-

Please refer to the National Uniform Claim Committee's official UB-04 Data Specification Manual for definitions, field attributes and notes. The manual can be located on the National Uniform Committee Website at www.nucc.org.

Please note:

- Changes in code values must be UB-04 compliant.
- If your submit claims electronically using a vendor or clearinghouse, you will want to check with them on the fields that require population. They may not have mapped a direct one to one match with the fields defined here.

Below are the Blue Cross VT requirements for the UB-04 form. Items highlighted in yellow are the changes for this version.

Definitions:
R = Required, must be submitted
O = Optional, field does not require population but if submitted will be accepted
S = Situational only required for certain circumstances

Form Locator	See Definitions	Special Blue Cross VT Instructions
01	R	Medicare Advantage: If service occurs at primary location line 3 positions 17-25. If service occurs at a secondary location, not applicable.
02	S	Regardless of how this form locator is populated, the payment will always be made to the mailing address of the billing provider indicated in form locator 01.
04	R	Interim bills should not be submitted on DRG claims. We only accept type of bills with a 4th digit of 1, 2, 3, 4 or 5. Click here to link to information on requirements for billing of institutional late charges: http://www.bcbsvt.com/export/sites/BCBSVT/provider/resources/referenceguides/Billing_Late_Charges_January_2012.pdf
06	R	Outpatient: If the beginning and ending dates are not the same, individual service dates must be entered in form locator 45.
12	R	Original admission date must be included on interim bills.
13	R	Admission hour must be reported on all Medicare Advantage claims, all other claim types only require reporting of admission hour for inpatient and emergency room claims.
14	R	FEP: Inpatient claims must report this information.
15	R	Providers must submit two claims for delivery stays: one for mother and one for baby. BlueCard and Medicare Advantage:

		Require the reporting of this field; for all other claims it is not required but will be accepted if submitted.
17	R	Status code 30 is not considered valid for type of bill ending in 1 or 4 Patient status codes 02, 05, 43, 66, 82, 85, 88 and 94 are processed as patient transfers and reimbursed according to terms of contract.
34	R	Required, please refer to manual for details.
38	S	Only required if different from patient information in FL08 and FL09.
39	R	Must be reported on any claim when Medicare co-insurance days are being processed. Medicare Advantage claims or Air Ambulance: If air ambulance, code AO (special zip code reporting) or its successor code specified by the National Uniform Billing Committee. Value, five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance.
40	R	Must be reported on any claim when Medicare co-insurance days are being processed. Medicare Advantage claims or Air Ambulance: If air ambulance, code AO (special zip code reporting) or its successor code specified by the National Uniform Billing Committee. Value, five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance.
41	R	Must be reported on any claim when Medicare co-insurance days are being processed. Medicare Advantage claims or Air Ambulance: If air ambulance, code AO (special zip code reporting) or its successor code specified by the National Uniform Billing Committee. Value, five-digit zip code of the location from which the beneficiary is initially placed on board the ambulance.
42	R	We require the use of the 4-digit revenue code. All Professional fees must be billed on the CMS 1500 form. Preventative Pap Smears – when billing for the preventative pap smears, we request that they be billed in with a 0311 or 0923 revenue code, this will allow services to be paid according to the contract. Although the 0310-revenue code is a correct code to bill for these services, a system set up issue prevents us from processing these services without incorrectly applying deductible. NDC reporting: NDC reporting for home infusion therapy or drugs dispensed or administered by a provider (other than pharmacy). See section 6 of the on-line provider handbook for specific details on what requires the billing of NDC. Right above the four-digit revenue code report in order: N4 product ID qualifier, 11-digit NDC (no hyphens), unit of measure and quantity (limited to 8 digits before the decimal point and 3 digits after the decimal point). If your software does not allow for automated population in this item number, we will accept the information if hand-written in this area. Acceptable values for the NDC Units of Measurement Qualifiers are as follows:

<table>
<tr><td></td><td></td><td>
<table>
<tr><th>Unit of Measure</th><th>Description</th></tr>
<tr><td>F2</td><td>International Unit</td></tr>
<tr><td>GR</td><td>Gram</td></tr>
<tr><td>ME</td><td>Milligram</td></tr>
<tr><td>ML</td><td>Milliliter</td></tr>
<tr><td>UN</td><td>Unit</td></tr>
</table>

For form locator 44 continue to report applicable CPT or HCPCS code. In form locator 46 (service units) continue to report applicable CPT or HCPCS units and not the NDC units.</td></tr>
<tr><td>44</td><td>S

R</td><td>Note: if billing for a NDC in form locator 42 continue to report applicable CPT or HCPCS code in this field.

BlueCard: Requires the reporting of HIPPS codes for revenue codes 0022, 0023 and 0024 when appropriate.

Medicare Advantage: Required on all claims</td></tr>
<tr><td>46</td><td>R</td><td>Inpatient Stay – we cover either the day of admission or the day of discharge, but not both. The units reported for the room charge must be one less than the date span identified in form locator 6.

Note: if billing for a NDC in form locator 42 continue to report applicable CPT or HCPCS units and not the NDC units in this field.</td></tr>
<tr><td>56</td><td>R</td><td>Required, please refer to manual for details</td></tr>
<tr><td>60</td><td>R</td><td>Enter the member’s identification number exactly as it appears on the identification card, including the 3-character alpha prefix and if applicable the 1- or 2-digit suffix. Do not enter the 2-digit patient code that appears after the member’s identification number.

The alpha prefix or alpha characters in the identification number must be reported as capital letters on paper claims.

Federal Employee Members will have a “R” alpha prefix.</td></tr>
<tr><td>62</td><td>R</td><td>Only required if applicable.</td></tr>
<tr><td>63</td><td>R</td><td>Medicare Advantage claims only.</td></tr>
<tr><td>67</td><td>R</td><td>Present on Admission (POA) indicators must be reported on all inpatient claims.</td></tr>
<tr><td>69</td><td>R</td><td>Medicare Advantage claims only.</td></tr>
<tr><td>72 a-c</td><td>R</td><td>Medicare Advantage claims: External Cause of Injury (ECI) Code and Present on Admission (POA) Indicator.

FEP: Must have POA indicator populated.</td></tr>
<tr><td>76</td><td>R</td><td>This field needs to contain the complete rendering or ordering provider NPI number, even if located out of state.</td></tr>
<tr><td>77</td><td>O</td><td>Not required for processing of claims, but if submitted will be accepted</td></tr>
<tr><td>78-79</td><td>O</td><td>Not required for processing of claims, but if submitted will be accepted</td></tr>
<tr><td>80</td><td>S</td><td>Effective 1/1/25: Required for claims that qualify for Act 111 Blueprint Primary Care Provider Waiver of Prior Authorization, see our on-line Provider Handbook for more details.</td></tr>
</table>

		Populate line 1 with qualifier DK (ordering provider) immediately followed by the ordering provider's NPI number. Example: