should be put together to be the quarterly reporting file. Once the facility IDs are added, records from different Ambulatory Surgical Treatment Centers can be in the same file. CMS-1500 and UB-04 records should always be submitted in separate files.

Most fields are character fields. Characters can be any valid ASCII character. They are generally numbers or letters of the alphabet, but can be special characters, such as commas, periods, colons, asterisks etc.

Some fields are numeric fields. These should generally only contain the ten digits: 0, and 1 through 9.

Justified Fields

Fields are said to be left-justified or right-justified. Left-justified means that the characters in the field begin in the first position of the field and continue until all the characters are used up. Generally the rest of the field is left blank.

Right-justified means that the characters are put into the field as far to the right as possible. The last character of the data is put into the last character of the field; the rest of the characters are put before in their normal order. When the beginning part of the field is unused, sometimes it will be left blank, but other times it will be zero-filled, i.e. all unused spaces before the data will be replaced with zeros.

Vendor Reporting Instructions (continued)

Implied Decimal Points

Decimal points often receive special treatment. In many fields the decimal point will be implied. This means that the decimal point is not written on the record, the position of the data on the record indicates where the decimal point is understood to be. If the amount is \$15,743.29 the ten digits in the field should be as follows:

0001574329

If no cents are given they should be replaced with two zeros. For example \$2,486 should be as follows:

0000248600

The other situation in which implied decimals are used is to fill in medical codes. These are generally given as character fields, left justified, blank filled, and with implied decimal point. For example, to put an ICD-9 code of 320.9 into a field with a length of six:

3209

The “3” is put into the first position of the field. The last two positions are left blank. It is important that any leading zeros of these codes be used because these codes are structured to have a fixed number of digits before the decimal point.

Date Fields

Date fields require some special explanations. All date fields on the Tennessee CMS-1500 and UB-04 ASTC file use the same format: MMDDCCYY.

The MM indicates the month. January is “01”, February is “02” etc. through December which is “12”.

DD indicates the day of the month. The fifth would be “05”, the sixteenth would be “16” etc.

CC indicates the century. Code it when given. Leave it blank if the century is not given. If the year is given as 2003, then code the century as “20”. If the year is given as 03, then code the century as blank.

YY indicates the year. Code 1948 as “48”. Code 2002 as “02”. Code 2001 as “01”. Code 1995 as “95”.

Vendor Reporting Instructions (continued)

Date Fields (continued)

For example suppose the given date is July 14, 2001. This should be coded as follows:

07142001

But if the century is not given, i.e. the given date is July 14, 01 the century would be left blank:

0714 01

Special Fields and Character Fields

For some fields special instructions are given. Follow those instructions as given in the Layout and Field Description. For example on the CMS-1500 file for Patient's Sex, put an "M" in the field if the M box is checked or an "F" if the F box is checked. If neither box is checked or if both boxes are checked the field should be coded as "U".

Many fields are left-justified character fields to enter such things as names, addresses, descriptions etc. Starting with the first position of the field, put in the appropriate data as it would be on the paper form.

Although a few fields on the form require special instructions (e.g. check boxes, amounts, dates) most fields should be filled as they would be on the paper CMS-1500 or UB-04 form.

CMS-1500 Data System Summary

Data Set Name: Ambulatory Surgical Treatment Center Data System (ASTC)

Location/Owner of Data Set: Tennessee Department of Health, Office of Health Statistics

System Administrator: George Wade (615) 532-7883

Purpose for Which Data Collected: This system collects and summarizes data so that charges for similar types of services may be analyzed and compared in order to help promote a more price competitive environment in the medical market place. This data also provides useful information for assessing the health status of Tennesseans.

Restrictions on Data Use: Confidential data is restricted and is not released or sold to the public. Non-confidential data can be sold to the public for research and commercial use.

Process for Accessing Data: Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or HealthStatistics.Health@tn.gov.

Description:

Method of Data Collection: CMS-1500 forms

Percent Return: 95% - 99%

Frequency of Updating: Annually

Years of Data: 2007, 2008, 2009, 2010 & 2011

Types of Data Output Available: Fixed format text files on CDs

Cost for Data Output: Yes

Standard Reports Generated: None currently

Current Data Elements:

Type of Insurance

Insured ID Number

Patient's Date of Birth and Patient's Sex

Patient's Address (City)

Patient's Address (State)

Patient's Address (Zip Code)

Patient's Relationship to Insured

Insured's Address (City)

Insured's Address (State)

Insured's Address (Zip Code)

Patient's Status (Marital)

Patient's Status (Employment)

Other Insured's Policy or Group Number

CMS-1500 Current Data Elements: (continued)

Insurance Plan or Program Name
Outside Lab
Outside Lab Charges
Patient's Condition Related to Employment
Patient's Condition Related to Auto Accident
Patient's Condition Related to Other Accident
Patient's Condition Related Place – State
Insured's Policy Group or FECA Number
Insured's Employer's or School Name
Insurance Plan or Program Name
Another Health Benefit Plan
Date of Current Illness or Injury / Pregnancy
First Date of Same or Similar Illness
Dates Patient Unable to Work – From and Through
ID of Referring Physician
NPI Number of Referring Physician
Hospitalization Dates Related to Current Services – From and Through
Diagnosis or Nature of Illness or Injury
Date(s) of Service – From and Through
Place of Service
Emergency Code
Procedures, Services or Supplies
Diagnosis Pointer
Charges
Days or Units EPSDT
Family Plan
Identification Qualifier
Rendering Provider Identification Number
Federal Tax ID Number
Federal Tax ID Number (SSN / EIN)
Patient's Account Number
Total Charges
Billing Provider NPI Number
Other Billing Provider Number
Patient Social Security Number
Patient's Race Ethnicity
Insurance Plan Program Classification Code (Primary)
Insurance Plan Program Classification Code (Other)
Patient Initials – First & Last Name
Primary Insured's Initials – First & Last Name
Secondary Insured's Initials – First & Last Name
Patient's Address – Street 1 & 2
Patient's Name – First & Last
Primary Insured' Name – First & Last
Secondary Insured's Name – First & Last

UB-04 Data System Summary

Data Set Name: Ambulatory Surgical Treatment Center Data System (ASTC)

Location/Owner of Data Set: Tennessee Department of Health, Office of Health Statistics

System Administrator: George Wade (615) 532-7883

Purpose for Which Data Collected: This system collects and summarizes data so that charges for similar types of services may be analyzed and compared in order to help promote a more price competitive environment in the medical market place. This data also provides useful information for assessing the health status of Tennesseans.

Restrictions on Data Use: Confidential data is restricted and is accessible only for approved research projects. This data may not be sold, transferred, or used for any purpose or purposes other than those stated in the approved request.

Process for Accessing Data: Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or HealthStatistics.Health@tn.gov.

Description:

Method of Data Collection: UB-04 forms

Percent Return: 95% - 99%

Frequency of Updating: Annually

Years of Data: 2007, 2008, 2009, 2010 & 2011

Types of Data Output Available: Fixed format text files on CDs

Cost for Data Output: Yes

Standard Reports Generated: None currently

UB-04 Data Elements: Patient

Control Number Medical/Health

Record Number Type of Bill

Federal Tax Sub ID Number

Federal Tax Number

Statement Covers Period – From and Through

Patient's Address – City

Patient's Address – State

Patient's Address – Zip Code

Patient's Address – Country Code

Patient's Date of Birth

Patient's Sex

UB-04 Data Elements: (continued)

Admission Date

Admission Hour
Type of Admission or Visit
Source of Admission
Patient Discharge Status
Do Not Resuscitate Flag
Accident State
Accident Code
Accident Date
Revenue Codes
HCPCS/Rates/HIPPS Rates Codes
Service Date(s)
Creation Date
Unit(s) of Service
Total Charges (by Revenue Code Category)
Non-Covered Charges (by Revenue Code Category)
Classification of Payer(s)
Health Plan ID (formerly Provider Number)
Patient's Relationship to Insured(s)
National Provider Identification (NPI)
Insured's Unique ID Number
Insurance Group Number(s)
Name of Insured's Employer
Diagnosis and Procedure Version Qualifier
Principal Diagnosis Code with POA
Other Diagnosis Codes with POA
Admitting Diagnosis Code
Patient Reason for Visit Code
Prospective Payment System (PPS)
External Cause of Injury Code (E-Code)
Attending Physician ID Numbers
Operating Physician ID Numbers
Other Provider1 ID Numbers
Other Provider2 ID Numbers
Patient's Social Security Numbers
Patient's Race/Ethnicity
Patient's Address – Street
Patient's Initials - First and Last Name
Primary Insured Initials – First and Last Name
Secondary Insured Initials – First and Last Name
Tertiary Insured Initials – First and Last Name

UB-04 Data Elements: (continued)

Patient's Name – First and Last

Primary Insured's Name – First and Last

Secondary Insured's Name – First and Last

Tertiary Insured's Name – First and Last

Condition Codes

Occurrence Codes

Occurrence Dates

Schedule of Data Submission

FROM ASTC TO VENDOR

Quarter	Time Span	ASTC Submission Deadline
Q1	January 1 – March 31	May 30
Q2	April 1 – June 30	August 30
Q3	July 1 – September 30	November 29
Q4	October 1 – December 31	March 1

The Vendor must receive all required data from the ASTC within 60 days following the close of the quarter.

FROM VENDOR TO DEPARTMENT OF HEALTH

Quarter	Time Span	Vendor Submission Deadline
Q1	January 1 – March 31	July 29
Q2	April 1 – June 30	October 28
Q3	July 1 – September 30	January 28
Q4	October 1 – December 31	May 1

All data submitted by a vendor must be in a format and medium approved by the Department of Health. The Department of Health must receive all required data from the Vendor 120 days following the close of the quarter.

Data reported to the Department by the vendor should be sent to:

Patient Record Data Systems
Office of Health Statistics
Cordell Hull Building
425 5th Avenue North, 6th Floor
Nashville, Tennessee 37243

Format for Data Submission

Data Submission to the Department of Health

Vendors will submit all data to the Department of Health in a format and medium approved by the Department.

Data Submission to the Vendor

Ambulatory Surgical Treatment Centers submitting data to the vendor should follow instructions provided by their own vendor.

PRDS Contacts

Technical questions regarding the Tennessee Patient Record Data Systems should be directed to:

George Wade
Manager, Patient Record Data Systems
Office of Health Statistics
(615) 532-7883
George.Wade@tn.gov

OR

Tanya Webster
Office of Health Statistics
(615)532-7869
Tanya.Y.Webster@tn.gov

SECTION III

CMS-1500 Data Dictionary

CMS-1500 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A: Alpha-Numeric	CMS-1500 Form Locator*	Page No.
1	Facility Type	A		27
2	Data Year	N		28
3	Vendor Identification No.	A		29
4	Bill Number	A		30
5	Record Sequence Number	A		31
6	Facility Identification Number	A		32
7	Filler	A		N/A
8	Form Type	A		33
9	Type of Insurance	A	Form Locator 1	34
10	Insured's ID Number	A	Form Locator 1A	35
11	Patient's Birth Date (DOB)	N	Form Locator 3	36
12	Patient's Sex	A	Form Locator 3	37
13	Patient's Address (City)	A	Form Locator 5	38
14	Patient's Address (State)	A	Form Locator 5	39
15	Patient's Address (Zip-Code)	A	Form Locator 5	40
16	Patient's Relationship to Insured	A	Form Locator 6	41
17	Insured's Address (City)	A	Form Locator 7	42
18	Insured's Address (State)	A	Form Locator 7	43
19	Insured's Address (Zip-Code)	A	Form Locator 7	44
20	Patient's Status (Marital)	A	Form Locator 8	45
21	Patient's Status (Employment)	A	Form Locator 8	46
22	Other Insured's Policy/Group Number	A	Form Locator 9A	47
23	Insurance Plan Name or Program Name(Other)	A	Form Locator 9D	48
24	Filler	A		N/A
25	Outside Lab?	A	Form Locator 20	49
26	Outside Lab Charges	N	Form Locator 20	50
27	Patient's Condition Related to Employment	A	Form Locator 10A	51
28	Patient's Condition Related to Auto Accident	A	Form Locator 10B	52

CMS-1500 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A: Alpha-Numeric	CMS-1500 Form Locator*	Page No.
29	Patient's Condition Related to Other Accident	A	Form Locator 10C	53
30	Patient's Condition Related Place (State)	A	Form Locator 10B	54
31	Insured's Policy, Group, or FECA Number	A	Form Locator 11	55
32	Insured's Employer/School Name	A	Form Locator 11B	56
33	Insurance Plan Name or Program Name (Primary)	A	Form Locator 11C	57
34	Another Health Benefit Plan	A	Form Locator 11D	58
35	Date of Current Illness, Injury, Pregnancy	N	Form Locator 14	59
36	First Date Patient Has Had Same or Similar Illness	N	Form Locator 15	60
37	Dates Patient Unable to Work (From Date)	N	Form Locator 16	61
38	Dates Patient Unable to Work (Through Date)	N	Form Locator 16	62
39	ID Number of Referring Physician	A	Form Locator 17A	63
40	National Provider Identification (NPI) Number of Referring Physician	A	Form Locator 17 B	64
41	Hospitalization Related Current SVCS (From Date)	N	Form Locator 18	65
42	Hospitalization Related Current SVCS (Through Date)	N	Form Locator 18	66
43 – 46	Diagnosis or Nature of Illness or Injury Code	A	Form Locator 21	67
47 – 52	Dates of Service (From Date)	N	Form Locator 24A	68
53 -58	Dates of Service (Through Date)	N	Form Locator 24A	69
59 – 64	Place of Service	A	Form Locator 24B	70
65 – 70	Emergency (EMG)	A	Form Locator 24C	71

CMS-1500 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A: Alpha-Numeric	CMS-1500 Form Locator*	Page No.
71 – 76	Procedures, Services & Supplies	A	Form Locator 24D	72
77 – 82	Diagnosis Pointer	A	Form Locator 24E	73
83 – 88	Charges	N	Form Locator 24F	74
89 – 94	Days or Units	A	Form Locator 24G	75
95 – 100	Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Family Plan	A	Form Locator 24H	76
101 – 106	ID Qualifier	A	Form Locator 24I	77
107 – 112	Rendering Provider ID. No.	A	Form Locator 24J	78
113 – 118	Rendering Provider NPI. No.	A	Form Locator 24J	79
119	Federal Tax ID Number	A	Form Locator 25	80
120	Federal Tax ID Number (SSN)	A	Form Locator 25	81
121	Federal Tax ID Number (EIN)	A	Form Locator 25	82
122	Patient's Account Number	A	Form Locator 26	83
123	Total \$Charges	N	Form Locator 28	84
124	Billing Provider NPI Number	A	Form Locator 33A	85
125	Billing Provider Other ID Number	A	Form Locator 33B	86
126	Patient's Social Security Number	A		87
127	Patient's Race/Ethnicity	A		88
128	Insurance Plan or Program Payer Classification Code	A		89 – 90
129	Insurance Plan or Program Payer Classification Code (Other)	A		91 – 92
130	Encryption Key	A		N/A
131	Patient Initials – First Name	A		93
132	Patient Initials – Last Name	A		94
133	Primary Insured's Initials – First Name	A		95

CMS-1500 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A: Alpha-Numeric	CMS-1500 Form Locator*	Page No.
134	Primary Insured's Initials – Last Name	A		96
135	Secondary Insured Initials – First Name	A		97
136	Secondary Insured Initials – Last Name	A		98
137 – 138	Vendor and State Generated Fields	A		N/A
139	Patient's Address (Street 1)	A	Form Locator 5	99
140	Patient's Address (Street 2)	A	Form Locator 5	100
141	Patient's First Name	A	Form Locator 2	101
142	Patient's Last Name	A	Form Locator 2	102
143	Primary Insured's First Name	A	Form Locator 4	103
144	Primary Insured's Last Name	A	Form Locator 4	104
145	Secondary Insured's First Name	A	Form Locator 9	105
146	Secondary Insured's Last Name	A	Form Locator 9	106

* A number that specifies the location of the data field on the paper CMS-1500 form.

A-N= Alpha Numeric
N= Numeric

CMS-1500 Data Dictionary

Field No.	Field Description
1	Facility Type

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	1-1	N/A	Yes	

Description:

This code is used to identify what facility type the data was submitted from.

A = Ambulatory Surgical Treatment Center

I = Hospital Inpatient

O = Hospital Outpatient

D = Outpatient Diagnostic Center

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
2	Data Year

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	4	2-5	Right Justified	Yes	

Description:

Records the year of the data using the format CCYY.

This data element used to determine the year of the data submitted. (It is part of the unique bill ID and the unique record ID.)

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
3	Vendor Identification Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	6 – 7	Left Justified	Yes	

Description:

This is used to identify the Vendor that has been chosen by the State to process ASTC data. It is assigned by the Department for each Vendor's as its unique ID. (It is a part of the unique bill ID and the unique record ID.)

Vendor Name	Vendor ID
Practice Resource Network, Inc	1V
Tennessee Hospital Association	2V
System13, Inc.	3V

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
4	Bill Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha -Numeric	7	8 – 14	Left Justified	Yes	

Description:

This is the value assigned by the Vendor to identify this particular bill. It must be a unique value for that vendor and data year. (It is part of the unique bill ID and the unique record ID.)

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
5	Record Sequence Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha Numeric	2	15 – 16	Left Justified	Yes	--

Description:

Identifies the logical record if more than one is needed to contain all the billing information.

00 = Only record of a one-record bill.

01 = First record of a multi-record bill.

02 – 97 = Nth record of a multi-record bill, except for the last record.

98 = 98th + record of a multi-record bill, except for the last record.

99 = Last record of a multi-record bill.

(It is part of the unique record ID.)

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
6	Facility Identification Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	5	17 – 21	Left Justified	Yes	--

Description:

The five (5) digit number assigned to each Ambulatory Surgical Treatment Center by the State of Tennessee.

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
8	Form Type

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	24 – 25	Left Justified	Yes	--

Description:

Indicates what form was used to submit data to the Vendor from the Ambulatory Surgical Treatment Center.

Form: CMS-1500 = 1
 UB-04 = 3

Type: Paper = 0
 HIPAA* = 1
 TDH File Layout = 2
 Other Electronic = 9

This is a two digit field with Form being the first digit and Type being the second digit. Example: The code for a paper submission for a CMS-1500 form would be “10”. The first digit (1) indicates the Form (CMS-1500), the second digit (0) indicates the Type (paper).

For Vendor use only.

***837 Professional 40/DA1 or revised specification**

CMS-1500 Data Dictionary

Field No.	Field Description
9	Type of Health Insurance

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	26 – 26	N/A	Yes	1

Description:

The type of payer organization from which the ASTC first expects some payment for the insurance bill.

Comments:

Listed below are the Valid Value Codes that should be used for the Type of Insurance that the patient will be using.

Valid Values Codes	Field Name	CMS-1500 Form Locator Number	ASTC File Positions
1	Medicare	1	26 – 26
2	Medicaid	1	
3	Tricare Champus	1	
4	Champva	1	
5	Group Health Plan	1	
6	FEC BLK Lung	1	
7	Other	1	

CMS-1500 Data Dictionary

Field No.	Field Description
10	Insured's ID Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	29	27 – 55	Left Justified	Yes	1-A

Description:

Put ID number of individual whose insurance is used. This should correspond to Type of Insurance, Form Locator 1.

Comments:

If TennCare is patient's primary insurance, provide the TennCare enrollee patient identification number for the HMO/BHO being billed from the enrollment materials provided the enrollee, i.e., ID card, etc. Otherwise provide the appropriate ID number for the insured individual.

CMS-1500 Data Dictionary

Field No.	Field Description
11	Patient's Date of Birth (DOB)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	56 – 63	Right Justified	Yes	3

Description:

Record the patient's date of birth using the format MMDDCCYY.

Use leading zeroes when appropriate.

If the century is not specified leave the CC blank.

Comments:

This data element is used to determine the age of the patient.

CMS-1500 Data Dictionary

Field No.	Field Description
12	Patient's Sex

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	64 – 64	N/A	Yes	3

Description:

Enter the sex of the patient according to the following codes:

M=Male

F=Female

U=Unknown

CMS-1500 Data Dictionary

Field No.	Field Description
13	Patient's Address (City)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	65 – 94	Left Justified	Yes	5

Description:

The patient's city address as defined by the payer organization.

CMS-1500 Data Dictionary

Field No.	Field Description
14	Patient's Address (State)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	95 – 98	Left Justified	Yes	5

Description:

The patient's state address as defined by the payer organization.

Use valid U.S. Postal Codes. Refer to **Section V.4, Appendices** in the back of this manual.

CMS-1500 Data Dictionary

Field No.	Field Description
15	Patient's Address (Zip Code)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	12	99 – 110	Left Justified	Yes	5

Description:

The patient's zip code as defined by the payer organization.

CMS-1500 Data Dictionary

Field No.	Field Description
16	Patient's Relationship to Insured

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	111 – 111	N/A	Yes	6

Description:

The Valid Value Code number below indicates the relationship of the patient to the insured individual.

Listed below are the valid values for this field.

Valid Values:

Valid Value Code	Type	Description
1	Self	Self-explanatory
2	Spouse	Self-explanatory
3	Child	Self-explanatory
4	Other	Self-explanatory

CMS-1500 Data Dictionary

Field No.	Field Description
17	Insured's Address (City)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	112 – 141	Left Justified	Yes	7

Description:

The insured's city as defined by the payer organization.

Comments:

Enter the city of the insured individual. If the city is the same as the patient's the word "Same" may be used to indicate this.

CMS-1500 Data Dictionary

Field No.	Field Description
18	Insured's Address (State)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	142 – 145	Left Justified	Yes	7

Description:

The insured's state as defined by the payer organization.

Use valid U.S. Postal Codes. Refer to **pg. 236** in back of this manual.

CMS-1500 Data Dictionary

Field No.	Field Description
19	Insured's Address (Zip Code)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	12	146 – 157	Left Justified	Yes	7

Description:

The insured's zip code as defined by the payer organization.

Comments:

Enter the zip code of the insured individual. If the zip code is the same as the patient's the word "Same" may be used to indicate this.

CMS-1500 Data Dictionary

Field No.	Field Description
20	Patient's Status (Marital)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	158 – 158	N/A	Yes	8

Description:

This code is used to define the marital status of the patient who is insured. The Valid Value Code assigned reflects the marital status of the patient as identified in Form Locator 8.

This data is used for statistical analysis.

Valid Values:

Valid Value Codes	Marital Status	Description
1	Single	Self-explanatory Self-explanatory Divorced, Widowed, etc.
2	Married	
3	Other	

CMS-1500 Data Dictionary

Field No.	Field Description
21	Patient's Status (Employment)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	159 – 159	N/A	Yes	8

Description:

This code is used to define the employment status of the individual who is insured. (This person may or may not be the patient). The code assigned reflects the employment status of the individual identified in Form Locator 8. This field may be left blank if information is not captured.

This data is used for statistical analysis.

Valid Values:

Valid Value Codes	Employment Status	Description
1	Employed	Insured is employed full time.
2	Full-time Student	Insured is a full-time student.
3	Part-time Student	Insured is a part-time student.

CMS-1500 Data Dictionary

Field No.	Field Description
22	Other Insured's Policy/GRP Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	160 – 189	Left Justified	Yes	9-A

Description:

Enter the policy or group number of the other insurance coverage for the enrollee. If the patient does not have other insurance coverage, leave this item blank.

Comments:

If the patient does not have other coverage, this item may be left blank.

CMS-1500 Data Dictionary

Field No.	Field Description
23	Insurance Plan Name or Program Name (Other)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	190 – 219	Left Justified	Yes	9-D

Description:

Enter the name of the other insured's health insurance plan or program. This is for the person shown in Form Locator 9.

Comments:

If the patient does not have other coverage, this item may be left blank.

CMS-1500 Data Dictionary

Field No.	Field Description
25	Outside Lab?

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	240 – 240	N/A	Yes	20

Description:

This field is used to indicate if a service was performed by an entity other than the billing provider.

Use the valid codes indicated below:

Y = Yes

N = No

CMS-1500 Data Dictionary

Field No.	Field Description
26	Outside Lab Charges

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	9	241 - 249	Right Justified	Yes	20

Description:

Charges indicate that services have been rendered by an independent provider.

CMS-1500 Data Dictionary

Field No.	Field Description
27	Patient's Condition Related to Employment

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	250 - 250	N/A	Yes	10-A

Description:

This code indicates if patient's condition is related to his or her employment and is applicable to one or more services described in Form Locator 24-D.

Use the Valid Codes indicated below:

Y=Yes

N=No

CMS-1500 Data Dictionary

Field No.	Field Description
28	Patient's Condition Related to Auto Accident

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	251 – 251	N/A	Yes	10-B

Description:

This code indicates if the patient's injury or illness is related to an automobile accident.

Use the Valid Codes indicated below:

Y=Yes

N=No

CMS-1500 Data Dictionary

Field No.	Field Description
29	Patient's Condition Related to Other Accident

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	252 – 252	N/A	Yes	10-C

Description:

This code indicates if the patient's condition is related to other accidents, i.e. those unrelated to employment or automobiles.

Use the Valid Codes indicated below:

Y=Yes

N=No

CMS-1500 Data Dictionary

Field No.	Field Description
30	Patient's Condition Related Place (State)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	253 – 254	Left Justified	Yes	10-B

Description:

This code indicates the state the auto accident occurred. It should be given if Field No. 28 has a value of "Y".

Comments:

Use valid U.S. Postal Codes. Refer to **Appendices Section V.4**, in the back of this manual.

CMS-1500 Data Dictionary

Field No.	Field Description
31	Insured's Policy, Group or FECA Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	255 – 284	Left Justified	Yes	11

Description:

The insured's policy, group or FECA number indicated in Form Locator 11.

CMS-1500 Data Dictionary

Field No.	Field Description
32	Insured's Employer/School Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	285 – 314	Left Justified	Yes	11-B

Description:

Enter the name of the employer or school of the insured as given.

CMS-1500 Data Dictionary

Field No.	Field Description
33	Insurance Plan Name or Program Name (Primary)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	315 – 344	Left Justified	Yes	11-C

Description:

Enter name of the insured's health plan or program.

CMS-1500 Data Dictionary

Field No.	Field Description
34	Another Health Benefit Plan

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	345 – 345	N/A	Yes	11-D

Description:

Use the codes below to indicate if patient is covered by another health plan:

Y=Yes

N=No

CMS-1500 Data Dictionary

Field No.	Field Description
35	Date of Current Illness, Injury, Pregnancy

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	346 – 353	Right Justified	Yes	14

Description:

Record the patient's date of current illness, injury or pregnancy by using the format MMDDCCYY.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
36	First Date Patient Had Same or Similar Illness

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	354 – 361	Right Justified	Yes	15

Description:

Record the first date patient had same or similar illness with format MMDDCCYY.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
37	Dates Patient Unable to Work (From Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	362 – 369	Right Justified	Yes	16

Description:

Record the beginning date patient unable to work by using the format MMDDCCYY.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
38	Dates Patient Unable to Work (Through Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	370 – 377	Right Justified	Yes	16

Description:

Record the last date patient unable to work by using the format MMDDCCYY.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
39	ID Number of Referring Provider

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	25	378 – 402	Left Justified	Yes	17-A

Description:

This item contains the qualifier code and ID Number of the referring or ordering provider listed in Form Locator 17-A.

The first two (378 -379) characters represent the qualifier codes listed below. The remaining (380 – 402) characters represent the Other ID number of the referring or ordering physician.

Valid Code	Description
0B	State License Number
1B	Blue Shield Provider Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
E1	Employer's Identification Number
G2	Provider Commercial Number
LU	Location Number
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare.)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy

CMS-1500 Data Dictionary

Field No.	Field Description
40	NPI Number of Referring Provider

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	10	403 – 412	Left Justified	Yes	17-B

Description:

Enter the NPI number of referring physician or provider as given in FL 17-B. The NPI number refers to the HIPAA National Provider Identifier number. The NPI is assigned to the physician by CMS.

CMS-1500 Data Dictionary

Field No.	Field Description
41	Hospitalization Related Current SVCS (From Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	413 – 420	Right Justified	Yes	18

Description:

Enter the admission date of any related hospitalization using the MMDDCCYY format.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
42	Hospital Related Current SVCS (Through Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	421 – 428	Right Justified	Yes	18

Description:

Enter the discharge date of any related hospitalization using the MMDDCCYY format.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

CMS-1500 Data Dictionary

Field No.	Field Description
43 – 46	Diagnosis or Nature of Illness or Injury Code

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	8	429 - 460	Left Justified	Yes	21

Description:

Diagnosis or nature of illness or injury (1-8): ICD-9-CM diagnosis code.

Diagnosis code has implied decimal point. Include any leading zeroes.

E codes and V codes are valid values.

Valid Codes:

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
43	Diagnosis or Nature of Illness or Injury Code (1)	Line – 1	429 – 436
44	Diagnosis or Nature of Illness or Injury Code (2)	Line – 2	437 – 444
45	Diagnosis or Nature of Illness or Injury Code (3)	Line – 3	445 – 452
46	Diagnosis or Nature of Illness or Injury Code (4)	Line – 4	453 – 460

CMS-1500 Data Dictionary

Field No.	Field Description
47 – 52	Dates of Service (From Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	461 – 508	Right Justified	Yes	24-A

Description:

Enter the beginning date of service using the MMDDCCYY format.

Use leading zero's when appropriate.

If the century is not specified leave the CC as blank.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
47	Dates of Service (From Date) (1)	Line – 1	461 – 468
48	Dates of Service (From Date) (2)	Line – 2	469 – 476
49	Dates of Service (From Date) (3)	Line – 3	477 – 484
50	Dates of Service (From Date) (4)	Line – 4	485 – 492
51	Dates of Service (From Date) (5)	Line – 5	493 – 500
52	Dates of Service (From Date) (6)	Line – 6	501 – 508

CMS-1500 Data Dictionary

Field No.	Field Description
53 – 58	Dates of Service (Through Date)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	8	509 – 556	Right Justified	Yes	24-A

Description:

Enter the ending date of service using the MMDDCCYY format.

Use leading zeroes when appropriate.

If the century is not specified leave the CC as blank.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
53	Dates of Service (Through Date) (1)	Line – 1	509 – 516
54	Dates of Service (Through Date) (2)	Line – 2	517 – 524
55	Dates of Service (Through Date) (3)	Line – 3	525 – 532
56	Dates of Service (Through Date) (4)	Line – 4	533 – 540
57	Dates of Service (Through Date) (5)	Line – 5	541 – 548
58	Dates of Service (Through Date) (6)	Line – 6	549 – 556

CMS-1500 Data Dictionary

Field No.	Field Description
59 – 64	Place of Service

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	557 – 568	Left Justified	Yes	24-B

Description:

This item indicates the site of service where services were rendered or an item was utilized. Use the code as indicated by provider.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
59	Place of Service (1)	Line – 1	557 – 558
60	Place of Service (2)	Line – 2	559 – 560
61	Place of Service (3)	Line – 3	561 – 562
62	Place of Service (4)	Line – 4	563 – 564
63	Place of Service (5)	Line – 5	565 – 566
64	Place of Service (6)	Line – 6	567 – 568

CMS-1500 Data Dictionary

Field No.	Field Description
65 – 70	Emergency (EMG)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	569 – 580	Left Justified	Yes	24-C

Description:

Put appropriate code as reported to payer.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
65	Emergency (EMG) 1	Line – 1	569 – 570
66	Emergency (EMG) 2	Line – 2	571 – 572
67	Emergency (EMG) 3	Line – 3	573 – 574
68	Emergency (EMG) 4	Line – 4	575 – 576
69	Emergency (EMG) 5	Line – 5	577 – 578
70	Emergency (EMG) 6	Line – 6	579 – 580

CMS-1500 Data Dictionary

Field No.	Field Description
71 - 76	Procedures, Services & Supplies

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	14	581 – 664	Left Justified	Yes	24-D

Description:

Procedures, services, or supplies (1-12): Put CPT/HCPCS code in the first six spaces of the field. Up to four two-digit modifiers may follow. The HCPCS/CPT code is to be left justified in the first 5 positions which would always leave the 6th position blank. Positions 7-14 of each of these fields are to be used to capture up to 4 2-digit modifiers for the code that is reported in the first 5 positions.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
71	Procedures, Services & Supplies (1)	Line – 1	581 – 594
72	Procedures, Services & Supplies (2)	Line – 2	595 – 608
73	Procedures, Services & Supplies (3)	Line – 3	609 – 622
74	Procedures, Services & Supplies (3)	Line – 4	623 – 636
75	Procedures, Services & Supplies (4)	Line – 5	637 – 650
76	Procedures, Services & Supplies (6)	Line – 6	651 – 664

CMS-1500 Data Dictionary

Field No.	Field Description
77 – 82	Diagnosis Pointer

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	665 – 688	Left Justified	Yes	24-E

Description:

Diagnosis Pointer code (1-12): Put Diagnosis Pointer code. These refer to the diagnosis codes in Field Numbers 43 – 46.

Field Number	Name/ Description	CMS-1500 Form Locator	ASTC File Positions
77	Diagnosis Pointer (1)	Line – 1	665 – 668
78	Diagnosis Pointer (2)	Line – 2	669 – 672
79	Diagnosis Pointer (3)	Line – 3	673 – 676
80	Diagnosis Pointer (4)	Line – 4	677 – 680
81	Diagnosis Pointer (5)	Line – 5	681 – 684
82	Diagnosis Pointer (6)	Line – 6	685 – 688

CMS-1500 Data Dictionary

Field No.	Field Description
83 – 88	Charges

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	10	689 – 748	Right Justified	Yes	24-F

Description:

Charges (1-12): Put charges. This field is right justified and zero filled. Negative value signs are in the first position when present. Charges have an implied decimal point.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
83	Charges (1)	Line – 1	689 – 698
84	Charges (2)	Line – 2	699 – 708
85	Charges (3)	Line – 3	709 – 718
86	Charges (4)	Line – 4	719 – 728
87	Charges (5)	Line – 5	729 – 738
88	Charges (6)	Line – 6	739 – 748

Example:

\$1487.07 = 0000148707

-\$955.00 = -000095500

CMS-1500 Data Dictionary

Field No.	Field Description
89 – 94	Days or Units

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	3	749 – 766	Left Justified	Yes	24-G

Description:

Enter the number of days or units. Use a decimal point if reporting a fraction of a unit.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
89	Days or Units (1)	Line – 1	749 – 751
90	Days or Units (2)	Line – 2	752 – 754
91	Days or Units (3)	Line – 3	755 – 757
92	Days or Units (4)	Line – 4	758 – 760
93	Days or Units (5)	Line – 5	761 – 763
94	Days or Units (6)	Line – 6	764 – 766

Comments:

Report the same information as submitted by provider.

CMS-1500 Data Dictionary

Field No.	Field Description
95 – 100	Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Family Plan

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	3	767 – 784	Left Justified	Yes	24-H

Description:

Put appropriate code as reported to payer. Enter the information from the shaded portion in the first two spaces of the field. Enter the information from the un-shaded portion in the third space of the field.

Field Number	Name/Description	CMS-1500 Form Locator	ASTC File Positions
95	EPSDT Family Plan (1)	Line – 1	767 – 769
96	EPSDT Family Plan (2)	Line – 2	770 – 772
97	EPSDT Family Plan (3)	Line – 3	773 – 775
98	EPSDT Family Plan (4)	Line – 4	776 – 778
99	EPSDT Family Plan (5)	Line – 5	779 – 781
100	EPSDT Family Plan (6)	Line – 6	782 – 784

CMS-1500 Data Dictionary

Field No.	Field Description
101 – 106	ID Qualifier

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	785 – 796	Left Justified	Yes	24-I

Description:

Put appropriate code as reported to payer. This code identifies the type of ID number (e.g. UPIN, state license number) used in the corresponding Field in 24-J

Field Number	Name/ Description	CMS 1500 Form Locator	ASTC File Positions
101	ID Qualifier (1)	Line – 1	785 – 786
102	ID Qualifier (2)	Line – 2	787 – 788
103	ID Qualifier (3)	Line – 3	789 – 790
104	ID Qualifier (4)	Line – 4	791 – 792
105	ID Qualifier (5)	Line – 5	793 – 794
106	ID Qualifier (6)	Line – 6	795 – 796

Valid Code	Description
0B	State License Number
1B	Blue Shield Provider Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
E1	Employer’s Identification Number
G2	Provider Commercial Number
LU	Location Number
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare.)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy

CMS-1500 Data Dictionary

Field No.	Field Description
107 – 112	Rendering Provider ID Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	11	797 – 862	Left Justified	Yes	24-J

Description:

Put appropriate ID code as reported to payer. The corresponding ID Qualifier (24-I) identifies the type of ID number used here.

Field Number	Name/ Description	CMS-1500 Form Locator	ASTC File Positions
107	Rendering Provider ID Number (1)	Line – 1	797 – 807
108	Rendering Provider ID Number (2)	Line – 2	808 – 818
109	Rendering Provider ID Number (3)	Line – 3	819 – 829
110	Rendering Provider ID Number (4)	Line – 4	830 – 840
111	Rendering Provider ID Number (5)	Line – 5	841 – 851
112	Rendering Provider ID Number (6)	Line – 6	852 – 862

CMS-1500 Data Dictionary

Field No.	Field Description
113 – 118	Rendering Provider NPI Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	10	863 - 922	Left Justified	Yes	24-J

Description:

Put appropriate NPI number as reported to payer.

Field Number	Name/ Description	CMS-1500 Form Locator	ASTC File Positions
113	Rendering Provider NPI Number (1)	Line – 1	863 – 872
114	Rendering Provider NPI Number (2)	Line – 2	873 – 882
115	Rendering Provider NPI Number (3)	Line – 3	883 – 892
116	Rendering Provider NPI Number (4)	Line – 4	893 – 902
117	Rendering Provider NPI Number (5)	Line – 5	903 – 912
118	Rendering Provider NPI Number (6)	Line – 6	913 – 922

CMS-1500 Data Dictionary

Field No.	Field Description
119	Federal Tax ID Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	15	923 – 937	Left Justified	Yes	25

Description:

Enter the federal tax identification number of the physician or supplier.

CMS-1500 Data Dictionary

Field No.	Field Description
120	Federal Tax ID Number (SSN)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	938 – 938	N/A	Yes	25

Description:

Designate Field Number 120 as an SSN by placing an “S” in this field.

CMS-1500 Data Dictionary

Field No.	Field Description
121	Federal Tax ID Number (EIN)

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	1	939 – 939	N/A	Yes	25

Description:

Designate Field Number 121 as EIN by placing an “E” in this field.

CMS-1500 Data Dictionary

Field No.	Field Description
122	Patient's Account Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	15	940 – 954	Left Justified	Yes	26

Description:

The patient's account number assigned by the physician's or supplier's accounting system should be entered here.

CMS-1500 Data Dictionary

Field No.	Field Description
123	Total Charges

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Numeric	10	955 – 964	Right Justified	Yes	28

Description:

Enter the total charges here. This field is right justified and zero filled. Negative value signs are in the first position when present. Total Charges has an implied decimal point. If more than 6 procedures/services/charges are submitted, this field will be left **blank** on the first form. A second form must be populated with the additional procedures/services/charges (plus all of the other information) and then the total of ALL charges (from both forms) will be entered in this field on the SECOND record. This is called a continuation record.

Example:

\$14,743.98 = 0001474398
-\$850.00 = -000085000

CMS-1500 Data Dictionary

Field No.	Field Description
124	Billing Provider NPI Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	10	965 – 974	Left Justified	Yes	33a

Description:

Enter the NPI number of the billing provider.

CMS-1500 Data Dictionary

Field No.	Field Description
125	Billing Provider Other ID Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	20	975 – 994	Left Justified	Yes	33b

Description:

The non-NPI ID number of the billing providers. The ID qualifier is put into the first two spaces of the field. The ID number begins in the third space (position 977).

Valid Code	Description
0B	State License Number
1B	Blue Shield Provider Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
E1	Employer's Identification Number
G2	Provider Commercial Number
LU	Location Number
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare.)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy

CMS-1500 Data Dictionary

Field No.	Field Description
126	Patient's Social Security Number

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	10	995 - 1004	Left Justified	Yes	N/A

Description:

Enter the social security number of the patient. If patient has no social security number or does not report it, code the field as "999999999".

Include any leading zeroes.

CMS-1500 Data Dictionary

Field No.	Field Description
127	Patient's Race/Ethnicity

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	1005-1006	Left Justified	Yes	N/A

Description:

Enter patient's race and ethnicity (2 parts). Put code for race in position 1005. Put code for ethnicity in position 1006.

Valid Codes:

Valid Code	Description (Race)	ASTC File Position
1	White	1005
2	Black	
3	American Indian, Eskimo, or Aleut	
4	Asian or Pacific Islander	
5	Other Race	
9	Unknown Race	

Valid Code	Description (Ethnicity)	ASTC File Position
1	Hispanic Origin	1006
2	Not Hispanic Origin	
9	Unknown if of Hispanic Origin	

Comments:

The Patient's Race/Ethnicity field is for statistical and epidemiological purposes only. Staff assessment of its value is sufficient.

CMS-1500 Data Dictionary

Field No.	Field Description
128	Insurance Plan or Program Payer Classification Code - Primary

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	1007-1010	Left Justified	Yes	Vendor Generated Field

Description:

The Code for the name or type of payer organization from which the ASTC might expect some payment for the bill.

The CMS-1500 form has one line for Form Locator 11C. This line represents the payer as primary.

This data is used to identify and analyze data for a particular payer and to analyze ASTC case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (<u>not</u> managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (<u>not</u> TennCare – see TennCare codes below)
I	Commercial Insurance (<u>not</u> managed care)
M	Medicare (<u>not</u> managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self-Pay
S	Self-Insured, Self-Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
<u>TennCare Codes</u>	
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State’s TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO)

CMS-1500 Data Dictionary

Field No.	Field Description
128	Insurance Plan or Program Payer Classification Code - Primary (continued from previous page)

Valid Values

Code	Payer Classification
E	<u>TennCare Behavioral Codes</u> BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	<u>Blue Cross Managed Care – HMO/PPO/Other Managed Care</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	<u>Commercial (Managed Care – HMO/PPO/Other Managed Care)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	<u>Medicare (HMO/PSO)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
129	Insurance Plan or Program Payer Classification Code - Other

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	1011-1014	Left Justified	Yes	Vendor Generated Field

Description:

The code for the name or type of payer organization from which the ASTC might expect some payment for the bill. **Many bills will lack other or secondary payer; this field will then be blank.**

The CMS-1500 form has one line for FL-9D. This line represents the payer as other or secondary.

This data is used to identify and analyze data for a particular payer and to analyze ASTC case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (<u>not</u> managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (<u>not</u> TennCare – see TennCare codes below)
I	Commercial Insurance (<u>not</u> managed care)
M	Medicare (<u>not</u> managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self-Pay
S	Self-Insured, Self-Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
<u>TennCare Codes</u>	
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State’s TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO)

CMS-1500 Data Dictionary

Field No.	Field Description
129	Insurance Plan or Program Payer Classification Code - Other (continued from previous page)

Valid Values

Code	Payer Classification
	<u>TennCare Behavioral Codes</u>
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	<u>Blue Cross Managed Care – HMO/PPO/Other Managed Care</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	<u>Commercial (Managed Care – HMO/PPO/Other Managed Care)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	<u>Medicare (HMO/PSO)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
131	Patient's Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	1055-1056	Left Justified	Yes	NA

Description:

Enter the first two letters of the patient's first name as given in FL 2. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = JO

T Anthony Jones = T

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
132	Patient's Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	1057-1060	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the patient's last name as given in FL 2. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
133	Primary Insured's Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	1061-1062	Left Justified	Yes	NA

Description:

Enter the first two letters of the primary insured's first name as given in FL 4. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = JO

Thony Jones = T

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
134	Primary Insured's Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	1063-1066	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the primary insured's last name as given in FL 4. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor Use only.

CMS-1500 Data Dictionary

Field No.	Field Description
135	Secondary Insured's Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	2	1067-1068	Left Justified	Yes	NA

Description:

Enter the first two letters of the secondary insured's first name as given in FL 9. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = JO

T Anthony Jones = T

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
136	Secondary Insured's Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	4	1069-1072	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the secondary insured's last name as given in FL 9. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

CMS-1500 Data Dictionary

Field No.	Field Description
139	Patient's Address Street – Line 1

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	40	1241-1280	Left Justified	Yes	FL - 5

Description:

Enter the first line of the Street Address of the patient. This information will be used by the Tennessee Department of Health for coding data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
140	Patient's Address Street – Line 2

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	40	1281-1320	Left Justified	Yes	FL - 5

Description:

Enter the second line of the Street Address of the patient. If there is no data, this field may be left blank. This information will be used by the Tennessee Department of Health for coding data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
141	Patient's First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	20	1321-1340	Left Justified	Yes	FL - 2

Description:

Enter the patient's first name as given in FL 2. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
142	Patient's Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	1341-1370	Left Justified	Yes	FL - 2

Description:

Enter the patient's last name as given in FL 2. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
143	Primary Insured's First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	20	1371-1390	Left Justified	Yes	FL - 4

Description:

Enter the first name of the Insured as given in FL 4. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
144	Primary Insured's Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	1391-1420	Left Justified	Yes	FL - 4

Description:

Enter the last name of the Insured as given in FL 4. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
145	Secondary Insured's First Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	20	1421-1440	Left Justified	Yes	FL - 9

Description:

Enter the first name of the Insured as given in FL 9. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 Data Dictionary

Field No.	Field Description
146	Secondary Insured's Last Name

Field Detail:

Field Type	Width	Position	Format	Required	CMS-1500 Form Locator
Alpha-Numeric	30	1441-1470	Left Justified	Yes	FL - 9

Description:

Enter the last name of the Insured as given in FL 9. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

CMS-1500 DATA RECORD FORMAT
(1470 Byte Record Length)

Field No.	Field Description	P C Format	Field Length	Position From	Position Thru
1	Facility Type	A-N	1	1	1
2	Data Year	N	4	2	5
3	Vendor Identification Number	A-N	2	6	7
4	Bill Number	A-N	7	8	14
5	Record Sequence Number	A-N	2	15	16
6	Facility Identification Number	A-N	5	17	21
7	Filler	A-N	2	22	23
8	Form Type	A-N	2	24	25
9	Type of Health Insurance	A-N	1	26	26
10	Insured's ID Number	A-N	29	27	55
11	Patient's Birth Date (DOB) MMDDCCYY	N	8	56	63
12	Patient's Sex-Male/Female/Other	A-N	1	64	64
13	Patient's Address (City)	A-N	30	65	94
14	Patient's Address (State)	A-N	4	95	98
15	Patient's Address (Zip code)	A-N	12	99	110
16	Patient's Relationship to Insured	A-N	1	111	111
17	Insured's Address (City)	A-N	30	112	141
18	Insured's Address (State)	A-N	4	142	145
19	Insured's Address (Zip Code)	A-N	12	146	157
20	Patient Status (Marital)	A-N	1	158	158
21	Patient Status (Employment)	A-N	1	159	159
22	Other Insured's Policy/GRP Number	A-N	30	160	189
23	Insurance Plan Name or Program Name	A-N	30	190	219
24	Filler	A-N	20	220	239
25	Outside Lab	A-N	1	240	240
26	Outside Lab Charges	N	9	241	249
27	Patient's Condition Related to Employment	A-N	1	250	250
28	Patient's Condition Related to Auto Accident	A-N	1	251	251
29	Patient's Condition Related to Other Accident	A-N	1	252	252
30	Patient's Condition Related Place (State)	A-N	2	253	254

CMS-1500 DATA RECORD FORMAT
(1470 Byte Record Length)

Field No.	Field Description	P C Format	Field Length	Position From	Position Thru
31	Insured's Policy, Group or FECA Number	A-N	30	255	284
32	Insured's Employer/School Name	A-N	30	285	314
33	Insurance Plan Name or Program Name	A-N	30	315	344
34	Another Health Benefit Plan	A-N	1	345	345
35	Date of Current Illness, Injury, Pregnancy MMDDCCYY	N	8	346	353
36	First Date Has Had Same or Similar Illness MMDDCCYY	N	8	354	361
37	Dates Patient Unable to Work From Date MMDDCCYY	N	8	362	369
38	Dates Patient Unable to Work Through Date MMDDCCYY	N	8	370	377
39	ID Number of Referring Physician	A-N	25	378	402
40	NPI Number of Referring Physician	A-N	10	403	412
41	Hospitalization Related Current SVCS From Date MMDDCCYY	N	8	413	420
42	Hospitalization Related Current SVCS Thru Date MMDDCCYY	N	8	421	428
43	Diagnosis or Nature of Illness or Injury Code (1)	A-N	8	429	436
44	Diagnosis or Nature of Illness or Injury Code (2)	A-N	8	437	444
45	Diagnosis or Nature of Illness or Injury Code (3)	A-N	8	445	452
46	Diagnosis or Nature of Illness or Injury Code (4)	A-N	8	453	460
47	Dates of Service From Date (1) MMDDCCYY	N	8	461	468
48	Dates of Service From Date (2) MMDDCCYY	N	8	469	476
49	Dates of Service From Date (3) MMDDCCYY	N	8	477	484
50	Dates of Service From Date 4) MMDDCCYY	N	8	485	492
51	Dates of Service From Date 5) MMDDCCYY	N	8	493	500
52	Dates of Service From Date (6) MMDDCCYY	N	8	501	508
53	Dates of Service Through Date (1) MMDDCCYY	N	8	509	516
54	Dates of Service Through Date (2) MMDDCCYY	N	8	517	524
55	Dates of Service Through Date (3) MMDDCCYY	N	8	525	532
56	Dates of Service Through Date (4) MMDDCCYY	N	8	533	540
57	Dates of Service Through Date (5) MMDDCCYY	N	8	541	548
58	Dates of Service Through Date (6) MMDDCCYY	N	8	549	556
59	Place of Service (1)	A-N	2	557	558
60	Place of Service (2)	A-N	2	559	560
61	Place of Service (3)	A-N	2	561	562

CMS-1500 DATA RECORD FORMAT
(1470 Byte Record Length)

Field No.	Field Description	P C Format	Field Length	Position From	Position Thru
62	Place of Service (4)	A-N	2	563	564
63	Place of Service (5)	A-N	2	565	566
64	Place of Service (6)	A-N	2	567	568
65	Emergency (EMG) (1)	A-N	2	569	570
66	Emergency (EMG) (2)	A-N	2	571	572
67	Emergency (EMG) (3)	A-N	2	573	574
68	Emergency (EMG) (4)	A-N	2	575	576
69	Emergency (EMG) (5)	A-N	2	577	578
70	Emergency (EMG) (6)	A-N	2	579	580
71	Procedures, Services & Supplies (1)	A-N	14	581	594
72	Procedures, Services & Supplies (2)	A-N	14	595	608
73	Procedures, Services & Supplies (3)	A-N	14	609	622
74	Procedures, Services & Supplies (4)	A-N	14	623	636
75	Procedures, Services & Supplies (5)	A-N	14	637	650
76	Procedures, Services & Supplies (6)	A-N	14	651	664
77	Diagnosis Pointer (1)	A-N	4	665	668
78	Diagnosis Pointer (2)	A-N	4	669	672
79	Diagnosis Pointer (3)	A-N	4	673	676
80	Diagnosis Pointer (4)	A-N	4	677	680
81	Diagnosis Pointer (5)	A-N	4	681	684
82	Diagnosis Pointer (6)	A-N	4	685	688
83	Charges (1)	N	10	689	698
84	Charges (2)	N	10	699	708
85	Charges (3)	N	10	709	718
86	Charges (4)	N	10	719	728
87	Charges (5)	N	10	729	738
88	Charges (6)	N	10	739	748
89	Days or Units (1)	A-N	3	749	751
90	Days or Units (2)	A-N	3	752	754
91	Days or Units (3)	A-N	3	755	757
92	Days or Units (4)	A-N	3	758	760

CMS-1500 DATA RECORD FORMAT
(1470 Byte Record Length)

Field No.	Field Description	P C Format	Field Length	Position From	Position Thru
93	Days or Units (5)	A-N	3	761	763
94	Days or Units (6)	A-N	3	764	766
95	EPSDT Family Plan (1)	A-N	3	767	769
96	EPSDT Family Plan (2)	A-N	3	770	772
97	EPSDT Family Plan (3)	A-N	3	773	775
98	EPSDT Family Plan (4)	A-N	3	776	778
99	EPSDT Family Plan (5)	A-N	3	779	781
100	EPSDT Family Plan (6)	A-N	3	782	784
101	ID Qualifier (1)	A-N	2	785	786
102	ID Qualifier (2)	A-N	2	787	788
103	ID Qualifier (3)	A-N	2	789	790
104	ID Qualifier (4)	A-N	2	791	792
105	ID Qualifier (5)	A-N	2	793	794
106	ID Qualifier (6)	A-N	2	795	796
107	Rendering Provider ID Number (1)	A-N	11	797	807
108	Rendering Provider ID Number (2)	A-N	11	808	818
109	Rendering Provider ID Number (3)	A-N	11	819	829
110	Rendering Provider ID Number (4)	A-N	11	830	840
111	Rendering Provider ID Number (5)	A-N	11	841	851
112	Rendering Provider ID Number (6)	A-N	11	852	862
113	Rendering Provider NPI Number (1)	A-N	10	863	872
114	Rendering Provider NPI Number (2)	A-N	10	873	882
115	Rendering Provider NPI Number (3)	A-N	10	883	892
116	Rendering Provider NPI Number (4)	A-N	10	893	902
117	Rendering Provider NPI Number (5)	A-N	10	903	912
118	Rendering Provider NPI Number (6)	A-N	10	913	922
119	Federal Tax ID Number	A-N	15	923	937
120	Federal Tax ID Number (SSN)	A-N	1	938	938
121	Federal Tax ID Number (EIN)	A-N	1	939	939
122	Patient's Account Number	A-N	15	940	954

CMS-1500 DATA RECORD FORMAT
(1470 Byte Record Length)

Field No.	Field Description	P C Format	Field Length	Position From	Position Thru
123	Total Charges	N	10	955	964
124	Billing Provider NPI Number	A-N	10	965	974
125	Billing Provider Other ID Number	A-N	20	975	994
126	Patient's Social Security Number	A-N	10	995	1004
127	Patient's Race/Ethnicity	A-N	2	1005	1006
128	Insurance Plan or Program Payer Classification Code- Primary	A-N	4	1007	1010
129	Insurance Plan or Program Payer Classification Code – Other	A-N	4	1011	1014
130	Encryption Key	A-N	40	1015	1054
131	Patient's Initials – First Name	A-N	2	1055	1056
132	Patient's Initials – Last Name	A-N	4	1057	1060
133	Primary Insured's Initials – First Name	A-N	2	1061	1062
134	Primary Insured's Initials – Last Name	A-N	4	1063	1066
135	Secondary Insured's Initials – First Name	A-N	2	1067	1068
136	Secondary Insured's Initials – Last Name	A-N	4	1069	1072
137	Vendor Generated Fields	A-N	28	1073	1100
138	State Generated Fields	A-N	140	1101	1240
139	Patient's Address Street 1	A-N	40	1241	1280
140	Patient's Address Street 2	A-N	40	1281	1320
141	Patient's First Name	A-N	20	1321	1340
142	Patient's Last Name	A-N	30	1341	1370
143	Primary Insured's First Name	A-N	20	1371	1390
144	Primary Insured's Last Name	A-N	30	1391	1420
145	Secondary Insured's First Name	A-N	20	1421	1440
146	Secondary Insured's Last Name	A-N	30	1441	1470

SECTION IV

UB – 04 Data Dictionary

UB-04 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A-N: Alpha-Numeric	UB-04 Form Locator*	Page No.
1	Facility Type	A-N		117
2	Data Year	A-N		118
3	Vendor ID Number	A-N		119
4	Bill Number	A-N		120
5	Record Sequence Number	A-N		121
6	Facility ID Number	A-N		122
7	Filler	A-N		N/A
8	Form Type	A-N		123
9	Patient Control Number	A-N	Form Locator 3A	124
10	Medical/Health Record Number	A-N	Form Locator 3B	125
11	Type of Bill	A-N	Form Locator 4	126
12	Federal Tax Sub ID Number	A-N	Form Locator 5	127
13	Federal Tax Number	A-N	Form Locator 5	128
14 – 15	Statement Covers Period – From and Through	N	Form Locator 6	129
16	Patient’s Address – City	A-N	Form Locator 9B	130
17	Patient’s Address – State	A-N	Form Locator 9C	131
18	Patient’s Address – Zip Code	A-N	Form Locator 9D	132
19	Patient’s Address – Country Code	A-N	Form Locator 9E	133
20	Patient’s Date of Birth	N	Form Locator 10	134
21	Patient’s Sex	A-N	Form Locator 11	135
22	Admission Date	N	Form Locator 12	136
23	Admission Hour	A-N	Form Locator 13	137
24	Type of Admission/Visit	A-N	Form Locator 14	138
25	Source of Admission	A-N	Form Locator 15	139 – 140
26	Patient Discharge Status	A-N	Form Locator 17	141
27	Do Not Resuscitate Flag	A-N		142
28	Accident State	A-N	Form Locator 29	143
29	Accident Code	A-N		144
30	Accident Date	N		145
31 – 53	Revenue Codes	A-N	Form Locator 42	146 – 147
54 – 76	HCPCS/Rates/HIPPS Rates Codes	A-N	Form Locator 44	148
77 – 99	Service Date(s)	N	Form Locator 45	149
100	Creation Date	N	Form Locator 45	150

UB-04 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A-N: Alpha-Numeric	UB-04 Form Locator*	Page No.
101 – 123	Unit(s) of Service	N	Form Locator 46	151
124 – 146	Total Charges (by Revenue Code Category)	N	Form Locator 47	152 – 153
147	Total of Total Charges	N		154
148 – 170	Non-Covered Charges (by Revenue Code Category)	N	Form Locator 48	155
171	Total of Non-Covered Charges	N		156
172	Payer Classification Code - Primary	A-N	Form Locator 50A	157 – 158
173	Payer Classification Code - Secondary	A-N	Form Locator 50B	159 – 160
174	Payer Classification Code - Tertiary	A-N	Form Locator 50C	161 – 162
175	Health Plan ID – Primary (formerly Provider Number)	A-N	Form Locator 51A	163
176	Health Plan ID – Secondary (formerly Provider Number)	A-N	Form Locator 51B	164
177	Health Plan ID – Tertiary (formerly Provider Number)	A-N	Form Locator 51C	165
178	National Provider ID (NPI)	A-N	Form Locator 56	166
179	Patient's Relationship to Insured-Primary	A-N	Form Locator 59A	167
180	Patient's Relationship to Insured – Secondary	A-N	Form Locator 59B	168
181	Patient's Relationship to Insured – Tertiary	A-N	Form Locator 59C	169
182	Insured's Unique ID Number – Primary	A-N	Form Locator 60A	170
183	Insured's Unique ID Number – Secondary	A-N	Form Locator 60B	171
184	Insured's Unique ID Number – Tertiary	A-N	Form Locator 60C	172
185	Insurance Group Number – Primary	A-N	Form Locator 62A	173
186	Insurance Group Number – Secondary	A-N	Form Locator 62B	174
187	Insurance Group Number – Tertiary	A-N	Form Locator 62C	175

UB-04 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A-N: Alpha-Numeric	UB-04 Form Locator*	Page No.
188	Name of Primary Insured's Employer	A-N	Form Locator 65A	176
189	DX and PX Version Qualifier	A-N	Form Locator 66	177
190	Principal Diagnosis Code	A-N	Form Locator 67	178
191 – 207	Other Diagnosis Codes	A-N	Form Locator 67A - Q	179 – 180
208	Admitting Diagnosis Code	A-N	Form Locator 69	181
209 – 211	Patient's Reason for Visit Code	A-N	Form Locator 70A–C	182
212	Prospective Payment System Code (PPS)	A-N	Form Locator 71	183
213 – 215	External Cause Of Injury Code (E Code)1, 2 & 3	A-N	Form Locator 72A, B, C	184– 185
216 - 227	Filler	A-N		N/A
228 – 230	Attending Physician ID Number	A-N		186
231 – 233	Operating Physician ID	A-N	Form Locator 77	187
234 – 236	Other Provider ID1 Number	A-N	Form Locator 78	188
237 – 239	Other Provider ID2 Number	A-N	Form Locator 79	189
240	Filler	A-N		N/A
241	Patient's Social Security Number	A-N		190
242	Patient's Race/Ethnicity	A-N		191
243 – 247	Fields for Vendor and State use only	A-N		N/A
248 – 249	Patient's Initials – First and Last Name	A-N		192 – 193
250 – 251	Primary Insured Initials – First and Last Name	A-N		194 – 195
252 – 253	Secondary Insured Initials – First and Last Name	A-N		196 – 197
254 – 255	Tertiary Insured Initials – First and Last Name	A-N		198 – 199
256	Patient's Address – Street	A-N	Form Locator 9A	200
257	Patient's Name – First	A-N	Form Locator 8A	201
258	Patient's Name – Last	A-N	Form Locator 8B	202
259 – 260	Primary Insured's Name – First and Last	A-N	Form Locator 58A	203 – 204

UB-04 Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type N: Numeric A-N: Alpha-Numeric	UB-04 Form Locator*	Page No.
261 – 262	Secondary Insured’s Name – First and Last	A-N	Form Locator 58B	205 – 206
263 – 264	Tertiary Insured’s Name – First and Last	A-N	Form Locator 58C	207 -208
265	Payer Name – Primary	A-N		209
266	Payer Name – Secondary	A-N		210
267	Payer Name – Tertiary	A-N		211
268 – 278	Condition Codes	A-N	Form Locator 18 - 28	212
279	Occurrence Code (1)	A-N	Form Locator 31a	213
280	Occurrence Date (1)	N	Form Locator 31a	214
281	Occurrence Code (2)	A-N	Form Locator 31b	213
282	Occurrence Date (2)	N	Form Locator 31b	214
283	Occurrence Code (3)	A-N	Form Locator 32a	213
284	Occurrence Date (3)	N	Form Locator 32a	214
285	Occurrence Code (4)	A-N	Form Locator 32b	213
286	Occurrence Date (4)	N	Form Locator 32b	214
287	Occurrence Code (5)	A-N	Form Locator 33a	213
288	Occurrence Date (5)	N	Form Locator 33a	214
289	Occurrence Code (6)	A-N	Form Locator 33b	213
290	Occurrence Date (6)	N	Form Locator 33b	214
291	Occurrence Code (7)	A-N	Form Locator 34a	213
292	Occurrence Date (7)	N	Form Locator 34a	214
293	Occurrence Code (8)	A-N	Form Locator 34b	213
294	Occurrence Date (8)	N	Form Locator 34b	220

* A number that specifies the location of the data field on the paper UB-04 form.

A-N = Alpha Numeric
N = Numeric

UB-04 Data Dictionary

Field No.	Field Description
1	Facility Type

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	1 – 1	Left Justified	Yes	N/A

Description:

This code is used to identify what facility type the data was submitted from.

A = Ambulatory Surgical Treatment Center

I = Hospital Inpatient

O = Hospital Outpatient

D = Ambulatory Surgical Treatment Center

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
2	Data Year

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2 – 5	Left Justified	Yes	N/A

Description:

Records the year of the data using the format CCYY.

This data element used to determine the year of the data submitted. (It is part of the unique bill ID and the unique record ID.)

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
3	Vendor Identification Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	6 – 7	Left Justified	Yes	N/A

Description:

This is used to identify the Vendor that has been chosen by the State to process ASTC data. It is assigned by the Department for each Vendor as its' unique ID. (It is a part of the unique bill ID and the unique record ID.)

Vendor Name	Vendor ID
Practice Resource Network, Inc.	1V
Tennessee Hospital Association	2V
System13, Inc.	3V

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
4	Bill Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha -Numeric	7	8 – 14	Left Justified	Yes	N/A

Description:

This is the value assigned by the Vendor to identify this particular bill. It must be a unique value for that vendor and data year. (It is part of the unique bill ID and the unique record ID.)

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
5	Record Sequence Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	15 – 16	Right Justified	Yes	N/A

Description:

Identifies the logical record if more than one is needed to contain all the billing information.

00 = Only record of a one-record bill.

01 = First record of a multi-record bill.

02 – 97 = Nth record of a multi-record bill, except for the last record.

98 = 98th + record of a multi-record bill, except for the last record.

99 = Last record of a multi-record bill.

(It is part of the unique record ID.)

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
6	Facility Identification Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	5	17 – 21	Right Justified	Yes	N/A

Description:

The five (5) digit number assigned to each Ambulatory Surgical Treatment Center by the State of Tennessee.

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
8	Form Type

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	24 – 25	Left Justified	Yes	N/A

Description:

Indicates what form was used to submit data to the Vendor from the Ambulatory Surgical Treatment Center.

Form: CMS-1500 = 1
 UB-04 = 3

Type: Paper = 0
 HIPAA* = 1
 TDH File Layout = 2
 Other Electronic = 9

This is a two digit field with Form being the first digit and Type being the second digit. Example: The code for a paper submission for a CMS-1500 form would be “10”. The first digit (1) indicates the Form (CMS-1500), the second digit (0) indicates the Type (paper).

For Vendor use only.

*ASTC X12N

UB-04 Data Dictionary

Field No.	Field Description
9	Patient Control Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	26 – 50	Left Justified	Yes	3A

Description:

Patient's unique identification number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

Used to uniquely identify a particular data record for systems development, management, and control purposes and to facilitate retrieval of claims or patient records by the facility for communication regarding errors found on individual records. Also used to merge interim claims.

Comments:

This data item is required. Providing this data does not breach individual patient confidentiality since the system has no number-name matching information. This field is not released to the public.

UB-04 Data Dictionary

Field No.	Field Description
10	Medical/Health Record Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	51 – 75	Left Justified	Yes	3B

Description:

The number assigned to the patient's medical/health record by the facility.

The medical/health record is typically used to do an audit of the history of treatment. This number should not be confused with the Patient Control Number (Form Locator 3A) which is used to track the financial history of the patient.

This data is used to assist facility personnel in locating a specific medical record. Selected types of discharges are studied in detail by the health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:

Do not substitute Patient Control Number. Both fields must be provided.

UB-04 Data Dictionary

Field No.	Field Description
11	Type of Bill

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha Numeric	4	76 – 79	Right Justified	Yes	4

Description:

A three-digit code indicating the specific type of facility, bill classification, and the frequency of billing. The first digit is a leading zero.

This code is used to verify and distinguish between type of facility claims, to identify and merge interim claims, and to verify discharge date.

Valid Values:

First Digit: Type of Facility	Second Digit: Inpatient or Outpatient	Third Digit: Frequency of Bill
1 = Hospital 4 = Christian Science Hospital 8 = Special Facility	1 = Inpatient 3 = Outpatient or Ambulatory Surgery Center 4 = Outpatient – Other (Observation) 5 = Critical Access Hospital	0 = Nonpayment 1 = Admission through Discharge Claim 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 5 = Late Charge(s) – Only Claim 7 = Replacement of Prior Claim 8 = Void/Cancel of Prior Claim

Example: 831 = Ambulatory Surgical Treatment Center, Admission through Discharge Claim

Comments:

The discharge date is not included on the UB-04 form. The Type of Bill and the Statement Covers Period data elements are used to determine the discharge date.

UB-04 Data Dictionary

Field No.	Field Description
12	Federal Tax Sub ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	80 – 83	Left Justified	Yes	5

Description:

The Federal Tax Sub ID Number assigned by the facility that uniquely identifies affiliated subsidiaries.

This number is used to identify subsidiaries of facilities submitting claims so that the data may be aggregated by and comparison made among facilities and among their subsidiaries.

Comments:

This field is defined by the provider. Blank is a valid response for a facility having no Federal Tax Sub ID Number.

UB-04 Data Dictionary

Field No.	Field Description
13	Federal Tax Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	10	84 – 93	Left Justified	Yes	5

Description:

The number assigned to the provider by the federal government for tax reporting purposes. The number is also known as the tax identification number (TIN) or employer identification number (EIN).

The format for the data is: AA-AAAAAAA.

A unique number used to identify individual facilities submitting claims so that the data may be aggregated by and comparison made among facilities.

UB-04 Data Dictionary

Field No.	Field Description
14 – 15	Statement Covers Period – From and Through

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	16	94 – 109	Right Justified	Yes	6

Description:

This date field covers the beginning and ending service dates of the entire period reflected by this bill.

If this is an interim bill (denoted by a “2” or “3” in the third digit of Type of Bill), the ending date would not be considered the discharge date. An individual may receive several interim bills before they are discharged. Interim bills should be held until they can be combined and submitted as a final bill. See Special Reporting Requirements on page 14.

The format for both Beginning Service Date (94 - 101) and Ending Service Date (102 - 109) is MMDDYYYY. Use leading zeroes when appropriate.

This data element is used in conjunction with Type of Bill (Field Number 4, Form Locator Number 4) to validate admission date and determine discharge date. This information is used to verify reporting period of data and for calculating length of stay of patient hospitalization.

Comments:

This data element can be used to assure that the claim is for the appropriate time period. The claims records should be admission through discharge; however, if this is an interim bill the Statement Covers Period will not be the beginning and ending date. Discharge date is not indicated explicitly on the UB-04 forms, therefore the fields Type of Bill and Statement Covers Period are used to determine length of stay and discharge date.

Note:

For services received on a single date, both the dates will be the same. These two dates are also known as “from” and “through” dates.

UB-04 Data Dictionary

Field No.	Field Description
16	Patient's Address – City

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	110 – 139	Left Justified	Yes	9B

Description:

The patient's city address as defined by the payer organization. This data is used to properly classify the patient's city of residence and to allow for analysis by place of residence.

Valid Values:

The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	Leave Blank	Leave Blank
City	Leave Blank	Leave Blank
Zip Code	H (in first position)	F (in first position)

UB-04 Data Dictionary

Field No.	Field Description
17	Patient's Address – State

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	140 – 141	Left Justified	Yes	9C

Description:

The patient's state address as defined by the payer organization. This data is used to properly classify the patient's state of residence and to allow for analysis by place of residence.

Valid Values:

The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	Leave Blank	Leave Blank
City	Leave Blank	Leave Blank
Zip Code	H (in first position)	F (in first position)

Comments:

Use the standard Post Office State Abbreviations for state addresses. These abbreviations are listed on page 236.

UB-04 Data Dictionary

Field No.	Field Description
18	Patient's Address - Zip Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	9	142 – 150	Left Justified	Yes	9D

Description:

The patient's zip code address as defined by the payer organization. This data is used to properly classify the patient's county of residence and to allow for analysis by place of residence.

Valid Values:

If unknown, fill the first five digits with 9. The remaining four digits can be left blank or filled with 9.

The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	Leave Blank	Leave Blank
City	Leave Blank	Leave Blank
Zip Code	H (in first position)	F (in first position)

Comments:

Do not include hyphen; it is implied.

UB-04 Data Dictionary

Field No.	Field Description
19	Patient's Address – Country Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	151 – 154	Left Justified	Yes	9E

Description:

The patient's country code address as defined by the payer organization. This data is used to properly classify the patient's country of residence and to allow for analysis by place of residence. If unknown or United States resident, leave blank.

Valid Values:

Use the Alpha – 2 Country Codes from Part I of ISO 3116. See pages **237-242** for a current list of codes.

UB-04 Data Dictionary

Field No.	Field Description
20	Patient's Date of Birth

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	155 – 162	Right Justified	Yes	10

Description:

Record the patient's date of birth using the format MMDDYYYY.

Use leading zeroes when appropriate.

This data element is used to determine the age of the patient.

UB-04 Data Dictionary

Field No.	Field Description
21	Patient's Sex

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	163 – 163	Left Justified	Yes	11

Description:

Enter the sex of the patient according to the following codes:

F = Female

M = Male

U = Unknown

UB-04 Data Dictionary

Field No.	Field Description
22	Admission Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	164 – 171	Right Justified	Yes	12

Description:

The date of start of care.

This data should be in the format MMDDYYYY. Use leading zeroes when appropriate.

This data element will be used to help determine the patient's length of stay and to verify the appropriateness of the reporting period for this record.

UB-04 Data Dictionary

Field No.	Field Description
23	Admission Hour

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	172 – 173	Left Justified	Yes	13

Description:

The code referring to the hour during which the patient was admitted for care.

Give the hour the patient was admitted using a twenty-four hour clock.

Valid time format:

Code – AM	Time – AM	Code – PM	Time – PM
00	12:00 Midnight – 12:59	12	12:00 Noon – 12:59
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

UB-04 Data Dictionary

Field No.	Field Description
24	Type of Admission/Visit

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	174 – 175	Left Justified	Yes	14

Description:

A code indicating the priority of the admission or visit.

This information will be used in data and patient referral analyses.

Valid Values:

Code	Type	Description
1	Emergency	The patient requires immediate intervention as a result of a severe, life threatening or potentially disabling condition.
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	Newborn	This code is for a baby born within the facility and it necessitates the use of special Source Of Admission Codes, Form Locator 15.
5	Trauma Center	This code is for a visit to a trauma center/hospital as designated by the state or local government authority or as verified by the American College of Surgeons and involving trauma activation.
6 – 8	Reserved	National assignment.
9	Unknown	Information not available.

Comments:

There are special instructions for Mother/Baby claims, see Form Locator 15 (Source of Admission). Source of Admission and Type of Admission should be used together when reviewing records. Form Locator 14 (Type of Admission) can be used independently of Form Locator 15 (Source of Admission) but not vice versa.

UB-04 Data Dictionary

Field No.	Field Description
25	Source of Admission

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	176 – 177	Left Justified	Yes	15

Description:

A code indicating the source of this admission to be used in data analysis and patient referral analysis.

Valid Values:

If Type of Admission (Form Locator 14) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes:

Code	Source	Description
1	Physician Referral	Patient was admitted for inpatient services or referred for outpatient services upon the recommendation of his/her personal physician, or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Patient was admitted to this facility for inpatient services or referred to this facility for outpatient services upon the recommendation of this facility's clinic physician, or by the facility's other outpatient department physician in the case of outpatient services.
3	HMO Referral	Patient was admitted for inpatient services or referred for outpatient or referenced diagnostic services upon the recommendation of a Managed Care Plan physician.
4	Transfer from an Acute Care Facility	Patient was admitted to this facility as a hospital transfer from an acute care facility where he/she was an inpatient or was referred to this facility for outpatient services by (a physician of) another acute care facility.
5	Transfer from a Skilled Nursing Facility	Patient was admitted to this facility as a hospital transfer from a skilled nursing facility where he/she was an inpatient or was referred to this facility for outpatient services by (a physician of) a skilled nursing facility.
6	Transfer from Another Health Care Facility	Patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or skilled nursing facility, including transfers from nursing homes, long-term care facilities and

UB-04 Data Dictionary

Field No.	Field Description
25	Source of Admission (continued from previous page)

Code	Source	Description
7	Emergency Room	skilled nursing facility patients that are at a non-skilled level of care, or referred to this facility for outpatient services by (a physician of) another health care facility where he/she is an inpatient. Patient was admitted for inpatient services or referred for outpatient services upon the recommendation of this facility's emergency room physician.
8	Court/Law Enforcement	Patient was admitted for inpatient services or referred for outpatient services upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9	Unknown	Information not available.
A	Transfer from a Critical Access Hospital	Patient was admitted to this facility as a hospital transfer from a critical access facility where they were an inpatient or was referred to this facility for outpatient services by (a physician of) another critical access facility.
D	Transfer from Hospital Inpatient same Facility	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

If Type of Admission (Form Locator 14) equals "4", (Newborn), use the following codes:

Code	Source	Description
1	Normal Delivery	A baby delivered without complications.
2	Premature	A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A newborn born in a non-sterile environment.
9	Unknown	Information not available.

Field No.	Field Description
26	Patient Discharge Status

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	178 – 179	Left Justified	Yes	17

Description:

A code indicating patient's status through the date the billing statement covers.

Valid Values:

Code	Patient Status
01	Discharged to home or self-care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to a skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Reserved for National Assignment.
09	Admitted as an inpatient to this hospital (only for Medicare outpatient claims).
20	Deceased.
30	Still a patient or expected to return for outpatient services.
40	Expired at home (Medicare and TRICARE claims for hospice care).
41	Expired in a medical facility (Medicare and TRICARE claims for hospice care).
42	Expired - place unknown (Medicare and TRICARE claims for hospice care).
43	Discharged/transferred to a Federal Health Care Facility.
50	Hospice - home.
51	Hospice - medical facility.
61	Discharged/transferred to a hospital-based swing bed within this institution.
62	Discharged/transferred to another rehabilitation facility including rehabilitation distinct parts units of a hospital.
63	Discharged/transferred to a long-term care hospital.
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH).

Effective 10/1/2007: 70 Discharged/transferred to another Type of Health Care Institution not defined Elsewhere in this Code List.

UB-04 Data Dictionary

Field No.	Field Description
27	Do Not Resuscitate Flag

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	180 – 180	Left Justified	Yes	N/A

Description:

Y = Yes

N = No

This is a one digit field. If any Condition Code (FL 18 – 28) has a value of “**P1**”, then report “Y” in this field; otherwise report “N”.

Comments:

Currently the national guidelines for designating ‘P1’ indicates that “a DNR order was written at the time of or within the first 24 hours of the patient’s admission and it is clearly documented in the patient’s record”.

This is a Vendor Generated field.

UB-04 Data Dictionary

Field No.	Field Description
28	Accident State

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	181 – 182	Left Justified	Yes	29

Description:

The state where the accident occurred. This data is used to properly classify the state in which the accident occurred.

Comments:

Use the standard Post Office State Abbreviations for state addresses. These abbreviations are listed in Section V.4.

UB-04 Data Dictionary

Field No.	Field Description
29	Accident Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	183 – 184	Left Justified	Yes	N/A

Description:

This is a two digit field. The appropriate codes for this field are 01 through 05 only.

If any Occurrence Code (FL 31 – 34) has a value of 01 through 05, then report the code here and its associated date in Field 23.

If **more than one Occurrence Code is 01 through 05**, then report the code that is associated with the most recent date.

If more than one Occurrence Code is 01 through 05 **with the same date**, then report the code with the lowest numeric value.

Report one Occurrence Code and **date only**.

Valid Values

Valid Codes	Description	Definition
01	Accident/Medical Coverage	Indicates accident-related injury for which there is medical payment coverage.
02	No Fault Insurance/Including Auto Accident/Other	State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by third party, other than no-fault liability.
04	Accident/Employment Related	Accident that relates to patient's employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage.

This is a Vendor generated field.

UB-04 Data Dictionary

Field No.	Field Description
30	Accident Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	185 -192	Right Justified	Yes	N/A

Description:

The valid format for this field is MMDDYYYY.

This date will correspond with the code reported in the Accident Code field. It is the occurrence date that corresponds to the Occurrence Code reported to the Accident Code field (field number 22).

If the Occurrence Code (FL 31 – 34) is 01 through 05, then report the date in the Accident Date field.

If **more than one Occurrence Code is 01 through 05**, then report the *most recent date*.

If more than one Occurrence Code is 01 through 05 with the same date, then report the *date with the associated code that has the lowest numeric value*.

Report one Occurrence Code and **date only**.

This is a Vendor generated field.

UB-04 Data Dictionary

Field No.	Field Description
31 – 53	Revenue Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha -Numeric	4	See below	Left Justified	Yes	42

Description:

This code identifies a specific accommodation, ancillary service, or billing calculation. The individual revenue code indicates that a part of the total charge claimed is categorized under a specific revenue source.

The record layout allows for 23 revenue codes. A second record may be necessary if there are more than 23 charges.

The revenue code is a four digit field; however, the first digit of the code is “0” for all current revenue codes. The second and third digits indicate the service and the fourth digit indicates the sub-category within the service.

This data is used to obtain a more valid comparison of charges by diagnosis.

Field Number	Field Name	UB-04 Form Locator Number 42	ASTC File Positions
31	Revenue Codes	Revenue Code 1, Line 1	193 – 196
32		Revenue Code 2, Line 2	197 – 200
33		Revenue Code 3, Line 3	201 – 204
34		Revenue Code 4, Line 4	205 – 208
35		Revenue Code 5, Line 5	209 – 212
36		Revenue Code 6, Line 6	213 – 216
37		Revenue Code 7, Line 7	217 – 220
38		Revenue Code 8, Line 8	221 – 224
39		Revenue Code 9, Line 9	225 – 228
40		Revenue Code 10, Line 10	229 – 232
41		Revenue Code 11, Line 11	233 – 236
42		Revenue Code 12, Line 12	237 – 240
43		Revenue Code 13, Line 13	241 – 244
44		Revenue Code 14, Line 14	245 – 248
45		Revenue Code 15, Line 15	249 – 252
46		Revenue Code 16, Line 16	253 – 256
47		Revenue Code 17, Line 17	257 – 260
48		Revenue Code 18, Line 18	261 – 264
49		Revenue Code 19, Line 19	265 - 268

UB-04 Data Dictionary

Field No.	Field Description
31 - 53	Revenue Codes (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number 42	ASTC File Positions
50	Revenue Codes	Revenue Code 20, Line 20	269 – 272
51		Revenue Code 21, Line 21	273 – 276
52		Revenue Code 22, Line 22	277 – 280
53		Revenue Code 23, Line 23	281 – 284

Comments:

Note that for any bill of two or more pages, a separate electronic record should be submitted for each page.

Example:

Revenue Code	Service Date	Service Units	Total Charges
0252 (Pharmacy/Non-Generic Drugs)		1	13.00
0261 (IV Therapy/Infusion Pump)		1	10.00
0001 (Total Charges)			23.00

Field No.	Field Description
54 – 76	HCPCS/Rates/HIPPS Rates Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	14	See below	Left Justified	Yes	44

Description:

The record layout allows for 23 HCPCS/Rates/HIPPS Rates Codes. A second record may be necessary if there are more than 23 codes. The HCPCS/CPT code is to be left justified in the first 5 positions which would always leave the 6th position blank. Positions 7-14 of each of these fields are to be used to capture up to 4 2-digit modifiers for the code that is reported in the first 5 positions.

Field Number	Field Name	UB-04 Form Locator Number 42	ASTC File Positions
54	HCPCS/Rates/ HIPPS Rates Codes	HCPCS/Rates/HIPPS Rates Code 1, Line 1	285 – 298
55		HCPCS/Rates/HIPPS Rates Code 2, Line 2	299 – 312
56		HCPCS/Rates/HIPPS Rates Code 3, Line 3	313 – 326
57		HCPCS/Rates/HIPPS Rates Code 4, Line 4	327 – 340
58		HCPCS/Rates/HIPPS Rates Code 5, Line 5	341 – 354
59		HCPCS/Rates/HIPPS Rates Code 6, Line 6	355 – 368
60		HCPCS/Rates/HIPPS Rates Code 7, Line 7	369 – 382
61		HCPCS/Rates/HIPPS Rates Code 8, Line 8	383 – 396
62		HCPCS/Rates/HIPPS Rates Code 9, Line 9	397 – 410
63		HCPCS/Rates/HIPPS Rates Code 10, Line 10	411 – 424
64		HCPCS/Rates/HIPPS Rates Code 11, Line 11	425 – 438
65		HCPCS/Rates/HIPPS Rates Code 12, Line 12	439 – 452
66		HCPCS/Rates/HIPPS Rates Code 13, Line 13	453 – 466
67		HCPCS/Rates/HIPPS Rates Code 14, Line 14	467 – 480
68		HCPCS/Rates/HIPPS Rates Code 15, Line 15	481 – 494
69		HCPCS/Rates/HIPPS Rates Code 16, Line 16	495 – 508
70		HCPCS/Rates/HIPPS Rates Code 17, Line 17	509 – 522
71		HCPCS/Rates/HIPPS Rates Code 18, Line 18	523 – 536
72		HCPCS/Rates/HIPPS Rates Code 19, Line 19	537 – 550
73		HCPCS/Rates/HIPPS Rates Code 20, Line 20	551 – 564
74		HCPCS/Rates/HIPPS Rates Code 21, Line 21	565 – 578
75		HCPCS/Rates/HIPPS Rates Code 22, Line 22	579 – 592
76		HCPCS/Rates/HIPPS Rates Code 23, Line 23	593 – 606

Field No.	Field Description
77 – 99	Service Date(s)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	See Below	Right Justified	Yes	45

Description:

The date the indicated service was provided. The field will be blank if the date the service was provided falls within the range of the dates reported in the Statement Covers Period (Form Locator 6).

The date should be in the following format: MMDDYYYY.

The record layout form allows 23 lines for Service Date(s).

Field Number	Field Name	UB-04 Form Locator Number 45	ASTC File Positions
77	Service Date(s)	Service Date 1, Line 1	607 – 614
78		Service Date 2, Line 2	615 – 622
79		Service Date 3, Line 3	623 – 630
80		Service Date 4, Line 4	631 – 638
81		Service Date 5, Line 5	639 – 646
82		Service Date 6, Line 6	647 – 654
83		Service Date 7, Line 7	655 – 662
84		Service Date 8, Line 8	663 – 670
85		Service Date 9, Line 9	671 – 678
86		Service Date 10, Line 10	679 – 686
87		Service Date 11, Line 11	687 – 694
88		Service Date 12, Line 12	695 – 702
89		Service Date 13, Line 13	703 – 710
90		Service Date 14, Line 14	711 – 718
91		Service Date 15, Line 15	719 – 726
92		Service Date 16, Line 16	727 – 734
93		Service Date 17, Line 17	735 – 742
94		Service Date 18, Line 18	743 – 750
95		Service Date 19, Line 19	751 – 758
96		Service Date 20, Line 20	759 – 766
97		Service Date 21, Line 21	767 – 774
98		Service Date 22, Line 22	775 – 782
99		Service Date 23, Line 23	783 – 790

Field No.	Field Description
100	Creation Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	791 – 798	Right Justified	Yes	45

Description:

Enter the date the bill was created or prepared for submission.

The date format for this field is MMDDYYYY.

Field No.	Field Description
101-123	Unit(s) of Service

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	7	See Below	Right Justified	Yes	46

Description:

A quantitative measure of services rendered to or for the patient by revenue category. Can include items such as number of accommodation days, miles, pints of blood, or renal dialysis, etc.

The record layout form allows 23 fields for Unit(s) of Service.

This data is used to properly classify, analyze and make comparisons for a particular revenue code.

Field Number	Field Name	UB-04 Form Locator Number 46	ASTC File Positions
101	Unit(s) of Service	Unit(s) of Service 1, Line 1	799 – 805
102		Unit(s) of Service 2, Line 2	806 – 812
103		Unit(s) of Service 3, Line 3	813 – 819
104		Unit(s) of Service 4, Line 4	820 – 826
105		Unit(s) of Service 5, Line 5	827 – 833
106		Unit(s) of Service 6, Line 6	834 – 840
107		Unit(s) of Service 7, Line 7	841 – 847
108		Unit(s) of Service 8, Line 8	848 – 854
109		Unit(s) of Service 9, Line 9	855 – 861
110		Unit(s) of Service 10, Line 10	862 – 868
111		Unit(s) of Service 11, Line 11	869 – 875
112		Unit(s) of Service 12, Line 12	876 – 882
113		Unit(s) of Service 13, Line 13	883 – 889
114		Unit(s) of Service 14, Line 14	890 – 896
115		Unit(s) of Service 15, Line 15	897 – 903
116		Unit(s) of Service 16, Line 16	904 – 910
117		Unit(s) of Service 17, Line 17	911 – 917
118		Unit(s) of Service 18, Line 18	918 – 924
119		Unit(s) of Service 19, Line 19	925 – 931
120		Unit(s) of Service 20, Line 20	932 – 938
121		Unit(s) of Service 21, Line 21	939 – 945
122		Unit(s) of Service 22, Line 22	946 – 952
123		Unit(s) of Service 23, Line 23	953 – 959

Field No.	Field Description
124 – 146	Total Charges (by Revenue Code Category)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	See Below	Right Justified	Yes	47

Description:

Total Charges pertaining to the related Revenue Code for the current billing period as reflected by the statement covers period.

The record layout form allows 23 fields for Charges.

This data is used to properly analyze and to obtain a more valid comparison of charges by revenue code.

Field Number	Field Name	UB-04 Form Locator Number	ASTC File Positions
124	Total Charges (by Revenue Code Category)	Charges 1, Line 1	960 – 969
125		Charges 2, Line 2	970 – 979
126		Charges 3, Line 3	980 – 989
127		Charges 4, Line 4	990 – 999
128		Charges 5, Line 5	1000 – 1009
129		Charges 6, Line 6	1010 – 1019
130		Charges 7, Line 7	1020 – 1029
131		Charges 8, Line 8	1030 – 1039
132		Charges 9, Line 9	1040 – 1049
133		Charges 10, Line 10	1050 – 1059
134		Charges 11, Line 11	1060 – 1069
135		Charges 12, Line 12	1070 – 1079
136		Charges 13, Line 13	1080 – 1089
137		Charges 14, Line 14	1090 – 1099
138		Charges 15, Line 15	1100 – 1109
139		Charges 16, Line 16	1110 – 1119
140		Charges 17, Line 17	1120 – 1129
141		Charges 18, Line 18	1130 – 1139
142		Charges 19, Line 19	1140 – 1149
143		Charges 20, Line 20	1150 – 1159
144		Charges 21, Line 21	1160 – 1169
145		Charges 22, Line 22	1170 – 1179
146		Charges 23, Line 23	1180 – 1189

UB-04 Data Dictionary

Field No.	Field Description
124 – 146	Total Charges (by Revenue Code Category) (continued from previous page)

Comments:

For any bill of two or more pages, a separate record should be submitted for each page if submission is via magnetic medium. The total charge for a multi-record bill will be on the last record of the bill in field 140 only (Total of Total Charges, see next page).

UB-04 Data Dictionary

Field No.	Field Description
147	Total of Total Charges

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	1190-1199	Right Justified	Yes	N/A

Description:

Give the total for all the Total Charges by Revenue Code fields for the bill.

Comment:

On the final record of a multi-record bill or on a single record bill this field should always have a valid numeric value (positive, negative, or zero).

On all non-final records of a multi-record bill this field should be left blank. If more than 23 charges are incurred, put any additional charges on a second form.

UB-04 Data Dictionary

Field No.	Field Description
148 - 170	Non-Covered Charges (by Revenue Code Category)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	See Below	Right Justified	Yes	48

Description:

The UB-04 form allows 23 lines for Charges.

This data is used to properly analyze and to obtain a more valid comparison of non-covered hospital charges by revenue code.

Field Number	Field Name	UB-04 Form Locator Number	ASTC File Positions
148	Non-Covered Charges (by Revenue Code Category)	Non-Covered Charges 1, Line 1	1200 – 1209
149		Non-Covered Charges 2, Line 2	1210 – 1219
150		Non-Covered Charges 3, Line 3	1220 – 1229
151		Non-Covered Charges 4, Line 4	1230 – 1239
152		Non-Covered Charges 5, Line 5	1240 – 1249
153		Non-Covered Charges 6, Line 6	1250 – 1259
154		Non-Covered Charges 7, Line 7	1260 – 1269
155		Non-Covered Charges 8, Line 8	1270 – 1279
156		Non-Covered Charges 9, Line 9	1280 – 1289
157		Non-Covered Charges 10, Line 10	1290 – 1299
158		Non-Covered Charges 11, Line 11	1300 – 1309
159		Non-Covered Charges 12, Line 12	1310 – 1319
160		Non-Covered Charges 13, Line 13	1320 – 1329
161		Non-Covered Charges 14, Line 14	1330 – 1339
162		Non-Covered Charges 15, Line 15	1340 – 1349
163		Non-Covered Charges 16, Line 16	1350 – 1359
164		Non-Covered Charges 17, Line 17	1360 – 1369
165		Non-Covered Charges 18, Line 18	1370 – 1379
166		Non-Covered Charges 19, Line 19	1380 – 1389
167		Non-Covered Charges 20, Line 20	1390 – 1399
168		Non-Covered Charges 21, Line 21	1400 – 1409
169		Non-Covered Charges 22, Line 22	1410 – 1419
170		Non-Covered Charges 23, Line 23	1420 – 1429

UB-04 Data Dictionary

Field No.	Field Description
171	Total of Non-Covered Charges

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	1430-1439	Right Justified	Yes	N/A

Description:

Give the total for all the Non-Covered charges for the bill.

UB-04 Data Dictionary

Field No.	Field Description
172	Payer Classification Code – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1440-1443	Left Justified	Yes	50A

Description:

The name or type of payer organization from which the facility first expects some payment for the bill.

The UB-04 form has three **lines for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer organization and to analyze case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (<u>not</u> managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (<u>not</u> TennCare – see TennCare codes below)
I	Commercial Insurance (<u>not</u> managed care)
M	Medicare (<u>not</u> managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self-Pay
S	Self-Insured, Self-Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
<u>TennCare Codes</u>	
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State’s TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO)

UB-04 Data Dictionary

Field No.	Field Description
172	Payer Classification Code – Primary (continued from previous page)

Code	Payer Classification
E	<u>TennCare Behavioral Codes</u> BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	<u>Blue Cross Managed Care – HMO/PPO/Other Managed Care</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	<u>Commercial (Managed Care – HMO/PPO/Other Managed Care)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	<u>Medicare (HMO/PSO)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna

Field No.	Field Description
173	Payer Classification Code – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1444-1447	Left Justified	Yes	50B

Description:

The name or type of payer organization from which the facility might second expect some payment for the bill. **Many bills will lack a secondary payer; this field will then be blank.**

The UB-04 form has three **lines for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer and to analyze case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (<u>not</u> managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (<u>not</u> TennCare – see TennCare codes below)
I	Commercial Insurance (<u>not</u> managed care)
M	Medicare (<u>not</u> managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self-Pay
S	Self-Insured, Self-Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
	<u>TennCare Codes</u>
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State’s TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO)

UB-04 Data Dictionary

Field No.	Field Description
173	Payer Classification Code – Secondary (continued from previous page)

Code	Payer Classification
	<u>TennCare Behavioral Codes</u>
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	<u>Blue Cross Managed Care – HMO/PPO/Other Managed Care</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	<u>Commercial (Managed Care – HMO/PPO/Other Managed Care)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	<u>Medicare (HMO/PSO)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna

Comments:

Many bills will not have a Secondary Payer.

Field No.	Field Description
174	Payer Classification Code – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1448-1451	Left Justified	Yes	50C

Description:

The name or type of payer organization from which the facility might third expect some payment for the bill. **Many bills will lack a third payer; this field will then be blank.**

The UB-04 form has three lines for **Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer and to analyze case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (<u>not</u> managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (<u>not</u> TennCare – see TennCare codes below)
I	Commercial Insurance (<u>not</u> managed care)
M	Medicare (<u>not</u> managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self-Pay
S	Self-Insured, Self-Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
	<u>TennCare Codes</u>
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State’s TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO)

UB-04 Data Dictionary

Field No.	Field Description
174	Payer Classification Code – Tertiary (continued from previous page)

Code	Payer Classification
	<u>TennCare Behavioral Codes</u>
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	<u>Blue Cross Managed Care – HMO/PPO/Other Managed Care</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	<u>Commercial (Managed Care – HMO/PPO/Other Managed Care)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	<u>Medicare (HMO/PSO)</u> Payer may be listed as, but is not limited to, names such as: <ul style="list-style-type: none"> • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna

Comments:

Many bills will not have a Tertiary Payer.

Field No.	Field Description
175	Health Plan ID – Primary (formerly Provider Number)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1452-1466	Left Justified	Yes	51A

Description:

The number assigned to the facility by the payer indicated in Form Locator 50A (Primary Payer Name). The number in Form Locator 51A corresponds to Form Locator 50A. **If this code is unknown or not applicable, the field should be completely filled with 9.**

This data is used to properly classify the source of the payer indicated in Form Locator 50A.

Field No.	Field Description
176	Health Plan ID – Secondary (formerly Provider Number)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1467-1481	Left Justified	Yes	51B

Description:

The number assigned to the facility by the payer indicated in Form Locator 50B (Secondary Payer Name). The number in Form Locator 51B corresponds to Form Locator 50B. **If this code is unknown the field should be completely filled with 9. If there is no Secondary Payer this field should be left blank.**

This data is used to properly classify the source of the payer indicated in Form Locator 50B.

Comments:

Many bills will lack a Secondary Payer Name and will have no Secondary Health Plan ID number.

Field No.	Field Description
177	Health Plan ID – Tertiary (formerly Provider Number)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1482-1496	Left Justified	Yes	51C

Description:

The number assigned to the facility by the payer indicated in Form Locator 50C (Tertiary Payer Name). The number in Form Locator 51C corresponds to Form Locator 50C. **If this code is unknown the field should be completely filled with 9. If there is no Tertiary Payer this field should be left blank.**

This data is used to properly classify the source of the payer indicated in Form Locator 50C (Payer Identification).

Comments:

Many bills will lack a Tertiary Payer and will have no Tertiary Health Plan ID Number.

Field No.	Field Description
178	National Provider ID (NPI)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1497-1511	Left Justified	Yes	56

Description:

Give the NPI number for the reporting facility.

Field No.	Field Description
179	Patient's Relationship to Insured – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1512-1513	Left Justified	Yes	59A

Description:

The code number indicates the relationship of the patient to the insured individual named in Form Locator 58A.

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:

The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
180	Patient's Relationship to Insured – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1514-1515	Left Justified	Yes	59B

Description:

The code number indicates the relationship of the patient to the insured individual named in Form Locator 58B. **If there is no second payer, this field should be left blank.**

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:

The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
181	Patient's Relationship to Insured – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1516-1517	Left Justified	Yes	59C

Description:

The code number indicates the relationship of the patient to the insured individual named in Form Locator 58C. **If there is no third payer this field should be left blank.**

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:

The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
182	Insured's Unique ID Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1518-1537	Left Justified	Yes	60A

Description:

A unique identification number assigned to the insured by the payer organization indicated in Form Locators 58A (Insured's Name Primary).

This data is used to assist personnel in locating a specific medical record. Selected types of discharges are studied in detail by health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:

This field should be filled with 9 if unknown. Note: Payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:

This number may be that of a person other than the patient if the patient's insurance coverage is through another person's individual or group insurance.

Field No.	Field Description
183	Insured's Unique ID Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1538-1557	Left Justified	Yes	60B

Description:

A unique identification number assigned to the insured by the payer organization indicated in Form Locator 58B (Insured's Name Secondary).

This data is used to assist personnel in locating a specific medical record. Selected types of discharges are studied in detail by health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:

Must be provided if there is a second payer: When there is no second payer this field should be left blank. This field should be filled with 9 if unknown. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:

This number may be that of a person other than the patient if the patient's insurance coverage is through another person's individual or group insurance.

Field No.	Field Description
184	Insured's Unique ID Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1558-1577	Left Justified	Yes	60C

Description:

A unique identification number assigned to the insured by the payer organization indicated in Form Locator 58C (Insured's Name Tertiary).

This data is used to assist personnel in locating a specific medical record. Selected types of discharges are studied in detail by health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:

Must be provided if there is a third payer: When there is no third payer this field should be left blank. This field should be filled with 9 if unknown. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:

This number may be that of a person other than the patient if the patient insurance coverage is through another person's individual or group insurance.

Field No.	Field Description
185	Insurance Group Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1578-1594	Left Justified	Yes	62A

Description:

The identification number or code assigned by the carrier or administrator to identify the group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58A.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:

This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
186	Insurance Group Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1595-1611	Left Justified	Yes	62B

Description:

The identification number or code assigned by the carrier or administrator to identify the second group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58B.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:

Must be provided if there is a second payer: When there is no second payer this field should be left blank. This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
187	Insurance Group Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1612-1628	Left Justified	Yes	62C

Description:

The identification number or code assigned by the carrier or administrator to identify the third group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58C.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:

Must be provided if there is a third payer: When there is no third payer this field should be left blank. This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Field No.	Field Description
188	Name of Primary Insured's Employer

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1629-1653	Left Justified	Yes	65A

Description:

The name of the employer who provides health care coverage for the insured person identified in Form Locator 58A. The insured person may or may not be the patient.

Comments:

This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error. This field may also be filled with 9 if the Employment Status Code is "3" (not employed), "5" (retired), or "9" (unknown).

Field No.	Field Description
189	Diagnosis and Procedure Version Qualifier (DX and PX)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1654-1655	Left Justified	Yes	66

Description:

The qualifier that denotes the version of International Classification (ICD) of Diseases reported.

Give the Diagnosis and Procedure version qualifier for the codes used in this bill.

Note: Qualifier codes reflect the edition portion of the ICD:

9 – Ninth Revision

0 – Tenth Revision

Field No.	Field Description
190	Principal Diagnosis Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	8	1656-1663	Left Justified	Yes	67

Description:

The ICD-9-CM code describing the principal diagnosis (i.e., the condition chiefly responsible for the admission of the patient for care). The principal diagnosis should reflect the information contained in the patient's medical record for the current stay. The principal diagnosis may be a V code. The V code can appear in the following situations:

- a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.
- b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

This data is used to identify the primary medical diagnosis or conditions for which the patient required hospital care. This data is also used to group hospital charges and may be grouped for comparisons and analyses according to similar diagnosis.

Comments:

Must be present. All valid ICD-9-CM codes are appropriate. Include leading zeroes when necessary for the code to appear exactly as represented by the appropriate ICD-9-CM code. *Example: If diagnosis code is 036.81 then report the code as 03681; not 3681.* If a V code is used, the "V" should be in the first position and left justified.

Do not include decimal point; it is implied.

Field No.	Field Description
191 – 207	Other Diagnosis Codes (A – Q)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	8	1664-1799	Left Justified	Yes	67A - Q

Description:

The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently and which have an effect on the treatment received or the length of stay.

This data is used to be able to further refine the principal diagnosis, so that hospital charges may be grouped for comparisons and analyzed according to similar diagnosis.

Comments:

Include leading zeroes when necessary for the code to appear exactly as represented by the appropriate ICD-9-CM code. *Example: If diagnosis code is 036.81 then report the code as 03681; not 3681.* When coded, the letters “V” or “E” should be in the first position of the field and left justified. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

The record layout does not allow for a V code field or more than three E code fields so the other diagnosis fields will have to be used when these conditions exist. The other diagnosis code fields will permit the use of ICD-9-CM V and E codes where appropriate. Note that the V code may also be in the principal diagnosis field. Note also that Form Locator 72 is the E code field; however, in some cases more than three E codes are appropriate.

E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. See Field No. 224 (External Cause of Injury Code) for a more complete description of E Code usage.

The V code can appear in the following situations:

- a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.
- b) When some circumstance or problem is present which influences the person’s health status but is not in itself a current illness or injury.

Field No.	Field Description
191- 207	Other Diagnosis Codes (A – Q) (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number	ASTC File Positions
191	Other Diagnosis Codes	Other Diagnosis 1, FL-67A	1664 – 1671
192		Other Diagnosis 2, FL-67B	1672 – 1679
193		Other Diagnosis 3, FL-67C	1680 – 1687
194		Other Diagnosis 4, FL-67D	1688 – 1695
195		Other Diagnosis 5, FL-67E	1696 – 1703
196		Other Diagnosis 6, FL-67F	1704 – 1711
197		Other Diagnosis 7, FL-67G	1712 – 1719
198		Other Diagnosis 8, FL-67H	1720 – 1727
199		Other Diagnosis 9, FL-67I	1728 – 1735
200		Other Diagnosis 10, FL-67J	1736 – 1743
201		Other Diagnosis 11, FL-67K	1744 – 1751
202		Other Diagnosis 12, FL-67L	1752 – 1759
203		Other Diagnosis 13, FL-67M	1760 – 1767
204		Other Diagnosis 14, FL-67N	1768 – 1775
205		Other Diagnosis 15, FL-67O	1776 – 1783
206		Other Diagnosis 16, FL-67P	1784 – 1791
207		Other Diagnosis 17, FL-67Q	1792 – 1799

Field No.	Field Description
208	Admitting Diagnosis Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1800-1806	Left Justified	Yes	69

Description:

This is the condition identified by the physician at the time of the patient's admission.

Field No.	Field Description
209 – 211	Patient's Reason for Visit Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1807-1827	Left Justified	Yes	70A – C

Description:

The ICD-CM diagnosis codes describing the patient's reason for visit at the time of registration.

Field No.	Field Description
212	Prospective Payment System Code (PPS)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1828-1831	Left Justified	Yes	71

Description:

Give the code indicating the Prospective Payment System (if any) used for this bill.

Field No.	Field Description
See next page	External Cause of Injury Code (E Code)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	8	Next page	Left Justified	Yes	72A - C

Description:

E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, or other adverse effects.

A code used to describe an external cause creating the need for medical attention. Valid range is E800 – E999. See ICD-9-CM, Volume 1 for classification of the codes and further clarification of the fifth and sixth digits.

The E code is used to compare and analyze causes of injury.

Comments:

E codes are required when an ICD-9 code of 800.xx – 995.8 xs is listed as the principal diagnosis.

If there is an E code reported in these positions, it may relate to an “Other diagnosis” code rather than to the principal diagnosis. While the edit requires an E code in these positions IF the principal diagnosis = 800.xx – 995.8x, there may be an E code in these positions when the principal diagnosis does NOT equal this range because the E code relates to one of the Other Diagnosis codes (see cases (2) and (3) below).

If more than one E code is applicable, use the following priorities for recording E codes in this field:

- (1) Principal diagnosis of an injury or poisoning.
- (2) Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis.
- (3) Other diagnosis with an external code.

If there are more than three E Codes, record any additional E codes in the Other Diagnosis Fields (FL 68 through FL 75).

Other Information:

E codes should not be confused with the 800 – 999 range of ICD-9-CM diagnosis codes. They have very different meanings. The E code describes the external cause of the injury; the ICD-9-CM diagnosis code describes the resulting trauma. For example, to compare E code 837.1 to ICD-9-CM diagnosis code 837.1:

UB-04 Data Dictionary

Field No.	Field Description
See below	External Cause of Injury Code (E Code) (continued from previous page)

E837 means “Explosion, Fire or Burning in water craft” and the fourth digit “1” means “Occupant of small boat, powered”.

ICD-9-CM code 837 means “Dislocation of Ankle” and the fourth digit “1” means “Open Dislocation”.

Field Number	Field Name	UB-04 Form Locator Number	ASTC File Positions
213	External Cause of Injury Code1	72A	1832 – 1839
214	External Cause of Injury Code2	72B	1840 – 1847
215	External Cause of Injury Code3	72C	1848 – 1855

UB-04 Data Dictionary

Field No.	Field Description
228 – 230	Attending Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1946-1970	Left Justified	Yes	See below

Description:

The identification numbers of the health care provider who has primary responsibility for the patient's medical care and treatment, and/or would be expected to certify the medical necessity of the services rendered.

This provider ID is broken into three components. The first gives a two-digit code to specify the profession of the provider. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**=midwife, **PS**=licensed psychologist and **DC**=doctor of chiropractic medicine.

The second component is the ten-digit state license number of the provider. This should be placed into the following ten-digit field. All leading zeroes should be used. Example: License number 2635 should be reported as 0000002635. For unknown profession code-state license number use 'UK99999999' (profession code 'UK' can only be used with '999999999' and '999999999' can only be used with 'UK').

The third component is the NPI number of the provider. This should be left-justified into the thirteen-digit field following the state license number. Note: Until May 23, 2007, the UPIN may be used instead of the NPI. Use 'OTH000' for unknown UPIN/NPI.

Facilities should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing costs and utilization data by the attending physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	ASTC File Position
228	Attending - Profession Code	N/A	2	1946 – 1947
229	Attending - TN License Number	76	10	1948 – 1957
230	Attending - UPIN/NPI	76	13	1958 – 1970

UB-04 Data Dictionary

Field No.	Field Description
231 – 233	Operating Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1971-1995	Left Justified	Yes	See below

Description:

The identification numbers of the health care provider who has primary responsibility for the patient’s surgical procedures.

This provider ID is broken into three components. The first gives a two-digit code to specify the profession of the provider. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician’s assistant, **NP**=nurse practitioner, **MW**=midwife, **PS**=licensed psychologist and **DC**=doctor of chiropractic medicine.

The second component is the ten-digit state license number of the provider. This should be placed into the following ten-digit field. All leading zeroes should be used. Example: License number 2635 should be reported as 0000002635. For unknown profession code-state license number use ‘UK99999999’ (profession code ‘UK’ can only be used with ‘9999999999’ and ‘9999999999’ can only be used with ‘UK’).

The third component is the NPI number of the provider. This should be left-justified into the thirteen-digit field following the state license number. Note: Until May 23, 2007, the UPIN may be used instead of the NPI. Use ‘OTH000’ for unknown UPIN/NPI.

Facilities should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing costs and utilization data by the attending physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	ASTC File Position
231	Operating - Profession Code	N/A	2	1971 - 1972
232	Operating - TN License Number	77	10	1973 - 1982
233	Operating - UPIN/NPI	77	13	1983 - 1995

UB-04 Data Dictionary

Field No.	Field Description
234 – 236	Other Provider ID1 Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1996-2020	Left Justified	Yes	See below

Description:

The identification numbers of a healthcare provider (other than the attending provider or operating provider) involved with this case. This field can be left blank.

This provider ID is broken into three components. The first gives a two-digit code to specify the profession of the provider. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician’s assistant, **NP**=nurse practitioner, **MW**=midwife, **PS**=licensed psychologist and **DC**=doctor of chiropractic medicine.

The second component is the ten-digit state license number of the provider. This should be placed into the following ten-digit field. All leading zeroes should be used. Example: License number 2635 should be reported as 0000002635. For unknown profession code-state license number use ‘UK99999999’ (profession code ‘UK’ can only be used with ‘9999999999’ and ‘9999999999’ can only be used with ‘UK’).

The third component is the NPI number of the provider. This should be left-justified into the thirteen-digit field following the state license number. Note: Until May 23, 2007, the UPIN may be used instead of the NPI. Use ‘OTH000’ for unknown UPIN/NPI.

Facilities should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing costs and utilization data by the other physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	ASTC File Position
234	Other ID1 - Profession Code	N/A	2	1996 - 1997
235	Other ID1 - TN License Number	78	10	1998 – 2007
236	Other ID1 - UPIN/NPI	78	13	2008 - 2020

UB-04 Data Dictionary

Field No.	Field Description
237 – 239	Other Provider ID2 Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	2021-2045	Left Justified	Yes	See below

Description:

The identification numbers of a healthcare provider (other than the attending provider, operating provider or the first other provider) involved with the case. This field can be left blank.

This provider ID is broken into three components. The first gives a two-digit code to specify the profession of the provider. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**=midwife, **PS**=licensed psychologist and **DC**=doctor of chiropractic medicine.

The second component is the ten-digit state license number of the provider. This should be placed into the following ten-digit field. All leading zeroes should be used. Example: License number 2635 should be reported as 0000002635. For unknown profession code-state license number use 'UK99999999' (profession code 'UK' can only be used with '999999999' and '999999999' can only be used with 'UK').

The third component is the NPI number of the provider. This should be left-justified into the thirteen-digit field following the state license number. Note: Until May 23, 2007, the UPIN may be used instead of the NPI. Use 'OTH000' for unknown UPIN/NPI.

Facilities should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing costs and utilization data by the other physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	ASTC File Position
237	Other ID2 - Profession Code	N/A	2	2021 - 2022
238	Other ID2 - TN License Number	79	10	2023 – 2032
239	Other ID2 - UPIN/NPI	79	13	2033 – 2045

UB-04 Data Dictionary

Field No.	Field Description
241	Patient's Social Security Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	10	2058-2067	Left Justified	Yes	N/A

Description:

This field is not specifically included on the UB-04 form. However, since the patient's social security number may or may not be included as part of another field (Insured's Unique ID Number Form Locator-60A - C), this field should be used only to collect and report the actual SSN of the patient.

A unique, identifying number for each patient. For patients who lack a social security number or for whom it is unknown, this field should be all 9 9s (999999999), with the 10th position left blank

This data will allow for linking of multiple records for the same patient. This field can be used to un-duplicate counts for different types of medical conditions when a patient is hospitalized more than once. Records are reviewed by the department to identify any cases of traumatic brain injuries and/or birth defects. This information is provided to staff for more detailed medical record abstraction. If SSN is provided on each discharge record, it could prevent the facility from being requested to abstract a medical record more than once (if a patient is seen more than once for the same condition).

Comments:

This field is confidential and not available for public release.

UB-04 Data Dictionary

Field No.	Field Description
242	Patient's Race/Ethnicity

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	2	2068-2069	Right Justified	Yes	N/A

Description:

This field is not included on the UB-04 form. This field is required to be reported in addition to the data elements contained on the UB-04.

This field should include information on the patient's race/ethnicity. This information may have to be brought in from other parts of the patient's record.

This data will be used for analysis by race/ethnicity.

Enter patient's race and ethnicity (2 parts). Put code for race in position 2068. Put code for ethnicity in position 2069.

Valid Codes:

Valid Code	Description (Race)	ASTC File Position
1	White or Caucasian	2068
2	Black or African American	
3	Native American or Alaskan Native	
4	Asian or Pacific Islander	
5	Other Race (other than 1 – 4)	
9	Unknown Race	

Valid Code	Description (Ethnicity)	ASTC File Position
1	Hispanic Origin	2069
2	Not Hispanic Origin	
9	Hispanic Origin Unknown	

Comments:

The Patient's Race/Ethnicity field is for statistical and epidemiological purposes only. Staff assessment of its value is sufficient.

UB-04 Data Dictionary

Field No.	Field Description
248	Patient's Initials - First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2275-2276	Left Justified	Yes	NA

Description:

Enter the first two letters of the patient's first name as given in FL 8A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = JO

T Anthony Jones = T

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
249	Patient's Initials - Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2277-2280	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the patient's last name as given in FL 8B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
250	Primary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2281-2282	Left Justified	Yes	NA

Description:

Enter the first two letters of the primary insured's first name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = JO

T Anthony Jones = T

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
251	Primary Insured Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2283-2286	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the primary insured's last name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
252	Secondary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2287-2288	Left Justified	Yes	NA

Description:

Enter the first two letters of the secondary insured's first name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = JO

TAnthony Jones = T

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
253	Secondary Insured Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2289-2292	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the secondary insured's last name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
254	Tertiary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2293-2294	Left Justified	Yes	NA

Description:

Enter the first two letters of the tertiary insured's first name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = JO

T Anthony Jones = T

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
255	Tertiary Insured Initials – Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2295-2298	Left Justified	Yes	NA

Description:

Enter the first two letters and the last two letters of the tertiary insured's last name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:

This field should be left blank by the facilities.

Example:

John Smith = SMTH

Robert Ray = RAY

Carla Thompson-Jones = THES

For Vendor use only.

UB-04 Data Dictionary

Field No.	Field Description
256	Patient Address – Street

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha Numeric	40	2299-2338	Left Justified	Yes	9A

Description:

Enter the street address of the patient as found in FL 9A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
257	Patient Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2339-2358	Left Justified	Yes	8A

Description:

Enter the patient's first name as given in FL 8A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
258	Patient Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2359-2388	Left Justified	Yes	8B

Description:

Enter the patient's last name as given in FL 8B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
259	Primary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2389-2408	Left Justified	Yes	58A

Description:

Enter the primary Insured's first name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
260	Primary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2409-2438	Left Justified	Yes	58A

Description:

Enter the primary Insured's last name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
261	Secondary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2439-2458	Left Justified	Yes	58B

Description:

Enter the secondary Insured's first name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
262	Secondary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2459-2488	Left Justified	Yes	58B

Description:

Enter the secondary Insured's last name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
263	Tertiary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2489-2508	Left Justified	Yes	58C

Description:

Enter the tertiary Insured's first name in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
264	Tertiary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2509-2538	Left Justified	Yes	58C

Description

Enter the tertiary Insured's last name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

UB-04 Data Dictionary

Field No.	Field Description
265	Payer Name – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	2539-2563	Left Justified	Yes	50A

Description:

The name of the payer organization from which the facility first expects some payment for the bill.

The UB-04 form has **three lines for Form Locator 50**. The appropriate payer source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

The Payer Name – Primary is use to generate the Payer Classification code – Primary. The Payer Classification Code – Primary is used to identify and analyze data for a particular payer organization and to analyze hospital case mix data.

Please refer to pages 159-160 for the appropriate payer name for each Payer Classification Code – Primary.

UB-04 Data Dictionary

Field No.	Field Description
266	Payer Name – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	2564-2588	Left Justified	Yes	50B

Description:

The name of the payer organization from which the facility might second expect some payment for the bill. **Many bills will lack a secondary payer; this field will then be blank.**

The UB-04 form has **three lines for Form Locator 50**. The appropriate payer source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

The Payer Name – Secondary is use to generate the Payer Classification code – Secondary. The Payer Classification Code – Secondary is used to identify and analyze data for a particular payer organization and to analyze hospital case mix data.

Please refer to pages 161-162 for the appropriate payer name for each Payer Classification Code – Secondary.

UB-04 Data Dictionary

Field No.	Field Description
267	Payer Name – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	2589-2613	Left Justified	Yes	50C

Description:

The name of the payer organization from which the facility might third expect some payment for the bill. **Many bills will lack a third payer; this field will then be blank.**

The UB-04 form has **three lines for Form Locator 50**. The appropriate payer source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

The Payer Name – Tertiary is use to generate the Payer Classification code – Tertiary. The Payer Classification Code – Tertiary is used to identify and analyze data for a particular payer organization and to analyze hospital case mix data.

Please refer to pages 163–164 for the appropriate payer name for each Payer Classification Code – Tertiary.

UB-04 Data Dictionary

Field No.	Field Description
268 - 278	Condition Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2614-2635	Left Justified	Yes	FL 18 – 28

Description:

Code(s) used to identify conditions or events relating to a bill that may affect processing. These codes are used by the Vendor to generate the Do Not Resuscitate Code.

Field No.	Field Name	UB-04 Form Locator Number	ASTC File Position
268	Condition Code 1	FL – 18	2614 – 2615
269	Condition Code 2	FL – 19	2616 – 2617
270	Condition Code 3	FL – 20	2618 – 2619
271	Condition Code 4	FL – 21	2620 – 2621
272	Condition Code 5	FL – 22	2622 – 2623
273	Condition Code 6	FL – 23	2624 – 2625
274	Condition Code 7	FL – 24	2626 – 2627
275	Condition Code 8	FL – 25	2628 – 2629
276	Condition Code 9	FL – 26	2630 – 2631
277	Condition Code 10	FL – 27	2632 – 2633
278	Condition Code 11	FL – 28	2634 – 2635

UB-04 Data Dictionary

Field No.	Field Description
See Below	Occurrence Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	See Below	Left Justified	Yes	31a – 34a

Description:

The code defining a significant event relating to a bill that may affect payer processing. The Occurrence Codes and Occurrence Dates are used by the vendor to generate the Accident Code and Date.

Field No.	Description	UB-04 Form Locator Number	ASTC File Position
279	Occurrence Code 1	FL – 31a	2636 – 2637
281	Occurrence Code 2	FL – 31b	2646 – 2647
283	Occurrence Code 3	FL – 31a	2656 – 2657
285	Occurrence Code 4	FL – 32b	2666 – 2667
287	Occurrence Code 5	FL – 33a	2676 – 2677
289	Occurrence Code 6	FL – 33b	2686 – 2687
291	Occurrence Code 7	FL – 34a	2696 – 2697
293	Occurrence Code 8	FL – 34b	2706 – 2707

UB-04 Data Dictionary

Field No.	Field Description
See Below	Occurrence Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	See Below	Right Justified	Yes	See Below

Description:

The associated date defining a significant event relating to a bill that may affect payer processing. The Occurrence Codes and Occurrence Dates are used by the Vendor to generate the Accident Code and Date.

The date format is MMDDCCYY.

Field No.	Description	UB-04 Form Locator Number	ASTC File Position
280	Occurrence Date 1	FL – 31a	2638 – 2645
282	Occurrence Date 2	FL – 31b	2648 – 2655
284	Occurrence Date 3	FL – 32a	2658 – 2665
286	Occurrence Date 4	FL – 32b	2668 – 2675
288	Occurrence Date 5	FL – 33a	2678 – 2685
290	Occurrence Date 6	FL – 33b	2688 – 2695
292	Occurrence Date 7	FL – 34a	2698 – 2705
294	Occurrence Date 8	FL – 34b	2708 – 2715

UB04 Data Record Format (2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
1	Facility Type	-	A-N	1	1	1
2	Data Year	-	A-N	4	2	5
3	Vendor Identification Number	-	A-N	2	6	7
4	Bill Number	-	A-N	7	8	14
5	Record Sequence Number	-	A-N	2	15	16
6	Facility Identification Number	-	A-N	5	17	21
7	Filler	-	A-N	2	22	23
8	Form Type	-	A-N	2	24	25
9	Patient Control Number	3A	A-N	25	26	50
10	Medical/Health Record Number	3B	A-N	25	51	75
11	Type of Bill	4	A-N	4	76	79
12	Federal Tax Sub ID Number	5	A-N	4	80	83
13	Federal Tax Number	5	A-N	10	84	93
14	Statement Covers Period - From Date MMDDYYYY	6	N	8	94	101
15	Statement Covers Period – Through Date MMDDYYYY	6	N	8	102	109
16	Patient’s Address – City	9B	A-N	30	110	139
17	Patient’s Address – State	9C	A-N	2	140	141
18	Patient’s Address – Zip Code	9D	A-N	9	142	150
19	Patient’s Address – Country Code	9E	A-N	4	151	154
20	Patient’s Date of Birth – MMDDYYYY	10	N	8	155	162
21	Patient’s Sex	11	A-N	1	163	163
22	Admission Date – MMDDYYYY	12	N	8	164	171
23	Admission Hour	13	A-N	2	172	173
24	Type of Admission/Visit	14	A-N	2	174	175
25	Source of Admission	15	A-N	2	176	177
26	Patient Discharge Status	17	A-N	2	178	179
27	Do Not Resuscitate Flag	-	A-N	1	180	180
28	Accident State	29	A-N	2	181	182
29	Accident Code	-	A-N	2	183	184
30	Accident Date – MMDDYYYY	-	N	8	185	192
31	Revenue Code (1)	42	A-N	4	193	196
32	Revenue Code (2)	42	A-N	4	197	200
33	Revenue Code (3)	42	A-N	4	201	204
34	Revenue Code (4)	42	A-N	4	205	208
35	Revenue Code (5)	42	A-N	4	209	212
36	Revenue Code (6)	42	A-N	4	213	216
37	Revenue Code (7)	42	A-N	4	217	220
38	Revenue Code (8)	42	A-N	4	221	224

UB-04 Data Record Format
(2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
39	Revenue Code (9)	42	A-N	4	225	228
40	Revenue Code (10)	42	A-N	4	229	232
41	Revenue Code (11)	42	A-N	4	233	236
42	Revenue Code (12)	42	A-N	4	237	240
43	Revenue Code (13)	42	A-N	4	241	244
44	Revenue Code (14)	42	A-N	4	245	248
45	Revenue Code (15)	42	A-N	4	249	252
46	Revenue Code (16)	42	A-N	4	253	256
47	Revenue Code (17)	42	A-N	4	257	260
48	Revenue Code (18)	42	A-N	4	261	264
49	Revenue Code (19)	42	A-N	4	265	268
50	Revenue Code (20)	42	A-N	4	269	272
51	Revenue Code (21)	42	A-N	4	273	276
52	Revenue Code (22)	42	A-N	4	277	280
53	Revenue Code (23)	42	A-N	4	281	284
54	HCPCS/Rates/HIPPS Rate Codes (1)	44	A-N	14	285	298
55	HCPCS/Rates/HIPPS Rate Codes (2)	44	A-N	14	299	312
56	HCPCS/Rates/HIPPS Rate Codes (3)	44	A-N	14	313	326
57	HCPCS/Rates/HIPPS Rate Codes (4)	44	A-N	14	327	340
58	HCPCS/Rates/HIPPS Rate Codes (5)	44	A-N	14	341	354
59	HCPCS/Rates/HIPPS Rate Codes (6)	44	A-N	14	355	368
60	HCPCS/Rates/HIPPS Rate Codes (7)	44	A-N	14	369	382
61	HCPCS/Rates/HIPPS Rate Codes (8)	44	A-N	14	383	396
62	HCPCS/Rates/HIPPS Rate Codes (9)	44	A-N	14	397	410
63	HCPCS/Rates/HIPPS Rate Codes (10)	44	A-N	14	411	424
64	HCPCS/Rates/HIPPS Rate Codes (11)	44	A-N	14	425	438
65	HCPCS/Rates/HIPPS Rate Codes (12)	44	A-N	14	439	452
66	HCPCS/Rates/HIPPS Rate Codes (13)	44	A-N	14	453	466
67	HCPCS/Rates/HIPPS Rate Codes (14)	44	A-N	14	467	480
68	HCPCS/Rates/HIPPS Rate Codes (15)	44	A-N	14	481	494
69	HCPCS/Rates/HIPPS Rate Codes (16)	44	A-N	14	495	508
70	HCPCS/Rates/HIPPS Rate Codes (17)	44	A-N	14	509	522
71	HCPCS/Rates/HIPPS Rate Codes (18)	44	A-N	14	523	536
72	HCPCS/Rates/HIPPS Rate Codes (19)	44	A-N	14	537	550
73	HCPCS/Rates/HIPPS Rate Codes (20)	44	A-N	14	551	564
74	HCPCS/Rates/HIPPS Rate Codes (21)	44	A-N	14	565	578
75	HCPCS/Rates/HIPPS Rate Codes (22)	44	A-N	14	579	592
76	HCPCS/Rates/HIPPS Rate Codes (23)	44	A-N	14	593	606
77	Service Date (1) – MMDDYYYY	45	N	8	607	614
78	Service Date (2) – MMDDYYYY	45	N	8	615	622

UB-04 Data Record Format
(2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
79	Service Date (3) – MMDDYYYY	45	N	8	623	630
80	Service Date (4) – MMDDYYYY	45	N	8	631	638
81	Service Date (5) – MMDDYYYY	45	N	8	639	646
82	Service Date (6) – MMDDYYYY	45	N	8	647	654
83	Service Date (7) – MMDDYYYY	45	N	8	655	662
84	Service Date (8) – MMDDYYYY	45	N	8	663	670
85	Service Date (9) – MMDDYYYY	45	N	8	671	678
86	Service Date (10) – MMDDYYYY	45	N	8	679	686
87	Service Date (11) – MMDDYYYY	45	N	8	687	694
88	Service Date (12) – MMDDYYYY	45	N	8	695	702
89	Service Date (13) – MMDDYYYY	45	N	8	703	710
90	Service Date (14) – MMDDYYYY	45	N	8	711	718
91	Service Date (15) – MMDDYYYY	45	N	8	719	726
92	Service Date (16) – MMDDYYYY	45	N	8	727	734
93	Service Date (17) – MMDDYYYY	45	N	8	735	742
94	Service Date (18) – MMDDYYYY	45	N	8	743	750
95	Service Date (19) – MMDDYYYY	45	N	8	751	758
96	Service Date (20) – MMDDYYYY	45	N	8	759	766
97	Service Date (21) – MMDDYYYY	45	N	8	767	774
98	Service Date (22) – MMDDYYYY	45	N	8	775	782
99	Service Date (23) – MMDDYYYY	45	N	8	783	790
100	Creation Date – MMDDYYYY	45	N	8	791	798
101	Unit(s) of Service (1)	46	N	7	799	805
102	Unit(s) of Service (2)	46	N	7	806	812
103	Unit(s) of Service (3)	46	N	7	813	819
104	Unit(s) of Service (4)	46	N	7	820	826
105	Unit(s) of Service (5)	46	N	7	827	833
106	Unit(s) of Service (6)	46	N	7	834	840
107	Unit(s) of Service (7)	46	N	7	841	847
108	Unit(s) of Service (8)	46	N	7	848	854
109	Unit(s) of Service (9)	46	N	7	855	861
110	Unit(s) of Service (10)	46	N	7	862	868
111	Unit(s) of Service (11)	46	N	7	869	875
112	Unit(s) of Service (12)	46	N	7	876	882
113	Unit(s) of Service (13)	46	N	7	883	889
114	Unit(s) of Service (14)	46	N	7	890	896
115	Unit(s) of Service (15)	46	N	7	897	903
116	Unit(s) of Service (16)	46	N	7	904	910
117	Unit(s) of Service (17)	46	N	7	911	917
118	Unit(s) of Service (18)	46	N	7	918	924

UB-04 Data Record Format
(2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
119	Unit(s) of Service (19)	46	N	7	925	931
120	Unit(s) of Service (20)	46	N	7	932	938
121	Unit(s) of Service (21)	46	N	7	939	945
122	Unit(s) of Service (22)	46	N	7	946	952
123	Unit(s) of Service (23)	46	N	7	953	959
124	Filler	-	N	10	960	969
125	Filler	-	N	10	970	979
126	Filler	-	N	10	980	989
127	Filler	-	N	10	990	999
128	Filler	-	N	10	1000	1009
129	Filler	-	N	10	1010	1019
130	Filler	-	N	10	1020	1029
131	Filler	-	N	10	1030	1039
132	Filler	-	N	10	1040	1049
133	Filler	-	N	10	1050	1059
134	Filler	-	N	10	1060	1069
135	Filler	-	N	10	1070	1079
136	Filler	-	N	10	1080	1089
137	Filler	-	N	10	1090	1099
138	Filler	-	N	10	1100	1109
139	Filler	-	N	10	1110	1119
140	Filler	-	N	10	1120	1129
141	Filler	-	N	10	1130	1139
142	Filler	-	N	10	1140	1149
143	Filler	-	N	10	1150	1159
144	Filler	-	N	10	1160	1169
145	Filler	-	N	10	1170	1179
146	Filler	-	N	10	1180	1189
147	Total of Total Charges	-	N	10	1190	1199
148	Non-Covered Charges (by Revenue Code) (1)	48	N	10	1200	1209
149	Non-Covered Charges (by Revenue Code) (2)	48	N	10	1210	1219
150	Non-Covered Charges (by Revenue Code) (3)	48	N	10	1220	1229
151	Non-Covered Charges (by Revenue Code) (4)	48	N	10	1230	1239
152	Non-Covered Charges (by Revenue Code) (5)	48	N	10	1240	1249
153	Non-Covered Charges (by Revenue Code) (6)	48	N	10	1250	1259
154	Non-Covered Charges (by Revenue Code) (7)	48	N	10	1260	1269
155	Non-Covered Charges (by Revenue Code) (8)	48	N	10	1270	1279
156	Non-Covered Charges (by Revenue Code) (9)	48	N	10	1280	1289
157	Non-Covered Charges (by Revenue Code) (10)	48	N	10	1290	1299
158	Non-Covered Charges (by Revenue Code) (11)	48	N	10	1300	1309

UB-04 Data Record Format
(2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
159	Non-Covered Charges (by Revenue Code) (12)	48	N	10	1310	1319
160	Non-Covered Charges (by Revenue Code) (13)	48	N	10	1320	1329
161	Non-Covered Charges (by Revenue Code) (14)	48	N	10	1330	1339
162	Non-Covered Charges (by Revenue Code) (15)	48	N	10	1340	1349
163	Non-Covered Charges (by Revenue Code) (16)	48	N	10	1350	1359
164	Non-Covered Charges (by Revenue Code) (17)	48	N	10	1360	1369
165	Non-Covered Charges (by Revenue Code) (18)	48	N	10	1370	1379
166	Non-Covered Charges (by Revenue Code) (19)	48	N	10	1380	1389
167	Non-Covered Charges (by Revenue Code) (20)	48	N	10	1390	1399
168	Non-Covered Charges (by Revenue Code) (21)	48	N	10	1400	1409
169	Non-Covered Charges (by Revenue Code) (22)	48	N	10	1410	1419
170	Non-Covered Charges (by Revenue Code) (23)	48	N	10	1420	1429
171	Total of Non-Covered Charges	-	N	10	1430	1439
172	Payer Classification Code – Primary	50A	A-N	4	1440	1443
173	Payer Classification Code – Secondary	50B	A-N	4	1444	1447
174	Payer Classification Code – Tertiary	50C	A-N	4	1448	1451
175	Health Plan ID – Primary	51A	A-N	15	1452	1466
176	Health Plan ID – Secondary	51B	A-N	15	1467	1481
177	Health Plan ID – Tertiary	51C	A-N	15	1482	1496
178	National Provider ID (NPI)	56	A-N	15	1497	1511
179	Patient’s Relationship to Insured – Primary	59A	A-N	2	1512	1513
180	Patient’s Relationship to Insured – Secondary	59B	A-N	2	1514	1515
181	Patient’s Relationship to Insured – Tertiary	59C	A-N	2	1516	1517
182	Insured’s Unique ID Number – Primary	60A	A-N	20	1518	1537
183	Insured’s Unique ID Number – Secondary	60B	A-N	20	1538	1557
184	Insured’s Unique ID Number – Tertiary	60C	A-N	20	1558	1577
185	Insurance Group Number – Primary	62A	A-N	17	1578	1594
186	Insurance Group Number – Secondary	62B	A-N	17	1595	1611
187	Insurance Group Number – Tertiary	62C	A-N	17	1612	1628
188	Name of Primary Insured’s Employer	65A	A-N	25	1629	1653
189	DX and PX Version Qualifier	66	A-N	2	1654	1655
190	Principal Diagnosis Code	67	A-N	8	1656	1663
191	Other Diagnosis Code (1)	67A	A-N	8	1664	1671
192	Other Diagnosis Code (2)	67B	A-N	8	1672	1679
193	Other Diagnosis Code (3)	67C	A-N	8	1680	1687
194	Other Diagnosis Code (4)	67D	A-N	8	1688	1695
195	Other Diagnosis Code (5)	67E	A-N	8	1696	1703
196	Other Diagnosis Code (6)	67F	A-N	8	1704	1711
197	Other Diagnosis Code (7)	67G	A-N	8	1712	1719

UB-04 Data Record Format (2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
198	Other Diagnosis Code (8)	67H	A-N	8	1720	1727
199	Other Diagnosis Code (9)	67I	A-N	8	1728	1735
200	Other Diagnosis Code (10)	67J	A-N	8	1736	1743
201	Other Diagnosis Code (11)	67K	A-N	8	1744	1751
202	Other Diagnosis Code (12)	67L	A-N	8	1752	1759
203	Other Diagnosis Code (13)	67M	A-N	8	1760	1767
204	Other Diagnosis Code (14)	67N	A-N	8	1768	1775
205	Other Diagnosis Code (15)	67O	A-N	8	1776	1783
206	Other Diagnosis Code (16)	67P	A-N	8	1784	1791
207	Other Diagnosis Code (17)	67Q	A-N	8	1792	1799
208	Admitting Diagnosis Code	69	A-N	7	1800	1806
209	Patient's Reason for Visit Code	70A	A-N	7	1807	1813
210	Patient's Reason for Visit Code	70B	A-N	7	1814	1820
211	Patient's Reason for Visit Code	70C	A-N	7	1821	1827
212	Prospective Payment System Code (PPS)	71	A-N	4	1828	1831
213	External Cause of Injury Code (1)	72A	A-N	8	1832	1839
214	External Cause of Injury Code (2)	72B	A-N	8	1840	1847
215	External Cause of Injury Code (3)	72C	A-N	8	1848	1855
216	Filler	-	A-N	7	1856	1862
217	Filler	-	N	8	1863	1870
218	Filler	-	A-N	7	1871	1877
219	Filler	-	N	8	1878	1885
220	Filler	-	A-N	7	1886	1892
221	Filler	-	N	8	1893	1900
222	Filler	-	A-N	7	1901	1907
223	Filler	-	N	8	1908	1915
224	Filler	-	A-N	7	1916	1922
225	Filler	-	N	8	1923	1930
226	Filler	-	A-N	7	1931	1937
227	Filler	-	N	8	1938	1945
228	Attending Physician – Profession Code	-	A-N	2	1946	1947
229	Attending Physician – TN License Number	76	A-N	10	1948	1957
230	Attending Physician – UPIN/NPI	76	A-N	13	1958	1970
231	Operating Physician – Profession Code	-	A-N	2	1971	1972
232	Operating Physician – TN License Number	77	A-N	10	1973	1982
233	Operating Physician – UPIN/NPI	77	A-N	13	1983	1995
234	Other Provider ID1 – Profession Code	-	A-N	2	1996	1997
235	Other Provider ID1 – TN License Number	78	A-N	10	1998	2007
236	Other Provider ID1 – UPIN/NPI	78	A-N	13	2008	2020
237	Other Provider ID2 – Profession Code	-	A-N	2	2021	2022

UB-04 Data Record Format
(2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
238	Other Provider ID2 – TN License Number	79	A-N	10	2023	2032
239	Other Provider ID2 – UPIN/NPI	79	A-N	13	2033	2045
240	Filler	-	A-N	12	2046	2057
241	Patient’s Social Security Number	-	A-N	10	2058	2067
242	Patient’s Race/Ethnicity	-	A-N	2	2068	2069
243	Filler	-	A-N	1	2070	2070
244	Filler	-	A-N	1	2071	2071
245	Encryption Key	-	A-N	40	2072	2011
246	Vendor Generated Flags	-	A-N	23	2112	2134
247	State Generated Flags	-	A-N	140	2135	2274
248	Patient Initials First Name	-	A-N	2	2275	2276
249	Patient’s Initials Last Name	-	A-N	4	2277	2280
250	Primary Insured Initials – First Name	-	A-N	2	2281	2282
251	Primary Insured Initials – Last Name	-	A-N	4	2283	2286
252	Secondary Insured Initials – First Name	-	A-N	2	2287	2288
253	Secondary Insured Initials – Last Name	-	A-N	4	2289	2292
254	Tertiary Insured Initials – First Name	-	A-N	2	2293	2294
255	Tertiary Insured Initials – Last Name	-	A-N	4	2295	2298
256	Patient’s Address – Street	9A	A-N	40	2299	2338
257	Patient’s Name – First	8A	A-N	20	2339	2358
258	Patient’s Name – Last	8B	A-N	30	2359	2388
259	Primary Insured’s Name – First	58A	A-N	20	2389	2408
260	Primary Insured’s Name – Last	58A	A-N	30	2409	2438
261	Secondary Insured’s Name – First	58B	A-N	20	2439	2458
262	Secondary Insured’s Name – Last	58B	A-N	30	2459	2488
263	Tertiary Insured’s Name – First	58C	A-N	20	2489	2508
264	Tertiary Insured’s Name – Last	58C	A-N	30	2509	2538
265	Payer Name – Primary	50A	A-N	25	2539	2563
266	Payer Name – Secondary	50B	A-N	25	2564	2588
267	Payer Name – Tertiary	50C	A-N	25	2589	2613
268	Condition Codes (1)	18	A-N	2	2614	2615
269	Condition Codes (2)	19	A-N	2	2616	2617
270	Condition Codes (3)	20	A-N	2	2618	2619
271	Condition Codes (4)	21	A-N	2	2620	2621
272	Condition Codes (5)	22	A-N	2	2622	2623
273	Condition Codes (6)	23	A-N	2	2624	2625
274	Condition Codes (7)	24	A-N	2	2626	2627
275	Condition Codes (8)	25	A-N	2	2628	2629
276	Condition Codes (9)	26	A-N	2	2630	2631
277	Condition Codes (10)	27	A-N	2	2632	2633

UB-04 Data Record Format (2715 Byte Record Length)

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
278	Condition Codes (11)	28	A-N	2	2634	2635
279	Occurrence Code	31A	A-N	2	2636	2637
280	Occurrence Date	31A	N	8	2638	2645
281	Occurrence Code	31B	A-N	2	2646	2647
282	Occurrence Date	31B	N	8	2648	2655
283	Occurrence Code	32A	A-N	2	2656	2657
284	Occurrence Date	32A	N	8	2658	2665
285	Occurrence Code	32B	A-N	2	2666	2667
286	Occurrence Date	32B	N	8	2668	2675
287	Occurrence Code	33A	A-N	2	2676	2677
288	Occurrence Date	33A	N	8	2678	2685
289	Occurrence Code	33B	A-N	2	2686	2687
290	Occurrence Date	33B	N	8	2688	2695
291	Occurrence Code	34A	A-N	2	2696	2697
292	Occurrence Date	34A	N	8	2698	2705
293	Occurrence Code	34B	A-N	2	2706	2707
294	Occurrence Date	34B	N	8	2708	2715

***PC Format**

A-N = Alpha Numeric

N = Numeric

SECTION V

Appendices

(Rule 1200-07-04-.01, continued)

ENABLING LEGISLATION: T.C.A. -68-1-119

68-1-119. Claims data discharge reports by ambulatory surgical treatment centers (ASTCs) -- Penalties -- Waiver -- Civil liability -- Exceptions.

(a) Each licensed ambulatory surgical treatment center (ASTC) and each licensed Outpatient Diagnostic Center (ODC) shall report all claims data found on the appropriate form on every discharge to the commissioner of health. ASTCs and ODCs shall file joint annual reports as required by the department of health. ASTCs and ODCs shall submit the data through third party entities approved by the department of health for the purpose of editing the data according to rules and regulations established by the commissioner. The ASTCs and ODCs shall be responsible for the costs associated with processing of the data by the approved vendors. An ASTC and an ODC shall report the claims data at least quarterly to the commissioner. No information shall be made available to the public by the commissioner that reasonably could be expected to reveal the identity of any patient. The claims data reported to the commissioner under this section are confidential and not available to the public until the commissioner processes and verifies the data. The commissioner shall prescribe conditions under which the processed and verified data are available to the public.

(b) A licensed ASTC and ODC shall pay to the commissioner a civil penalty of five cents (5cent(s)) for each day the claims data discharge report is delinquent. A claims data report is delinquent if the commissioner does not receive it before sixty (60) days after the end of the quarter. If the commissioner receives the report in incomplete form, the commissioner shall notify the ASTC and ODC and provide fifteen (15) additional days to correct the error. The notice shall provide the ASTC and ODC an additional fifteen (15) days to complete the form and return it to the commissioner prior to the imposition of any civil penalty. The maximum civil penalty for a delinquent report is ten dollars (\$10.00) for each discharge record. The commissioner shall issue an assessment of the civil penalty to the ASTC and ODC. The ASTC and ODC has a right to an informal conference with the commissioner, if the ASTC and ODC requests the conference within thirty (30) days of receipt of the assessment. After the informal conference or, if no conference is requested, after the time for requesting the informal conference has expired, the commissioner may proceed to collect the penalty by setting the penalty off against funds owed to the ASTC and ODC or by instituting litigation.

(c) In its request for an informal conference, the ASTC and ODC may request the commissioner to waive the penalty. The commissioner may waive the penalty in cases of an act of God or other acts beyond the control of the ASTC and ODC. Waiver of the penalty is in the sole discretion of the commissioner. None of these proceedings are subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) No person or entity may be held liable in any civil action with respect to any report or disclosure of information made under this section, unless the person or entity has knowledge of any falsity of the information reported or disclosed.

(e) This section shall not affect or replace any other reporting responsibility placed upon ASTCs. The report filed pursuant to this section shall not be required for discharges reported by ASTCs under § 68-3-505.

(f) The claims data required to be reported by this section shall be collected and reported only to the extent it is collected and reported in the normal billing process, unless other claims data is deemed by the commissioner to be essential to the development or use of the ASTC claims data reporting system, in which case the identified data that is outside the normal billing process must be collected and reported; provided, however, that other claims data that may be required to be collected and reported shall be consistent with data required to be collected and reported by other healthcare providers. Any data that is submitted to the commissioner pursuant to this section shall be made available to the public no more frequently and no sooner after the data is submitted than the data collected and reported by licensed hospitals pursuant to § 68-1-108.

[Acts 2002, ch. 513, § 1; 2004, ch. 917, §§ 6, 7; 2006, ch. 625, §§ 1-3]

(Rule 1200-07-04-.01, continued)

Rules of
Tennessee Department of Health
Bureau of Health Informatics
Office of Health Statistics

Chapter 1200-07-04
Ambulatory Surgical Treatment Center Data System

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1200-07-04-.01 Definitions

1. "Ambulatory Surgical Treatment Center" shall have the same definition as contained in T.C.A. §68-11-201.
2. "ASTC" is the acronym for ambulatory surgical treatment center.
3. "Claim" shall mean a charge or bill for services rendered, billed to the patient, to another private individual, or to a third party payer, public or private.
4. "Claims Data" shall mean all data elements collected for all patients for whom an ASTC or ODC provides services that are entered on any claim form prepared by the ASTC or ODC and shall always include those required data elements identified in the subparagraphs listed in rule 1200-07-04-04, paragraphs (1) and (2).
5. "CMS-1500" shall mean the claim form "Centers for Medicare & Medicaid Services 1500" or its successor form.
6. "Commissioner" shall mean the commissioner of the Tennessee Department of Health.
7. "Data Element" shall mean any individual piece of information collected from a patient by an ASTC or ODC during the process of providing services to that patient for which the ASTC or ODC will file a claim.
8. "Department" shall mean the Tennessee Department of Health.
9. "Error" shall mean data that are incomplete or inconsistent with the specifications in the ASTC Data System Procedural Manual, the ODC Data System Procedural Manual, or these rules.
10. "Final Joint Annual Report" shall mean the most recent Joint Annual Report filed by an ASTC or ODC where the data contained in the report have been edited, queried, and updated when appropriate, by the Department.
11. "JAR" is the acronym for Joint Annual Report.
12. "ODC" is the acronym for outpatient diagnostic center.
13. "Outpatient Diagnostic Center" shall have the same definition as contained in T.C.A. §68-11-201.

June, 2013 (Revised)

(Rule 1200-07-04-.01, continued)

14. "Personal Identifiers" shall be defined to include all the identifiers contained in 45 C.F.R. § 164.514 (b) or (e).
15. "Processed Data" shall mean data that have been analyzed by the Department or the Department's designated data vendor(s) and errors, inconsistencies, and/or incomplete elements in the data set, if any, have been identified.
16. "Public" shall mean anyone other than the Tennessee Department of Health, its vendors, and its contracted agencies.
17. "Record Level Data" shall mean a set of data that is specific to individual patient claims.
18. "State" shall mean the government of the State of Tennessee including all its agencies.
19. "UB-04" shall mean the CMS Form 1450, [a.k.a. "the Uniform Hospital Billing Form"], or its successor forms as established by the National Uniform Billing Committee and the State Uniform Billing Implementation Committee.
20. "Vendor" shall mean a third party entity, approved by the Department, through whom an ASTC or ODC submits its claims data for the purpose of compilation and editing according to these rules and the instructions of the Department.
21. "Verified Data" shall mean data that have been processed by the Department after the ASTCs or ODCs have had the opportunity to suggest corrections and/or deletions, and all appropriate revisions have been made to the data and approved by the Department.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** *Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.*

1200-07-04-.02 Purpose

- (1) The reporting of ambulatory surgical and outpatient diagnostic data will provide two statewide databases and permit assessment of variations in utilization, practice parameters, access to care, and charges.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** *Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.*

1200-07-04-.03 Reporting Requirements

- (1) Each ASTC and ODC shall contract with one of the approved vendors and shall report through its vendor all its claims data. Claims data for all free or charity services provided by any ASTC or ODC that otherwise submits claims for reimbursement shall also be reported to the vendor.
- (2) No claim reporting is required for any of the following:
 - (a) From a licensed ASTC or ODC that provides only free care and never bills for any services.
 - (b) Regarding any procedures already reported by an ASTC or ODC to the Department under T.C.A. § 68-3-505 or services ancillary thereto such as counseling, testing, or follow-up.

June, 2013 (Revised)

(Rule 1200-07-04-.03, continued)

- (3) The Department will prepare the ASTC and ODC Data System-Procedural Manuals that will list the variables to be reported, their descriptions and reporting format, and other information associated with data submission. The Department shall issue revisions to the Procedural Manuals when the Commissioner deems it necessary. The Department will notify each ASTC, ODC, and vendor of all revisions. These revisions become effective one hundred and eighty (180) days following the date of notification. At that time, failure to meet the amended requirements is subject to the penalties as prescribed by T.C.A. §68-1-119.
- (4) Each ASTC or ODC shall report all data elements using the actual values used for billing by the ASTC or the ODC. No data elements shall be encrypted or otherwise altered. This rule shall not be interpreted to prevent encryption of entire files for security in transmission to parties having the appropriate decryption software.
- (5) Each ASTC and ODC shall be responsible for submitting its data to the approved vendor in a format and medium approved by the State.
- (6) Each ASTC and ODC shall be responsible for the costs associated with the processing of the data by the approved vendors.
- (7) Each ASTC and ODC shall report in a format using the data elements which correspond with the claim form used by the ASTC or ODC for billing. If an ASTC or ODC submits claims using both the CMS-1500 and UB-04 forms, the claims data shall be submitted in separate data sets for each form.
- (8) Each ASTC and ODC shall report the claims data at least quarterly, pursuant to rule 1200-07-04-05, to its approved vendor with a separate data set for each facility location.
- (9) Each ASTC and ODC shall designate one staff member to be responsible for reporting the claims data and shall notify the Department and its approved vendor of the name, title, work address, work telephone number, and e-mail address of the designated staff member.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** *Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.*

1200-07-04-.04 Required Data Elements

(1) CMS-1500 Claims Forms

- (a) Each ASTC and ODC must report to the Department all the following data elements for each and every claim based on the CMS-1500 form:
 1. Patient's Birth Date
 2. Patient's Sex
 3. Patient's Address (State)
 4. Patient's Address (Zip Code)
 5. Dates of Service (Through Date)
 6. Diagnosis or Nature of Illness or Injury
 7. Total Charge

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(Rule 1200-07-04-.04, continued)

8. Patient's Social Security Number

9. Patient's Race/Ethnicity

(b) Each ASTC and ODC must report to the Department all CMS-1500 data elements listed in the relevant ASTC or ODC Procedural Manual whenever the data element is collected by the ASTC or ODC and/or used for billing.

(2) UB-04 Claims Forms

(a) Each ASTC and ODC must report to the Department all the following data elements for each and every claim based on the UB-04 form:

1. Statement Covers Period

2. Patient's Address (State)

3. Patient's Address (Zip Code)

4. Patient's Date of Birth

5. Patient's Sex

6. Revenue Codes

7. Total Charges (By Revenue Code Category)

8. Principal Diagnosis Code

9. Patient's Social Security Number

10. Patient's Race/Ethnicity

(b) Each ASTC and ODC must report to the Department all UB-04 data elements listed in the relevant ASTC or ODC Procedural Manual whenever the data element is collected by the ASTC or ODC and/or used for billing.

(3) Each ASTC and ODC shall report to the Department all data elements that it collected from patients and which it reported by making an entry in any or all of the data element spaces contained on any form other than the CMS-1500 or UB-04 on which it submits a claim. However, the data elements identified in paragraphs (1)(a) and (2)(a) above that must be collected, entered and reported to the Department by the ASTC or ODC for the identified claim form shall also be reported to the Department when any other claim form is used.

(4) Data elements collected by the ASTC or ODC that are not specifically identified in either paragraphs (1) through (3) of this rule or in the procedural manual shall not be reported to the vendor or the Department.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.05 Submission Schedule

(1) Each ASTC or ODC shall submit all required claims to its approved vendor according to the following quarterly schedule:

(Rule 1200-07-04-.05, continued)

Quarter	Time Span	Submission Due Date
Q1	January 1 -March 31	May 30
Q2	April 1 -June 30	August 29
Q3	July 1 – September 30	November 29
Q4	October 1 -December 31	March 1

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.06 Vendor Requirements

(1) An applicant desiring to be approved as a statewide data processing vendor shall make written application to the Department. To be selected as a statewide vendor by the Department the applicant must demonstrate the ability to do all of the following:

- (a) Process the claims data as specified by the Department using the codes and the standards for completeness and quality specified by the Department.
- (b) Include in each claims data record the JD number approved by the Department for the reporting ASTC or ODC and all vendor-generated fields specified by the Department.
- (c) Examine the claims data it receives for accuracy, inform the ASTC or ODC submitting the data of all potential errors in the data which are discovered as a result of the examination of accuracy, and correct the data as directed by the ASTC, the ODC, and/or the Department.
- (d) Submit the claims data to the Department in an electronic or magnetic medium or process approved by the Department.
- (e) Report to the Department each ASTC or ODC that has either failed to submit claims data or is tardy in doing so.
- (f) Affirm that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations and will comply with all applicable and current HIPAA requirements in the course of doing business with the State. The applicant shall affirm that it will cooperate with the State in the course of its performance so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. The applicant will sign any documents that are reasonably necessary to keep both parties in compliance with HIPAA, including, but not limited to, business associate agreements.

(2) If any approved vendor fails to carry out its requirements as specified in the rules of the Tennessee

Department of Health, the Department may remove its approval as a statewide data processing vendor.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.07 Processing and Verification

- (1) Each vendor must review all claims data submitted for completeness and accuracy. If errors, inconsistencies or incomplete elements are identified by the vendor, the vendor must report the errors to the ASTC or ODC in writing.
- (2) Upon receiving written notification of errors, the ASTC or ODC shall investigate the problem and shall supply correct information to the vendor within fifteen (15) days from notification.
- (3) Each approved vendor must report quarterly to the Department the reporting status of all ASTCs or ODCs utilizing its services. The status of facilities that failed to report, that were delinquent in reporting, or that exceeded the acceptable error rate shall be provided to the Department quarterly and then updated at the initiative of the vendor or upon request of the Department. Each vendor shall maintain and report to the Department any information the Department deems necessary for penalty assessment.
- (4) Each approved vendor must report all data received each quarter, including additions and corrections, to the Department no more than sixty (60) days following the submission due date specified in rule 1200-07-04-.05.
- (5) Each ASTC and ODC shall be given a ten (10) day period to review the quarterly data set relating to their facility after the quarterly data have been computerized, edited, updated, and determined to be the final corrected set by the Department. Upon the expiration of the ten (10) day period, absent receipt of corrections and/or revisions from an ASTC or ODC, the quarterly data is considered verified. If corrections and/or revisions are received by the Department within the ten day period, the quarterly data is considered verified only after the Department has made any corrections and/or revisions it considers appropriate.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.08 Penalty Assessment

- (1) The Department will assess the civil penalties authorized by T.C.A. § 68-1-119(b) each day claims data are reported later than the submission due date identified in rule 1200-07-04-.05 or not reported at all up to the statutory maximum for each claim record.
- (2) Any ASTC or ODC not submitting any claims data by the submission deadline will have the number of quarterly unreported claims records calculated, for purposes of civil penalty assessment, by dividing by four (4), the number of total discharges or admissions reported on Schedule D (Availability and Utilization of Services) of the most current final JAR of the ASTC or ODC on file with the Department for that facility.
- (3) An ASTC or ODC not submitting any claims data by the submission deadline will begin accruing penalties the day immediately following the submission deadline and ending the day when the actual claims data are received by the vendor or the maximum penalty is reached.
- (4) The Department will report the rate of error it identifies to the ASTC or ODC in writing. The acceptable error rate will be two percent (2%). Records that fall within the acceptable error rate will not be subject to penalties. ASTCs or ODCs that exceed the acceptable error rate will be penalized based on total errors.
- (5) ASTC or ODC that does not timely submit corrected claims records will accrue delinquent penalties starting the sixteenth (16th) day after error notification and ending the day when the

(Rule 1200-07-04-.08, continued)

actual corrected claims data are received by the Department or the maximum penalty is reached.

(6) Upon receipt of the notice of civil penalty assessment the ASTC or ODC has the right to an informal conference with the Commissioner or a formal hearing to contest the assessment.

(a) Informal conferences are governed by T.C.A. § 68-1-119(b) and (c).

(b) A request for a formal hearing must be made in writing and received by the Department within thirty (30) days of the receipt of the notice of assessment or, if an informal conference pursuant to subparagraph (a) was requested, within thirty (30) days of the receipt of the written disposition of the informal conference. Proceedings involving formal contests of civil penalties are subject to the contested case provisions of the Uniform Administrative Procedures Act.

(c) Civil penalties for any ASTC or ODC that continues to violate the law during the pendency of the informal conference will continue to accrue until either the violation ends or the maximum civil penalty is reached.

(d) Waiver of penalties is governed by T.C.A. § 68-1-119(c). However, the ASTC or ODC must make a request for the waiver in its request for an informal conference pursuant to subparagraph (a) or in its request for a formal hearing pursuant to subparagraph (b).

(7) Unless a request for a formal hearing pursuant to subparagraph (6)(b) is timely received, the civil penalties become final and collectable either on the date that the time for requesting an informal conference has expired without a request being filed, or on the date on which the written final disposition of the informal conference is received.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.09 Data Availability

(1) If the Commissioner determines that the quality or completeness of the information is not acceptable, he or she has the authority to delay release of any particular data element(s).

(2) The Department may create reports for public release using any available processed and verified data. It may also provide custom reports, as requested by the public, using any available processed and verified data. Facility specific data reports will not be released to the public based on less than four (4) consecutive quarters of data.

(3) The State, its agents and the vendors may receive reports of any record necessary, together with any needed patient identifiers, to carry out their contractual duties. This includes any organization contracted with to provide editing, quality control, database management services, or research for the State, or to provide keying of paper claims forms for the vendors. Any such contractual agent must agree in writing to establish and maintain appropriate controls to protect the confidentiality of the data and must agree to return or destroy any data or records at the termination of the contract.

(4) The Department will make record level data files available for public release and purchase under the following conditions. The fee for a quarter of data for each data system will be two hundred fifty dollars (\$250.00). The fee for a subset of a quarter of data for each data system will be two hundred fifty dollars (\$250.00) The Department maintains a proprietary interest in all record level data it sells or distributes and such data are made available solely for use by the purchaser and may not be given or sold to another entity.

(Rule 1200-07-04-.09, continued)

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

1200-07-04-.10 Confidential Information

- (1) All information reported to the Commissioner under this part is confidential until processed and verified by the Department.
- (2) The Commissioner may use or authorize use of this data, including the personal identifiers, for purposes that are necessary to provide for or protect the health of the population and as permitted by Jaw. In no event may personal identifiers be released to the public.
- (3) Information regarding the name of an employer will not be released to the public. Information about any employer may be released to the employer identified in the data record. A facility may receive information regarding the name of an employer for its claims only.
- (4) The data may be released pursuant to the provisions of 45 C.F. R. § 164.514 (b) or (e). However, any data released to the public, in addition to those items required by Jaw to be deleted, will also not contain any of the following:
 - (a) Any patient's address city;
 - (b) An insured's address city;
 - (c) The month and day of all dates;
 - (d) Any numbers after the first three numbers of all zip codes for areas having a population under 20,000;
 - (e) Any numbers after the first five numbers of all zip codes for areas having a population
 - (f) 20,000 or more;
 - (g) The year of birth and the actual age of any person over eighty nine (89) years of age; and
 - (h) Information that reasonably could be expected to reveal the identity of a patient, including those items contained in 45 C.F.R. § 164.514 (a) and (b) (2) (i).
- (5) Any agency of the State of Tennessee seeking confidential ASTC or ODC claims data or reports containing such confidential information, must agree in writing to follow all confidentiality restrictions of the Department concerning use of this data. The agency must also agree in writing to release no record level information to any other entity, and shall forward all such requests for record level information to the Department.

Authority: T.C.A. §§ 68-1-103 and 68-1-119. **Administrative History:** Original rule filed January 27, 2005; effective April 12, 2005. Repeal and new rule filed January 29, 2013; effective June 30, 2013.

June, 2013 (Revised)

CMS-1500 Form
(HCFA-1500 Form)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA		<input type="checkbox"/> PIGA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No., Street)	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. PATIENT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		b. EMPLOYER'S NAME OR SCHOOL NAME	
SIGNED _____ DATE _____		c. INSURANCE PLAN NAME OR PROGRAM NAME	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY/ILMPT		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM DD YY) TO (MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
1. _____ 3. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATES(S) OF SERVICE From (MM DD YY) To (MM DD YY)		23. PRIOR AUTHORIZATION NUMBER	
B. PLACE OF SERVICE ENJO		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	
E. DIAGNOSIS POINTER		F. \$ CHARGES	
G. DAYS OR UNITS		H. I. ID. OUAL	
J. RENDERING PROVIDER ID. #		K. L.	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()		SIGNED _____ DATE _____	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0038-0099 FORM CMS-1500 (08-05)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

UB-04 FORM

1		2		3 PAT. CRTL. # 4. MED. REC. #		4 TYPE OF BILL	
5 PAT. NAME		6 PATIENT ADDRESS		7		8 STATEMENT COVERS PERIOD FROM THROUGH	
9 BIRTHDATE		10 SEX		11 DATE		12 ADMISSION 13 NR 14 TYPE 15 SRC 16 DHR 17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30 OCCURRENCE DATE		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
38		39		40		41	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / H/P/S CODE		45 SERV. DATE	
46		47		48		49	
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PAGE _____ OF _____ CREATION DATE _____ TOTALS →

MS-1450 UBC OMB APPROVAL PENDING NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY HEREOF.

U.S. STANDARD STATE ABBREVIATIONS

ALABAMA	AL	NEW JERSEY	NJ
ALASKA	AK	NEW MEXICO	NM
ARIZONA	AZ	NEW YORK	NY
ARKANSAS	AR	NORTH CAROLINA	NC
CALIFORNIA	CA	NORTH DAKOTA	ND
COLORADO	CO	OHIO	OH
CONNECTICUT	CT	OKLAHOMA	OK
DELAWARE	DE	OREGON	OR
DISTRICT OF COLUMBIA	DC	PENNSYLVANIA	PA
FLORIDA	FL	RHODE ISLAND	RI
GEORGIA	GA	SOUTH CAROLINA	SC
HAWAII	HI	SOUTH DAKOTA	SD
IDAHO	ID	TENNESSEE	TN
ILLINOIS	IL	TEXAS	TX
INDIANA	IN	UTAH	UT
IOWA	IA	VERMONT	VT
KANSAS	KS	VIRGINIA	VA
KENTUCKY	KY	WASHINGTON	WA
LOUISIANA	LA	WEST VIRGINIA	WV
MAINE	ME	WISCONSIN	WI
MARYLAND	MD	WYOMING	WY
MASSACHUSETTS	MA		
MICHIGAN	MI	<u>AMERICAN TERRITORIES</u>	
MINNESOTA	MN		
MISSISSIPPI	MS	AMERICAN SAMOA	AS
MISSOURI	MO	CANAL ZONE	CZ
MONTANA	MT	GUAM	GU
NEBRASKA	NE	PUERTO RICO	PR
NEVADA	NV	TRUST TERRITORIES	TT
NEW HAMPSHIRE	NH	VIRGIN ISLANDS	VI

CANADIAN PROVINCES

ALBERTA	AB	NOVA SCOTIA	NS
BRITISH COLUMBIA	BC	ONTARIO	ON
LABRADOR	LB	PR. EDWARD ISLAND	PE
MANITOBA	MB	QUEBEC	QB
NEW BRUNSWICK	NB	SASKATCHEWAN	SK
NEWFOUNDLAND	NF	YUKON	YK
NORTHWEST TERRITORY	NT		

IF OTHER THAN THE UNITED STATES OR CANADA, USE CODE – XX

ENGLISH COUNTRY NAMES AND CODE ELEMENTS

ISO 3166-1

AFGHANISTAN	AF
ÅLAND ISLANDS	AX
ALBANIA	AL
ALGERIA	DZ
AMERICAN SAMOA	AS
ANDORRA	AD
ANGOLA	AO
ANGUILLA	AI
ANTARCTICA	AQ
ANTIGUA AND BARBUDA	AG
ARGENTINA	AR
ARMENIA	AM
ARUBA	AW
AUSTRALIA	AU
AUSTRIA	AT
AZERBAIJAN	AZ
BAHAMAS	BS
BAHRAIN	BH
BANGLADESH	BD
BARBADOS	BB
BELARUS	BY
BELGIUM	BE
BELIZE	BZ
BENIN	BJ
BERMUDA	BM
BHUTAN	BT
BOLIVIA	BO
BOSNIA AND HERZEGOVINA	BA
BOTSWANA	BW
BOUVET ISLAND	BV
BRAZIL	BR
BRITISH INDIAN OCEAN TERRITORY	IO
BRUNEI DARUSSALAM	BN
BULGARIA	BG
BURKINA FASO	BF
BURUNDI	BI
CAMBODIA	KH
CAMEROON	CM
CANADA	CA
CAPE VERDE	CV
CAYMAN ISLANDS	KY
CENTRAL AFRICAN REPUBLIC	CF
CHAD	TD

English Country Names and Code Elements (continued)

CHILE	CL
CHINA	CN
CHRISTMAS ISLAND	CX
COCOS (KEELING) ISLANDS	CC
COLOMBIA	CO
COMOROS	KM
CONGO	CG
CONGO, THE DEMOCRATIC REPUBLIC OF THE	CD
COOK ISLANDS	CK
COSTA RICA	CR
CÔTE D'IVOIRE	CI
CROATIA	HR
CUBA	CU
CYPRUS	CY
CZECH REPUBLIC	CZ
DENMARK	DK
DJIBOUTI	DJ
DOMINICA	DM
DOMINICAN REPUBLIC	DO
ECUADOR	EC
EGYPT	EG
EL SALVADOR	SV
EQUATORIAL GUINEA	GQ
ERITREA	ER
ESTONIA	EE
ETHIOPIA	ET
FALKLAND ISLANDS (MALVINAS)	FK
FAROE ISLANDS	FO
FIJI	FJ
FINLAND	FI
FRANCE	FR
FRENCH GUIANA	GF
FRENCH POLYNESIA	PF
FRENCH SOUTHERN TERRITORIES	TF
GABON	GA
GAMBIA	GM
GEORGIA	GE
GERMANY	DE
GHANA	GH
GIBRALTAR	GI
GREECE	GR
GREENLAND	GL
GRENADA	GD
GUADELOUPE	GP

English Country Names and Code Elements (continued)

GUAM		GU
GUATEMALA		GT
GUERNSEY		GG
GUINEA		GN
GUINEA-BISSAU		GW
GUYANA		GY
HAITI		HT
HEARD ISLAND AND MCDONALD ISLANDS		HM
HOLY SEE (Vatican City STATE)	VA	
HONDURAS		HN
HONG KONG		HK
HUNGARY		HU
ICELAND		IS
INDIA		IN
INDONESIA		ID
IRAN, ISLAMIC REPUBLIC OF		IR
IRAQ		IQ
IRELAND		IE
ISLE OF MAN		IM
ISRAEL		IL
ITALY		IT
JAMAICA		JM
JAPAN		JP
JERSEY		JE
JORDAN		JO
KAZAKHSTAN		KZ
KENYA		KE
KIRIBATI		KI
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF		KP
KOREA, REPUBLIC OF		KR
KUWAIT		KW
KYRGYZSTAN		KG
LAO PEOPLE'S DEMOCRATIC REPUBLIC		LA
LATVIA		LV
LEBANON		LB
LESOTHO		LS
LIBERIA		LR
LIBYAN ARAB JAMAHIRIYA		LY
LIECHTENSTEIN		LI
LITHUANIA		LT
LUXEMBOURG		LU
MACAO		MO
MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF		MK
MADAGASCAR		MG

English Country Names and Code Elements (continued)

MALAWI	MW
MALAYSIA	MY
MALDIVES	MV
MALI	ML
MALTA	MT
MARSHALL ISLANDS	MH
MARTINIQUE	MQ
MAURITANIA	MR
MAURITIUS	MU
MAYOTTE	YT
MEXICO	MX
MICRONESIA, FEDERATED STATES OF	FM
MOLDOVA, REPUBLIC OF	MD
MONACO	MC
MONGOLIA	MN
MONTENEGRO	ME
MONTSERRAT	MS
MOROCCO	MA
MOZAMBIQUE	MZ
MYANMAR	MM
NAMIBIA	NA
NAURU	NR
NEPAL	NP
NETHERLANDS	NL
NETHERLANDS ANTILLES	AN
NEW CALEDONIA	NC
NEW ZEALAND	NZ
NICARAGUA	NI
NIGER	NE
NIGERIA	NG
NIUE	NU
NORFOLK ISLAND	NF
NORTHERN MARIANA ISLANDS	MP
NORWAY	NO
OMAN	OM
PAKISTAN	PK
PALAU	PW
PALESTINIAN TERRITORY, OCCUPIED	PS
PANAMA	PA
PAPUA NEW GUINEA	PG
PARAGUAY	PY
PERU	PE
PHILIPPINES	PH
PITCAIRN	PN

English Country Names and Code Elements (continued)

POLAND	PL
PORTUGAL	PT
PUERTO RICO	PR
QATAR	QA
RÉUNION	RE
ROMANIA	RO
RUSSIAN FEDERATION	RU
RWANDA	RW
SAINT HELENA	SH
SAINT KITTS AND NEVIS	KN
SAINT LUCIA	LC
SAINT PIERRE AND MIQUELON	PM
SAINT VINCENT AND THE GRENADINES	VC
SAMOA	WS
SAN MARINO	SM
SAO TOME AND PRINCIPE	ST
SAUDI ARABIA	SA
SENEGAL	SN
SERBIA	RS
SEYCHELLES	SC
SIERRA LEONE	SL
SINGAPORE	SG
SLOVAKIA	SK
SLOVENIA	SI
SOLOMON ISLANDS	SB
SOMALIA	SO
SOUTH AFRICA	ZA
SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS	GS
SPAIN	ES
SRI LANKA	LK
SUDAN	SD
SURINAME	SR
SVALBARD AND JAN MAYEN	SJ
SWAZILAND	SZ
SWEDEN	SE
SWITZERLAND	CH
SYRIAN ARAB REPUBLIC	SY
TAIWAN, PROVINCE OF CHINA	TW
TAJIKISTAN	TJ
TANZANIA, UNITED REPUBLIC OF	TZ
THAILAND	TH
TIMOR-LESTE	TL
TOGO	TG
TOKELAU	TK

English Country Names and Code Elements (continued)

TONGA	TO
TRINIDAD AND TOBAGO	TT
TUNISIA	TN
TURKEY	TR
TURKMENISTAN	TM
TURKS AND CAICOS ISLANDS	TC
TUVALU	TV
UGANDA	UG
UKRAINE	UA
UNITED ARAB EMIRATES	AE
UNITED KINGDOM	GB
UNITED STATES	US
UNITED STATES MINOR OUTLYING ISLANDS	UM
URUGUAY	UY
UZBEKISTAN	UZ
VANUATU	VU
Vatican City State see HOLY SEE	
VENEZUELA	VE
VIET NAM	VN
VIRGIN ISLANDS, BRITISH	VG
VIRGIN ISLANDS, U.S.	VI
WALLIS AND FUTUNA	WF
WESTERN SAHARA	EH
YEMEN	YE
Zaire see CONGO, THE DEMOCRATIC REPUBLIC OF THE	
ZAMBIA	ZM
ZIMBABWE	ZW

This list states the **country names** (official short names **in English**) in alphabetical order as given in ISO 3166-1 **and** the corresponding **ISO 3166-1-alpha-2 code elements**. This list is updated whenever a change to the official code list in ISO 3166-1 is effected by the ISO 3166/MA. It lists 244 official short names and code elements.