Claim Form Reference Guide

Please fill out all required information on the proper claim form. Hospitals and Ambulatory Surgery Centers (ASC) are required to use form UB-04/CMS 1450. Please <u>type</u> all information, handwritten claim forms will be denied. *Incorrect or incomplete claim forms may cause processing delays or rejection of claims. California Correctional Health Care Services reserves the right to request supporting documentation for any services provided. For assistance with completing the UB04/CMS 1450, please contact California Correctional Health Care Services, Healthcare Invoicing Section Help Desk at (916) 691-0699.*

Hospital Information	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid denial** of the claim:*
	
	• Box 1 – **Hospital or ASC Physical Address:**
	  ○ There are four lines available for use in this field. The Hospital or ASC name and physical address must be listed in this field.
	  ▪ In the event of a subsidiary providing service, list the parent company name on the first line followed by the subsidiary name on the second line with the physical address on the remaining lines.
	• Box 2 – **Billing Address:**
	  ○ There are four lines available for use in this field. The Billing Provider name and remittance address must be listed in this field.
	  ▪ In the event of a subsidiary providing service, list the parent company name on the first line followed by the subsidiary name on the second line with the remittance address on the remaining lines.
	• Box 3a – Enter the Patient Control Number. This may also be referred to as the providers claim number.
	• Box 3b – This is an optional field and may be left blank.
	• Box 4 – Enter the appropriate bill type for the claim submission.
	  ○ Please note that corrected claims should end with a seven. **Example: Hospital Inpatient corrected claim bill type would be 117.**
	• Box 5 – Enter the Billing Provider's Federal Tax ID number. This information must be included to process the claim.
	• Box 6 – Enter the Date of Service (DOS) range for the claim. Beginning DOS in the first space, ending DOS in the second.
	• Box 7 – Leave blank.

Patient Information	*This information is **required** unless otherwise noted. Please ensure to complete these fields to avoid **a denial** of the claim:* • Box 8b – Enter the Patient's name as Last Name, First Name and no Middle Name or initial Ensure that the name is in the proper format to avoid a claim denial. • Box 10 – Enter the Patient's Date of Birth. • Box 11 – Enter the Patient's Gender.

Institution Address (Patient Address)	• All claims billed for California Department of Corrections and Rehabilitation (CDCR) patients must include either the institution acronym where the patient is incarcerated, along with the City, State and Zip Code **or** the Institution/REPS Facility's address.
	  ○ Place Institution/REPS Facility acronym/abbreviation where the Patient is housed in Box 9a. The City, State and Zip code should be listed in boxes 9b, 9c, and 9d, respectively.
	  ○ If the patient is housed in a Skilled Nursing Facility or State Hospital, list the facility name in box 9a along with the City, State and Zip code in boxes 9b, 9c, and 9d, respectively.

Admission, Condition and Occurrence Information	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:* • Box 12 – Enter the Admission date or DOS. • Boxes 13-17 – Ensure any information required for billing is entered in the corresponding box. • Boxes 18-29 – Ensure that all fields are filled out if condition codes are required for billing. • Box 30 – Leave blank. • Boxes 31-36 – Ensure that all fields are filled out if Occurrence Codes and dates are required for billing. • Box 37 – Leave blank. • Boxes 39-41 – Ensure any information required for billing is entered in the corresponding box.
CorrectCare's Address	Claims for Hospital services shall all be sent to CorrectCare Integrated Health for processing. • For form UB-04/CMS-1450, place CorrectCare's address in Box 38. **CorrectCare Integrated Health** **P.O. Box 349026** **Sacramento, CA 95834-9026**
Service(s) Provided	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:* • Box 42 – Enter the Revenue Code that corresponds to the provided service(s). ○ Please note that Administrative Day claims must use Revenue Code 169. See below for more direction on billing Administrative Day claims. • Box 43 – List the brief description of the service(s) provided. • Box 44 – List any HCPCS/CPT Codes as would be required for the billed services. Some codes may need modifiers to "unbundle" from other more comprehensive or global services. Ensure that all modifiers that may be needed are included. Missing modifiers may result in denials of those line items, or the entire claim. • Box 45 – Enter the DOS that corresponds to the service(s) provided. • Box 46 – Enter the number of units for each service.

	• Box 47 – List the charges being billed for the provided service(s). • Box 48 – Only enter charges if the provided service(s) is being billed without the expectation of reimbursement. • Page __ of __ – If multiple claim forms are required to complete billing, ensure the page number is listed. • Creation Date – Ensure the creation date of the claim form is entered. • Totals – Enter the total billed charges for the claim. If the claim is multiple pages, leave this field blank until the final page.
Facility ID Number	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:* • Box 56 – List the NPI number of the facility. • Box 57 – List additional provider identification numbers if needed.

CDCR Number	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:*
	
	• Box 60 – Enter the Patient's CDCR number.
	  ○ CDCR numbers consist of six alphanumeric characters. **Anything other than the six characters will result in a denial of the claim.**
	  ▪ **Adult Identifications can be obtained at:** California Incarcerated Records & Information Search (CIRIS) - CDCR

Diagnosis and DRG Codes	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:*
	
	• Box 66/67-67Q – List all Diagnosis codes required for billing.
	• Box 68 – Leave blank.
	• Box 69 – Enter the Admitting Diagnosis code.
	• Box 70 – Not required, leave blank.
	• Box 71 – Enter the three-digit DRG Code. A leading zero in this field **will result in a denial** of the claim.
	  ○ **Note: DRG Codes are only required for Inpatient Hospital services and are required to process the claim.**
	  ▪ **If billing for Administrative Days, either leave the DRG code blank, or enter 000 as the DRG code.**
	• Boxes 72 and 73 – Leave blank.
	• Box 74 – Enter any procedure codes that may be required for billing.

Physician Information	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:* • Boxes 76-79 – List all required Physician Names and National Provider Identifier (NPI) Numbers.

Administrative Days	*This information is **required** unless otherwise noted. Please ensure to complete these fields **to avoid a denial** of the claim:*
	
	• Hospital providers who bill for administrative days must use revenue code 169 and submit claims separately from claims for other hospital services.
	• Providers who bill administrative days must attach required documentation to the claim form. Documentation includes:
	  ○ A copy of the physician's order to transfer the Patient to a lower level of care, and
	  ○ Form ADJ-01 with proof of communication with Utilization Management (UM) staff pre-authorizing the Administrative Day stay.