DevotedHealth

UB-04 Form Paper Claim Requirements

This guide describes how to complete a paper UB-04 claim form. Devoted Health requires that UB-04 paper claim forms be submitted with the (Required or If applicable) fields, to avoid returned and/or rejected claims that will be sent back to the providers for correction or resubmission.

It is important that providers submit claims to Devoted Health on the standard red and white version of the UB-04 form to ensure timely and accurate processing. We do not accept black and white and/or copied UB-04 forms, along with any handwritten data elements or information.

Additional updates are available in the Provider Manual or on our website at www.Devoted.com . For further assistance regarding paper claim submission, please contact Devoted Health Provider Service Call Center at 1-877-762-3515.

Field Location	Field Name	Required, Optional, or If applicable
1	Billing Provider Name, Address & Phone #	Required
2	Pay Address	If applicable
3a.	Patient Control Number	Required
3b.	Medical Record Number	Optional
4	Type of Bill	Required
5	Federal Tax Number	Required
6	Statement Covers Period (From/Through)	Required
7	Blank	Optional
8 (a-b)	Patient Name	Required
9 (a-e)	Patient Address	Required
10	Birth date	Required
11	Sex	Required
12	Admission Date	If applicable
13	Admission Hour (HR)	If applicable
14	Admission Type	If applicable

15	Admission Source (SRC)	Required
16	Discharge Hour (DHR)	If applicable
17	Patient discharge status (STAT)	Required
18 - 28	Condition Codes	If applicable
29	Accident State (ACDT)	Optional
30	Blank	Optional
31 - 34	Occurrence (Code and Date)	If applicable
35 - 36	Occurrence Span (Code and From/Through)	If applicable
37	Blank	Optional
38	Responsible Party Name & Address	Optional
39 - 41 (a-d)	Value Codes (Code and Amount)	If applicable
42	Revenue Code (Rev. Code)	Required
43	Description	Required
44	HCPCS/Rate/CPT Code	Required ***NOTE: Rates (Optional) and for Inpatient services CPT Code is (Optional)
45	Service Date (Serv. Date)	Required ****NOTE: For Inpatient claims date of service is not applicable.
46	Units of Service (Serv. Units)	Required
47	Total Charges - NOTE: Line Level	Required
48	Non-Covered Charges	If applicable
49	Blank	Optional
Page _ of _	Page _ of _	If applicable
Creation Date	Creation Date	If applicable
Totals	Totals	Required
50 (a-c)	Payer Name	Required

51 (a-c)	Health Plan ID	Required
52 (a-c)	Release of Information (Rel. Info)	Required
53 (a-c)	Assignment of Benefits (Asg. Ben.)	Required
54 (a-c)	Prior Payments	If applicable
55 (a-c)	Est. Amount Due	If applicable
56	National Provider Identifier (NPI)	Required
57	Other Provider ID	If applicable
58 (a-c)	Insured's Name	If applicable
59 (a-c)	Patient's relationship to Insured (P. Rel.)	Required
60 (a-c)	Insured's Unique ID	If applicable
61 (a-c)	Group Name	If applicable
62 (a-c)	Insurance Group No.	If applicable
63 (a-c)	Treatment Authorization Codes	If applicable
64 (a-c)	Document Control Number	If applicable
65 (a-c)	Employer Name	If applicable
66	Diagnosis version qualifier (DX)	Required
67	Principal Diagnosis/Present on Admission (POA Indicator)	Required
67 (A-Q)	Principal Diagnosis/Present on Admission (POA Indicator)	Required
68	Blank	Optional
69	Admitting Diagnosis (Admit DX)	If applicable
70 (a - c)	Patient Reason DX	If applicable
71	Prospective Payment System (PPS)	If applicable
72 (a - c)	External Cause of Injury (ECI)	If applicable
73	Blank	Optional

74	Principal Procedure (Code and Date)	If applicable
74 (a - e)	Other Procedure (Code and Date)	If applicable
75	Blank	Optional
76	Attending Physician - (NPI, Qual., Last Name, First Name)	Required
77	Operating Physician - (NPI, Qual., Last Name, First Name)	If applicable
78	Other Physician - (NPI, Qual., Last Name, First Name)	If applicable
79	Other Physician - (NPI, Qual., Last Name, First Name)	If applicable
80	Remarks	Optional
81CC (a-d)	CC	Optional