blue california
Promise Health Plan

How to use the UB-04 claim form for submitting long-term care claims to Blue Shield of California Promise Health Plan

This guide is intended for providers who need to submit a claim to Blue Shield of California Promise Health Plan. Although a UB-04 claim form may not typically be used for long-term care claims by all health plans, it is necessary to use the UB-04 in this instance for long-term facility claims in order for Blue Shield Promise to process the claim.

Please follow the instructions provided below for each type of submission.

Long-term care: skilled nursing facilities

Box	Description
1	Facility name, address, and telephone number
2	Facility pay-to name and address
3	Member control number for your facility
4	Type of Bill = **021X** **X represents:** **0** – Non-payment/zero claim **1** - Admit through discharge **2** - Interim first claim **3** - Interim continuing claim **4** - Interim last claim **7** - Replacement of prior claim **8** - Void/cancel of prior claim
5	Federal tax ID number
6	Statement covers period (from/through): Dates of service billing
8&9	Member name and address
10	Member date of birth (DOB)
11	Member sex
12	Admission date
17	Status Code: **30** - Still a patient/still under care/leave of absence to acute hospital (bed hold)/leave of absence to home **09** - Admitted **20** – Expired **70** – Discharged to acute hospital **01** – Discharged to home **84** – Discharged to another LTC facility/transferred to LTC status in same facility **05** – Leave of absence to acute hospital/discharged **06** – Leave of absence to home/discharged
38	Responsible party name and address
39	Value codes: **23**: Patient's share of cost **24**: Accommodation code **66**: Non-covered cost

Box	Description
42	Revenue Code: The following revenue codes are used based on the accommodation code billed. **Revenue Code/Accommodation Codes:** Revenue code 160 = Accommodation codes 01, 04, 21 Revenue code 169 = Accommodation codes 11, 31 Revenue code 180 = Accom. Codes 03, 05, 12, 23, 32, 79, 80, 81, 82, 89, 90, 95, 96 Revenue code 185 = Accom. Codes 02, 22, 73, 74, 77, 78, 87, 88, 93, 94 Revenue code 199 = Accommodation codes 71, 72, 75, 76, 83, 84, 85, 86, 91, 92, 97, 98
43	Description of service
45	Service date ("from" date of service)
46	Service units (number of days billing)
47	Total charges
50	Payer = **Blue Shield of California Promise Health Plan**
55	Estimated amount due. This is the difference between the total charges and other deductions, such as SOC/NCS
56	National Provider Identifier
58	Member name
60	Member ID number from the members Blue Shield Promise Health Plan ID card
63	Treatment authorization code(s) (authorization number(s))
66	Diagnosis qualifier (distinguish between ICD-9 and ICD-10 coding). Default value = 0
67	Diagnosis
76	Attending physician's national provider identifier (NPI), first and last name, as required.
80	Remarks – field for additional comments not found in any field of the UB-04 form

For a visual example of this type of claim, please refer to page 2 of this document.

Visual example of claim submission for skilled nursing facilities using the UB-04 form

1 Facility Name Facility Address	2	3a PAT. CNTL. # 1234567890 b. MED. REC. #	4 TYPE OF BILL 0213
		5 FED. TAX NO. 951234567	6 STATEMENT COVERS PERIOD FROM 01/01/2020 THROUGH 01/31/2020

8 PATIENT NAME a Jane Doe		9 PATIENT ADDRESS a 123 Main Street, Los Angeles, CA 90001	
10 BIRTHDATE 4/20/1950	11 SEX F	12 ADMISSION DATE 01/01/2020	13 HR 14 TYPE 15 SRC 16 DHR
17 STAT 30	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
Jane Doe 123 Main Street Los Angeles, CA 90001	a 24	01				
	b 23	800.00				
	c 66	150.00				
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0160	Room & Board		01/01/2020	31	3100.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	3100.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
A Blue Shield of California					245.00	57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Jane Doe		9123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A H12345678		

66 DX	A	B	C	D	E	F	G	H	66
0	I10	F72							

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
e. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
Additional comments	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. NUBC LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Long-term care: intermediate care facility for developmentally disabled (ICF/DD)

Box	Description
1	Facility name, address, and telephone number
2	Facility pay-to name and address
3a	Member control number for your facility
4	Type of Bill = **021X** **X represents:** **0** – Non-payment/zero claim **1** - Admit through discharge **2** - Interim first claim **3** - Interim continuing claim **4** - Interim last claim **7** - Replacement of prior claim **8** - Void/cancel of prior claim
5	Federal tax ID number
6	Statement covers period (from/through): dates of service billing
8 & 9	Member name and address
10	Member date of birth (DOB)
11	Member sex
12	Admission date
17	Status Code: **30** - Still a patient/still under care **09** - Admitted **20** – Expired
38	Responsible party name and address
39	Value codes: **23:** Patient's share of cost **24:** Accommodation code **66:** Non-covered cost **Accommodation Code:** **41** - ICF/DD Regular Services **61** - ICF/DD-H (4-6 beds) Regular Services **62** - ICF/DD-N (4-6 beds) Regular Services **65** - ICF/DD-H (7-15 beds) Regular Services **66** - ICF/DD-N (7-15 beds) Regular Services **43** - ICF/DD Leave Days **63** - ICF/DD-H (4-6 beds) Leave Days **64** - ICF/DD-N (4-6 beds) Leave Days **68** - ICF/DD-H (7-15 beds) Leave Days **69** - ICF/DD-N (7-15 beds) Leave Days
42	Revenue code: The following revenue codes are used based on the accommodation code billed: **Revenue Code/Accommodation Codes:** Revenue code 160 = Accommodation codes 41, 61, 62, 65 or, 66 Revenue code 180 = Accommodation codes 43, 63, 64, 68 or, 69
43	Description of service
45	Service date (From date of service)

Box	Description
46	Service units (number of days billing)
47	Total charges
50	Payer = **Blue Shield of California Promise Health Plan**
55	Estimated amount due: This is the difference between the total charges and other deductions such as SOC/NCS.
56	National provider identifier (NPI)
58	Member name
60	Member ID number from the member's Blue Shield Promise Health Plan ID card
63	Treatment authorization code(s) (authorization number(s))
66	Diagnosis qualifier: Distinguish between ICD-9 and ICD-10 coding. **Default value = 0**
67	Diagnosis
80	Remarks – field for additional comments not found in any field of the UB-04 form

For a visual example of this type of claim, please refer to page 4 of this document.

Visual example of claim submission for ICF/DD facilities using the UB-04 form