Nursing Facility Billing Instructions
Completing the UB04 Web Portal Claim Form
In the “Sign In” block, select “Providers”
Nursing Facility Web Billing

• Enter your User ID and Password
• Select “Login”
Select the option you want to perform
For Claims Entry
   • Click on the “Claims” tab on the menu line
• Under the heading “Create Claims” select “Institutional Claim”
The “New Institutional Claim” screen will appear

- Is this a void/replacement?
- This field will default to “No.” Select “Yes” only if you are voiding or replacing a previously processed claim.

Submitter Information

- This section will auto-fill with your user information based on your User ID
## Nursing Facility Web Billing

### Provider Information

Go to Other Claim Info to enter information for other providers.

**Billing Provider**

Note: Healthcare Providers are required to submit National Provider ID.

<table>
<thead>
<tr>
<th>Medicaid Provider ID</th>
<th>National Provider ID</th>
<th>Taxonomy Code</th>
<th>*Tax ID</th>
<th>Location Number</th>
</tr>
</thead>
</table>

### Additional Billing Provider Information

- **Currency Code:**

- **Org/Last Name:**

- **Address 1**

- **City**

- **State**

- **Zip and Extension**

- **Country**

- **Subdivision Code**

### Contact Information

- **Is the Billing Provider Address also the Pay-To Address?**
  - Yes
  - No

### Attending Provider

### Rendering Provider
Billing Provider

- REQUIRED
- Medicaid Provider ID and National Provider ID will auto-fill based on your User ID
- Enter the Nursing Facility Taxonomy Code 314000000X
- Enter your Tax ID
- Enter the Location Number BI (Billing)
<table>
<thead>
<tr>
<th>Currency Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Org/Last Name</td>
</tr>
<tr>
<td>*Address 1</td>
</tr>
<tr>
<td>Address 2</td>
</tr>
</tbody>
</table>

- **Additional Billing Provider Information**
  - REQUIRED
  - Enter your facility name, address, city, state, and zip code
Is the Billing Provider Address also the Pay-To Address?
- Yes
- No

Pay-To Address

*Address 1
*City
State
Zip and
Extension
Country
Subdivision Code

Address 2

- Is the Billing Provider also the Pay-To Address?
  - Will default to “Yes”
  - If Pay-To Address is different, select “No”
  - Complete the Pay-To Address section with the facility name, address, city, state, and zip code
Attending Provider

- REQUIRED
- Enter the Attending Provider’s Medicaid Provider ID
- Enter the Attending Provider’s NPI
- Enter the Attending Provider’s Taxonomy Code
- Enter the Location Code AT (Attending)
Nursing Facility Web Billing

Member Information

- Member ID
- Last Name
- First Name
- MI
- Suffix
- Date of Birth
- Gender
- SSN

Property Casualty Number

- Member Information
  - REQUIRED
  - Enter the member’s 9-digit ID number
  - Enter the member’s last name
  - Enter the member’s first name
  - Enter the member’s date of birth
    - Use format: MM/DD/YYYY
  - Enter the member’s gender
    - F = Female
    - M = Male
Nursing Facility Web Billing

## Member Address

<table>
<thead>
<tr>
<th>Address 1</th>
<th>City</th>
<th>State</th>
<th>Zip and</th>
<th>Extension</th>
<th>Country</th>
<th>Subdivision Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Member Address
  - REQUIRED
  - Enter the member’s address, city, state, and zip code
**Nursing Facility Web Billing**

<table>
<thead>
<tr>
<th>Subscriber Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Insurance Information</strong></td>
</tr>
<tr>
<td><em>Does the member have other insurance?</em></td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Note:** Please go to the Other Claim Info Tab in the Coordination of Benefits Section.

- **Other Insurance Information**
  - REQUIRED
  - Does the member have other insurance?
  - Select “Yes” or “No”
  - If you select “Yes” you must complete the Other Claim Info tab with the Other Insurance information
Nursing Facility Web Billing

Claim Information

Go to Other Claim Info to include the following claim level information:
Specialized Services, Misc. Claim, Service Facility, Coordination of Benefits and Adjustments.

Claim Data

*Statement From Date

*Statement To Date

*Total Claim Charge Amount

$_

*Patient Account#

*Type of Bill

First 2 Type of Bill digits.

*Claim Frequency Code

Last Type of Bill digits; automatically populated on resubmission.

*Patient Status

Admission Type

Admission Source

Admission Date / Hour:Minute

Discharge Hour:Minute

*Medicare Assignment Code

*Benefits Assignment Certification

*Release of Information Code
o Claim Information - Bill for only one (1) month at a time
  • REQUIRED
  • Statement From Date
    • Use format: MM/DD/YYYY
  • Statement To Date
    • Use format: MM/DD/YYYY
  • Total Claim Charge Amount
    • Enter the total amount billed
Nursing Facility Web Billing

- Claim Information (continued)
  - REQUIRED
  - Patient Account #
    - Enter the internal patient account number
  - Type of Bill
    - Select 21 for Nursing Facility
  - Claim Frequency Code
    - Select the last digit 1-8 for the specific bill type
    - See “Bill Type List” pages 37-39
Claim Information (continued)

- REQUIRED
- Patient Status
  - Select the appropriate status from the dropdown menu
- Admission Type
  - Select the appropriate type from the dropdown menu
- Admission Date/Hour:Minute
  - Use date format: MM/DD/YYYY
  - Use military format: HH:MM
  - Example: 4:15pm = HH:MM = 16:15
- SITUATIONAL – Discharge Hour:Minute
  - If patient is other than “Still a Patient” you must enter the hour:minute patient was discharged
    - Use military format: HH:MM
    - Example: 4:15pm = HH:MM = 16:15
Nursing Facility Web Billing

Claim Information (continued)
- REQUIRED
- Medicare Assignment Code
  - Select the appropriate code from the dropdown menu
- Benefits Assignment Certification
  - Select the appropriate response from the dropdown menu
- Release of Information Code
  - Select the appropriate code from the dropdown menu
Value Information

- REQUIRED
- Click on the “+” next to the heading
- Enter the value code 80
  - 80 = Covered Days
  - Value Code 80 should equal the sum of the revenue code units
- Enter the value amount
  - Value amount should be entered as a dollar amount
    - Example: 30 days = 30.00
- SAVE value
  - Click on “Save” at the top right of the section
Diagnosis Information

- REQUIRED
- Click on the “+” next to the heading
- Version #
  - 09 – Ninth Revision (ICD-9-CM)
  - 10 – Tenth Revision (ICD-10-CM)
- Principal Diagnosis Code
  - Enter the diagnosis code for the member’s primary condition
    - ICD-9 codes for date(s) of service prior to September 30, 2015
    - ICD-10 codes for date(s) of service on or after October 1, 2015
Nursing Facility Web Billing
## Nursing Facility Web Billing

### Basic Line Item Information
- **REQUIRED**
- **New Line Item**
  - Service Date Begin
    - Use format: MM/DD/YYYY
  - Service Date End
    - Use format: MM/DD/YYYY
  - Revenue Code
    - Must be 4 digits
    - 0110 – Private room and board
    - 0120 – Semi-Private room and board
    - 0160 – Medicare full benefit days
    - 0169 – Medicare co-insurance days
    - 0182 – Medicare non-covered days
    - 0183 – Therapeutic/home leave days
    - 0185 – Hospital leave days
Basic Line Item Information (continued)
- REQUIRED
- Unit Qualifier
  - Select DAYS as the appropriate unit from the dropdown menu
- Service Units
  - Enter the number of units (Days) for the revenue code
  - The number of units (Days) billed must include the day of discharge or death
  - A separate line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed
- Line Item Charge Amount
  - Enter the total charges for the line item
- SAVE LINE ITEM – small SAVE at the top right of the New Line Item Section
- If there is more than one line item to be billed, select “Add Service Line Item” and follow the above instructions
- Enter each line item separately and SAVE each line item before entering a new line item
- When all information is entered on the claim, click “SAVE CLAIM” at bottom right.
- If no errors appear at the top left and the system state “Successfully Saved”, click “SUBMIT CLAIM”.
Bill Type List

• 1 Admit through Discharge Claim  
   This code is to be used when a member is admitted and discharged in the same month. Member CANNOT be in the “Still a Patient” status.

• 2 Interim – First Claim  
   This code is used for the first claim and the Discharge Status (fld17) as “Still a Patient.”

• 3 Interim – Continuing Claim  
   This code is used for the second and any ongoing months that have a Discharge Status (fld17) as “Still a Patient”.

• 4 Interim – Last Claim  
   This code is used for the Final claim billed for the member.
Nursing Facility Web Billing

7 Replacement of Prior Claim

A claim replacement may be submitted to modify a previously processed claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

Field 4: Use 7 as the last digit in the Type of Bill Code
Field 64: Enter the claim’s Transaction Control Number (TCN) or Internal Control Number (ICN)

If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

Example:
Legacy ICN: 2015153141010
Replaced Legacy ICN: 202015153141010
Nursing Facility Web Billing

- **Void/Cancel of Prior Claim**

  Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

  Field 4: Use 8 as the last digit in the Type of Bill Code

  Field 64: Enter the claim’s Transaction Control Number (TCN) or Internal Control Number (ICN)

If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

**Example:**
Legacy ICN: 2015153141020
Replaced Legacy ICN: 202015153141020
Nursing Facility Billing
Instructions
Completing the UBO4 Paper Claim Form
### Nursing Facility Paper Billing

<table>
<thead>
<tr>
<th>1 North Dakota Basic Care</th>
<th>2</th>
<th>3x PAT. CNTR.</th>
<th>4x TYPE OF BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>address</td>
<td></td>
<td>1234</td>
<td>0212</td>
</tr>
<tr>
<td>City, State and Zip</td>
<td></td>
<td>5 MEDI. REC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 FED TAX NO.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 STATEMENT COVERS PERIOD FROM</td>
<td>7 STATEMENT COVERS PERIOD THROUGH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45-1234567</td>
<td>010116</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8 PATIENT NAME</th>
<th>9 PATIENT ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane P</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 BIRTHDATE</th>
<th>11 SEX</th>
<th>12 DATE</th>
<th>13 ADMISSION</th>
<th>14 TYPE</th>
<th>15 SRC</th>
<th>16 OTHR</th>
<th>17 STAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>20210917</td>
<td>F</td>
<td>010116</td>
<td>3</td>
<td>1</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31 OCCURRENCE CODE</th>
<th>32 OCCURRENCE DATE</th>
<th>33 OCCURRENCE CODE</th>
<th>34 OCCURRENCE DATE</th>
<th>35 OCCURRENCE CODE</th>
<th>36 OCCURRENCE SPAN FROM</th>
<th>37 OCCURRENCE SPAN THROUGH</th>
</tr>
</thead>
</table>

- Billing Provider Name and Address
- Patient Control Number
- Type of Bill
- Federal Tax Number
- Statement Cover From and Through Period
- Patient Name
- Patient Date of Birth
- Sex of Patient
- Admission Date
- Admission Type
- Admission Source
- Patient Discharge Status
## Nursing Facility Paper Billing

<table>
<thead>
<tr>
<th>Value Code</th>
<th>Value Amount</th>
<th>Revenue Code</th>
<th>Description of Service</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 0110</td>
<td>In-house</td>
<td>010116</td>
<td>10</td>
<td>2000 00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 0185</td>
<td>Hospital Leave</td>
<td>011116</td>
<td>4</td>
<td>600 00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 0160</td>
<td>Medicare Full</td>
<td>011516</td>
<td>5</td>
<td>1000 00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 0182</td>
<td>Medicare non-covered</td>
<td>012016</td>
<td>2</td>
<td>300 00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 0110</td>
<td>In-house</td>
<td>012216</td>
<td>10</td>
<td>2000 00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Value Code
- Value Amount
- Revenue Code
- Description of Service
- Service Date
- Service Units
- Total Charges
### Nursing Facility Paper Billing

**Example:** January 2016, admitted on 1/1/16, still a patient, bill type 0212

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Serv Date</th>
<th>Serv Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0110</td>
<td>In-house</td>
<td>01/01/16</td>
<td>10</td>
<td>2000.00</td>
<td>0.00</td>
</tr>
<tr>
<td>0185</td>
<td>Hospital Leave</td>
<td>01/11/16</td>
<td>4</td>
<td>600.00</td>
<td>0.00</td>
</tr>
<tr>
<td>0160</td>
<td>Medicare Full</td>
<td>01/15/16</td>
<td>5</td>
<td>1000.00</td>
<td>0.00</td>
</tr>
<tr>
<td>0182</td>
<td>Medicare non-covered</td>
<td>01/20/16</td>
<td>2</td>
<td>300.00</td>
<td>0.00</td>
</tr>
<tr>
<td>0110</td>
<td>In-house</td>
<td>01/22/16</td>
<td>10</td>
<td>2000.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

- Covered days for the 80 value code would be 31.00 for Value Amount
- Need to bill in date of service order
### Nursing Facility Paper Billing

<table>
<thead>
<tr>
<th>ZG PAYER NAME</th>
<th>51 HEALTH PLAN ID</th>
<th>Z2 REL INFO</th>
<th>53 ASSN NO.</th>
<th>54 PRIOR PAYMENTS</th>
<th>55 EST. AMOUNT DUE</th>
<th>56 NPI</th>
<th>57 OTHER</th>
<th>58 INSURED'S NAME</th>
<th>60 REL</th>
<th>65 INSURED'S UNIQUE ID</th>
<th>61 GROUP NAME</th>
<th>62 INSURANCE GROUP NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doe, Jane P</td>
<td></td>
<td>D001234567</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Page ___ of ___
- Creation Date
- Totals
- NPI Number
- Payer Name
- Est. Amount Due
- Insured’s Name
- Insured’s Unique Id
### Nursing Facility Paper Billing

#### Diagnosis Indicator – ICD 9 = 9 and ICD10 = 0

#### Diagnosis Code

#### Admit Diagnosis Code

#### Patient Reason Diagnosis

#### Attending NPI Number

#### Attending Physician Taxonomy Code

#### Attending Last Name

#### Attending First Name

#### Provider Code Qualifier

#### Provider Taxonomy