TrailBlazer Health Enterprises
UB-04 Skilled Nursing Facility
Billing Examples
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Add any additional information here.
### Skilled Services – First Interim Claim

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#### HCPCS / RATE / HIPPS CODE

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#### Condition Codes

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- CODE

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### Skilled Services – Third Interim Claim

**Provider Name:**
**Pay-to Name:**
**Street Address:**
**Street Address or Post Office Box:**
**City, State, ZIP Code:**
**City, State, ZIP Code:**
**Telephone; Fax; Country Code:**

**Patient Last, First, Middle Initial:**
**City:**
**State:**
**ZIP Code:**
**Country Code:**

**Date of Birth:**
**Admission Date:**
**Admission Time:**
**Discharge Date:**
**Discharge Time:**

** occupation:**
**occurrence span:**
**condition codes:**

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**Payer Name:**
**Health Plan ID:**
**NPI:**

**Beneficiary Last, First Name:**
**Insured's Name:**
**Insured's Unique ID:**
**Group Name:**
**Insurance Group No.:**

**Remarks:**

Add any additional information here.
**Skilled Services – Fourth Interim Claim - Benefits Exhaust During the Month**

### Provider Information
- **Name:**
- **Address:**
- **City, State, ZIP:**
- **Telephone:**

### Pay-to Information
- **Name:**
- **Address:**
- **City, State, ZIP:**
- **Telephone:**

### Claim Details
- **Claim Number:**
- **Claim Type:**
- **Occurrence Code:**
- **Occurrence Span:**
- **Service Date:**
- **Diagnosis Code:**
- **Description:**
- **Rate:**
- **HIPPS Code:**
- **Total Charges:**
- **Non-Covered Charges:**

### Medicare Details
- **Medicare Number:**
- **Name:**
- **Address:**
- **City, State, ZIP:**
- **Telephone; Fax; Country Code:**

### Beneficiary Information
- **Last Name:**
- **First Name:**
- **Middle Initial:**
- **Date of Birth:**
- **Sex:**
- **Admission Date:**
- **Hospital:**
- **Insurance Group No.:**
- **Group Name:**
- **SubID:**
- **Statement Covers Period:**
- **Employer Name:**
- **Payer Name:**
- **Health Plan ID:**
- **NPI:**

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### Notes
- **All charges for services rendered after the A3 date should be billed as non-covered.**

---

**STATE**
- **State Code:**
- **Account Code:**
- **Admit Code:**
- **Attendance Code:**
- **Principles Code:**
- **Other Procedures Code:**
- **Date:**
- **Country Code:**

**OTHERS**
- **Last Name:**
- **First Name:**
- **Middle Initial:**
- **PRV ID:**
- **INSURED’S NAME:**
- **P.REL:**
- **INSURED’S UNIQUE ID:**
- **GROUP NAME:**
- **INSURANCE GROUP NO.:**

**OTHERS REMARKS**
- **A:**
- **B:**
- **C:**
- **D:**
- **E:**
- **F:**
- **G:**
- **H:**
- **I:**
- **J:**
- **K:**
- **L:**
- **M:**
- **N:**
- **O:**
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**LAST FIRST LAST FIRST LAST FIRST**
- **First Name:**
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- **Middle Initial:**
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**Provider Name:**

**Pay-to Name:**

**Street Address:**

**Street Address or Post Office Box:**

**City, State, ZIP Code:**

**Telephone; Fax; Country Code:**

**Patient Last, First, Middle Initial:**

**City:**

**State:**

**ZIP Code:**

**MMDDCCYY:**

**ADMISSION:**

**ADMISSION DATE:**

**ADMISSION TIME:**

**CONDITION CODES:**

**CODE:**

**DATE:**

**VALUE CODES:**

**AMOUNT CODE:**

**AMOUNT CODE:**

**AMOUNT CODE:**

**TOTAL CHARGES:**

**NON-COVERED CHARGES:**

---

**Medicare**

**Beneficiary Last, First Name:**

**INSURED'S NAME:**

**P.REL:**

**INSURED'S UNIQUE ID:**

**GROUP NAME:**

**INSURANCE GROUP NO.:**

**PRV ID:**

**OTHER:**

**Medicare PRV ID:**

**OTHER NPI QUAL:**

---

**PRINCIPAL PROCEDURE:**

**OTHER PROCEDURE:**

**OPERATING NPI:**

**Attending NPI:**

**Other Procedure:**

**Other Procedure:**

**Other Procedure:**

**Additional Information:**

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**Add any additional information here.**

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**Creation Date:**

**Page MMDDYY:**

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**Medicare**

**Medicare PRV ID:**

**Insured's Name:**

**Group Name:**

**Insurance Group No.:**

**TREATMENT AUTHORIZATION CODES:**

**INSURED'S UNIQUE ID:**

**PRINCIPAL PROCEDURE:**

**OTHER PROCEDURE**

Add any additional information here.
**Skilled Services – Fourth Interim Claim - Level of Care Change During the Month**

**Provider Name**  
Provider Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Pay-to Name**  
Pay-to Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Patient Name**  
Patient Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Date of Birth**  
Gender

**State**  
Date of Admission

**Diagnosis Code**  
Admission Reason

**Condition Codes**  
Condition Onset

**Gender**  
Date of Discharge

**Age**  
Date of Admission

**Provider Name**  
Provider Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Certified/Registered Nurse**  
Certified/Registered Nurse Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Diagnosis Code**  
Admission Reason

**Condition Codes**  
Condition Onset

**Gender**  
Date of Discharge

**Provider Name**  
Provider Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Certified/Registered Nurse**  
Certified/Registered Nurse Address  
City, State, ZIP Code  
Telephone; Fax; Country Code

**Diagnosis Code**  
Admission Reason

**Condition Codes**  
Condition Onset

**Gender**  
Date of Discharge

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**Payer Name:**

**Health Plan ID:**

**NPI:**

**Beneficiary Last, First Name:**

**Insured’s Unique ID:**

**Group Name:**

**Insurance Group No.:**

**Remarks:**

Add any additional information here.
### Non-Skilled Services

**Patient Last, First, Middle Initial:**

- **City:**
- **State:**
- **ZIP Code:**
- **County Code:**

**Insurance Information:**

- **Insured's Name:**
- **Insured's Unique ID:**
- **Group Name:**
- **Insurance Group No.:**

**Provider Information:**

- **Provider Name:**
- **Pay-to Name:**
- **Street Address:**
- **Street Address or Post Office Box:**
- **City:**
- **State:**
- **ZIP Code:**
- **Country Code:**

**Additional Information:**

- **Patient Name:**
- **Patient Address:**
- **Telephone:**
- **Fax:**
- **Country Code:**

**Date of Service:**

- **Date:**
- **Entry Date:**
- **Conditions Codes:**
- **Occurrence Codes:**

**Diagnosis Codes:**

- **Primary Diagnosis Code:**
- **Secondary Diagnosis Code:**

**Procedure Codes:**

- **PROCEDURE DATE CODE:**
- **DESCRIPTION:**
- **AMOUNT CODES:**
- **VALUE CODES:**

**billing details:**

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- **BILLING DATE:**
- **REMARKS:**
- **CC:**

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**REMARKS**

Add any additional information here.
### Sanctioned Provider – Denial of Payment on New Admissions - Entire Stay

#### Patient Last, First, Middle Initial

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#### Other Information

- **Beneficiary Last, First Name**: XX XXX-XX-XXXXX
- **Provider Name**: Required
- **Pay-to Name**: Required
- **Provider Address**: Required
- **Beneficiary Address**: Recommended
- **Insurance Group Number**: Required
- **SubID**: Required
- **Statement Covers Period**: Required

*Add any additional information here.*
Sanctioned Provider – Denial of Payment on New Admissions - Partial Month

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</table>

Provider Name: [Redacted]
Pay-to Name: [Redacted]
Street Address: [Redacted]
Street Address or Post Office Box: [Redacted]
City, State, ZIP Code: [Redacted]
City, State, ZIP Code: [Redacted]
Telephone; Fax; Country Code: [Redacted]

Provider Last, First, Middle Initial: [Redacted]
City: [Redacted]
State: [Redacted]
Device: [Redacted]
Device: [Redacted]
Device: [Redacted]
Device: [Redacted]

Insurance Plan: Medicare

Beneficiary Last, First Name: XX XXX-XX-xxxx

Beneficiary's Unique Identification Number: [Redacted]
Beneficiary's Name: [Redacted]
Beneficiary's Social Security Number: [Redacted]

Principal Procedure: [Redacted]
Other Procedure: [Redacted]
Non-Covered Charges: [Redacted]
Reimbursement Information: [Redacted]
Add any additional information here.

Add any additional information here.