

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE**

Policy/Procedure Number: CLPM-03		Lead Department: Claims	
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 9/1/25		Next Review Date: 01/01/2026 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> Employees
Reviewing Entities:	<input type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input checked="" type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD		<input type="checkbox"/> FINANCE <input type="checkbox"/> PAC
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING <input checked="" type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: <i>Lisa Malvo</i>			Approval Date: 09/01/2025

I. RELATED POLICIES:

A. N/A

II. IMPACTED DEPTS:

A. Claims

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidance of the required billing forms and the completion of these forms to Providers.

VI. POLICY / PROCEDURE:

Partnership Healthplan of California (Partnership) accepts the following billing forms for claims submitted on paper:

- A. CMS1500
- B. UB04

The information list below are the CMS1500 fields that must be completed accurately and completely in order to avoid claim suspense or denial:

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
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Explanation of Form Items Table

Item	Description
1	<p>Medicaid/Medicare/Other ID. If the claim is a Medi-Cal claim, enter an "X" in the Medicaid box. If submitting a Medicare/Medi-Cal crossover claim, use a copy of the original <i>CMS-1500</i> billed to Medicare and enter an "X" in both the <i>Medicaid</i> and <i>Medicare</i> boxes</p> <p>Note: For more information about crossover claims, refer to the <i>Medicare/Medi-Cal Crossover Claims: CMS-1500</i> section in the appropriate Part 2 manual</p>
1a	<p>Insured's ID Number. «Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC), paper Medi-Cal ID card or Medi-Cal Eligibility Confirmation Letter.»</p>

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 2 on a following page).

Explanation of Form Items Table (continued)

Item	Description
2	<p>Patient's Name. Enter the recipient's last name, first name, and middle initial (if known). Avoid nicknames or aliases.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
2	<p>When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 2. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn also must be designated by a number or letter (example: Jones Baby Girl Twin A). Providers may also wish to use the <i>Patient's Account No.</i> field (Box 26) to enter Twin A (or B). This is not a required field, and only for provider convenience. This field is repeated in all payment information (such as the <i>Remittance Advice Details</i> [RAD]), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.</p> <p>Enter the infant's sex and date of birth in Box 3 and check the <i>Child</i> box in Box 6 (<i>Patient's Relationship to Insured</i>). Enter the mother's name in Box 4 (<i>Insured's Name</i>).</p> <p>Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number. To facilitate reimbursement for infants (including twins) using the mother's ID number, enter Newborn Infant Using Mothers ID in the <i>Additional Claim Information</i> (Box 19) or Newborn Infant Using Mother's ID (Twin A) or (Twin B).</p>
3	<p>Patient's Birth Date/Sex. Enter the recipient's date of birth in six-digit MMDDYY (Month, Day, Year) format (for example, September 1, 1963 = 090163). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns, see Item 2).</p> <p>If the recipient is 100 years or older, enter the recipient's age and the full <u>four</u>-digit year of birth in the <i>Additional Claim Information</i> field (Box 19).</p> <p>«Enter an "X" in the "M" or "F" box. (For newborns, see Item 2.)»</p>
4	<p>Insured's Name. Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
5	Patient's Address/Telephone. Enter recipient's complete address and telephone number.
6	Patient Relationship to Insured. Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.
7	Insured's Address. Not required by Medi-Cal.
8	Reserved for NUCC Use. Not required by Medi-Cal.
9	Other Insured's Name Not required by Medi-Cal.
9a	Other Insured's Policy or Group Number. Not required by Medi-Cal.
9b	Reserved for NUCC Use. Not required by Medi-Cal.
9c	Reserved for NUCC Use. Not required by Medi-Cal.
9d	Insurance Plan Name or Program Name. Not required by Medi-Cal.
10	Is Patient Condition Related To:
10a	Employment. Complete this field if services were related to an accident or injury. Enter an "X" in the <i>Yes</i> box if accident/injury is employment related. Enter an "X" in the <i>No</i> box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14).
10b	Auto Accident/Place. Not required by Medi-Cal.
10c	Other Accident. Not required by Medi-Cal.
10d	«Claim Codes (Designated by NUCC). Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about SOC, refer to the <i>Share of Cost (SOC)</i> section in the Part 1 manual. Also refer to the <i>Share of Cost (SOC): CMS-1500</i> section in the appropriate Part 2 manual.»

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
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Item	Description
11	Insured's Policy Group or FECA Number. Not required by Medi-Cal.
11a	Insured's Date of Birth/Sex. Not required by Medi-Cal.
11b	Other Claim ID (Designated by NUCC). Not required by Medi-Cal.
11c	Insurance Plan Name or Program Name. For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.
11d	<p>Is There Another Health Benefit Plan. Enter an "X" in the Yes box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.</p> <p>If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in <i>Figure 2</i> on a following page in this section. Do not enter a decimal point or dollar sign (\$).</p>
12	Patient's or Authorized Person's Signature. Not required by Medi-Cal.
13	Insured's or Authorized Person's Signature. Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.
14	Date of Current Illness, Injury or Pregnancy (LMP). Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP). Medi-Cal does not require a qualifier (QUAL) in this field.
15	Other Date. Not required by Medi-Cal.
16	Dates Patient Unable to Work in Current Occupation Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
17	<p>Name of Referring Provider or Other Source. Indent to the right of the dotted line and enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the non-physician medical practitioner must be entered.</p> <p>Note: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.</p>
17a	Unlabeled. Not required by Medi-Cal.
17b	<p>NPI. Enter the National Provider Identifier (NPI).</p> <p><u>Boxes 17 and 17b must be completed by the following providers:</u></p> <ul style="list-style-type: none"> • Clinical laboratory (services billed by laboratory) • Durable Medical Equipment (DME) and medical supply • Hearing aid dispenser • Orthotist • Prosthetist • Nurse anesthetist • Occupational therapist • Physical therapist • Podiatrist (when services are rendered in a Skilled Nursing Facility [NF Level A or B]) • Portable imaging services • Radiologist • Speech pathologist • Audiologist • Pharmacies

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
17b (continued)	<p>Boxes 17 and 17b (continued)</p> <p><u>In-State Referring Provider.</u> A Universal Provider Information Number (UPIN) is not allowed.</p> <p><u>Out-of-State Referring Provider:</u> Claims must include a referring provider number using the referring provider's individual (not group) number. A license number or UPIN is not allowed.</p> <p><u>Dental Referring Providers: In-State.</u> Claims must include a referring provider number. Add the prefix "DDS" to the referring provider license number on the claim. A provider number or UPIN is not allowed.</p> <p><u>Dental Referring Providers: Out-of-State.</u> Claims must include a referring provider number. Add the prefix "DEN" to the referring provider license number on the claim. UPINs are not allowed.</p> <p>A non-physician medical practitioner authorized to refer with the physician's provider number should include the number of the supervising physician on the referral. The billing provider also should enter the number of the supervising physician. Claims with a non-physician medical practitioner number will not be reimbursed.</p> <p>When a billing provider receives a denial due to an invalid referring provider number, the referring provider should be contacted to verify the status of the provider number.</p> <p>A physician's assistant (and other non-physician practitioners authorized to refer with the physician's number) should include the provider number of the supervising physician on the referral. The billing provider should enter the provider number of the supervising physician. Claims with a Non-physician Medical Practitioner (NMP) license number will not be reimbursed.</p> <p>Note: Referring providers who would like to participate in the Medi-Cal program may contact the Telephone Service Center (TSC) at 1-800-541-5555.</p>
18	<p>Hospitalizations Dates Related to Current Services. Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
19	<p>Additional Claim Information (Designated by NUCC). Use this area for procedures that require additional information or justification. For specific "By Report" attachment requirements, refer to the <i>CMS-1500 Special Billing Instructions</i> section of this manual.</p> <p>Claims for "By Report" codes, complicated procedures (modifier 22), unlisted services and anesthesia time require attachments. This information may also be entered in the <i>Additional Claim Information</i> field (Box 19) if space permits.</p> <p>«Reports are not required for routine procedures. Non-reimbursable CPT® codes are listed in the <i>TAR and Non-Benefit List: Codes 10000 thru 99999</i> and <i>0001M thru 0999U</i> sections of the appropriate Part 2 manual.» Refer to "Attachments" in the <i>CMS-1500 Special Billing Instructions</i> section in this manual, the CPT book or in the appropriate policy sections for details.</p> <p>Note: Please do not staple attachments.</p>
20	<p>Outside Lab? If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." "Outside" laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.</p> <p>Outside Lab Monetary Charges. Not required by Medi-Cal.</p>
21	<p>Diagnosis or Nature of Illness or Injury. Relate A to L to service line below (24E).</p> <p>ICD Ind. Enter the appropriate ICD indicator, either a "9" or "0", depending on the date of service for the claim. Claims submitted without a diagnosis code do not require an ICD indicator.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
21A	<p>Diagnosis or Nature of Illness or Injury Enter all letters and/or numbers of the ICD-10-CM code for the <u>primary</u> diagnosis, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point).</p> <p>The following services are exempt from diagnosis descriptions and codes when they are the only services billed on the claim:</p> <ol style="list-style-type: none"> 1. Anesthesia services 2. Assistant surgeon services 3. Medical supplies and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances 4. Medical transportation 5. Pathology services (referenced in the CPT book) 6. Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable imaging services, which <u>require</u> diagnosis codes).
21B - 21L	Diagnosis or Nature of Illness or Injury. If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point.)
22	Resubmission Code/Original Reference Number. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are «in the table below».

Code	Explanation
0	Under 65, does not have Medicare coverage
1†	Benefits exhausted
2†	Utilization committee denial or physician non-certification
3†	No prior hospital stay
4†	Facility denial
5†	Non-eligible provider
6†	Non-eligible recipient
7†	Medicare benefits denied or cut short by Medicare intermediary
8†	Non-covered services
9†	PSRO denial
L†	Medi/Medi Charpentier: Benefit Limitations
R†	Medi/Medi Charpentier: Rates
T†	Medi/Medi Charpentier: Both Rates and Benefit Limitations

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
23	<p>Prior Authorization Number. For physician and podiatry services requiring a <i>Treatment Authorization Request (TAR)</i>, enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>«Note: TAR and non-TAR procedures should not be combined on the same claim.»</p>
24.1	<p>Claim Line. Information for completing a claim line follows in Items 24A thru 24J. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>Note: Do not enter data in the shaded area except as noted for Boxes 24A, C and D</p>
24A	<p>Date (S) of Service. In the unshaded area, enter the date the service was rendered in the "From" and "To" boxes in the six-digit, MMDDYY (Month, Day, Year) format; for example, April 2, 2013 written as 040213. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>National Drug Code (NDC) for Physician-Administered Drugs: In the shaded area, enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). Refer to the <i>Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions</i> section in this manual for more information.</p> <p>Universal Product Number (UPN) for contracted disposable incontinence and medical supplies: In the shaded area, enter the appropriate UPN [REDACTED]</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
24B	Place of Service. Enter one code from the list below indicating where the service was rendered:

Table of Place of Service Codes (Item 24B)

Code	Place of Service
01	Pharmacy
02	Telehealth Provided Other than in Patient's Home
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
<<09	Correctional Facility>>
10	Telehealth Provided in Patient's Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
25	Birth Center

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Code	Place of Service
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

Note: If subacute care, specify the appropriate Place of Service and use modifier U2.

Item	Description
24C	<p>EMG. Emergency or delay reason codes.</p> <p>Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. (Refer to the <i>CMS-1500 Submission and Timeliness Instructions</i> section in this manual).</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
24C (continued)	« Emergency Code: Enter an “X” or “Y” when billing for emergency services, or the claim may be reduced or denied.» Only one emergency indicator is allowed per claim, and must be placed in the unshaded, bottom portion of Box 24C. An Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist or pharmacist’s statement, describing the nature of the emergency, including relevant clinical information about the patient’s condition. A mere statement that an emergency existed is not sufficient.
24D	Procedures, Services or Supplies/Modifier. Enter the applicable procedure code (HCPCS or CPT) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Medi-Cal accepts up to four modifiers for a procedure on a single claim line. Enter modifiers in the boxes provided. Note: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier UD in the modifier area of Box 24D. Section 340B drugs may be billed on the same claim as non-340B drugs.

Item	Description
24E	Diagnosis Pointer. As required by Medi-Cal.

Item	Description
24F	Charges. In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000, not 100). If an item is a taxable medical supply, include the applicable state and county sales tax. When billing “outside” laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
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Item	Description
24G	<p>Days or Units Enter the number of medical “visits” or procedures, surgical “lesions,” hours of “detention time,” units of anesthesia time, items or units of service, etc.</p> <p>The field permits entries of up to 999. For entries greater than 999, carry the remaining value to the next claim line. For example, if the entry value is 1236, the first claim line should read, “999”; the second claim line should read, “237.” Both figures total the original value of “1236.”</p> <p>Do not enter a decimal point. Therefore, a quantity of “1” entered anywhere in the field, or with leading zeroes, would be seen by the Medi-Cal system as “001” and a “10” entered anywhere in the field would be seen as “010. Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).</p>
24H	<p>EPSDT Family Plan. Enter code “1” or “2” if the services rendered are related to family planning (FP). «Enter code “3” if the services rendered are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening related.» Leave blank if not applicable. Refer to the codes in the table below.</p>

Code	Description
1	Family Planning/Sterilization (Sterilization Consent Form must be attached to the claim if code 1 is entered)
2	Family Planning/Other
3	«EPSDT Screening Related»

Item	Description
24I	ID Qualifier for Rendering Provider. Not required by Medi-Cal
24J	Rendering Provider ID Number. Enter the NPI for a rendering provider (unshaded area) if the provider is billing under a group NPI. If the provider is not billing under a group NPI, leave this field blank in order for claims to be reimbursed correctly. This applies to all services.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
24.2 thru 24.6	Additional Claim Lines. Follow instructions for each claim line
25	Federal Tax I.D. Number. Not required by Medi-Cal.
26	Patient's Account Number. This is an optional field that will help providers to easily identify a recipient on a <i>Remittance Advice Details (RAD)</i> . Enter the patient's control number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RAD. Refer to the <i>Remittance Advice Details (RAD)</i> examples sections in this manual.
27	Accept Assignment? Not required by Medi-Cal.
28	Total Charge. In full dollar amount, enter the total for all services. Do not enter a decimal point or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).
29	Amount Paid. Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D). Do not enter a decimal point or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). <u>Do not enter Medicare payments in this box.</u> The Medicare payment amount will be calculated from the Medicare <i>Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)/Remittance Advice (RA)</i> when submitted with the claim.
30	Rsvd for NUCC USE. Effective September 22, 2014, providers no longer complete this field.
31	Signature of Physician or Supplier Including Degrees or Credentials The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only. An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.
32	Service Facility Location Information. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office. Note: Not required for clinical laboratories when billing for their own services.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
32a	Enter the NPI of the facility where the services were rendered.
32b	Enter the Medi-Cal provider number for an atypical service facility.
33	Billing Provider Info and Phone Number. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
33a	Enter the billing provider's NPI.
33b	Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider. Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

The information list below are the UB04 fields that must be completed accurately and completely in order to avoid claim suspense or denial:

Outpatient:

Item	Description
1.	Unlabeled (Use for clinic or facility information). Enter the clinic or facility name. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. A telephone number is optional in this field. Note: The nine-digit ZIP code entered in this box must match the billing provider's ZIP code on file for claims to be reimbursed correctly.
2.	Unlabeled. For FI use only. This field must be left blank on all claims submitted to Medi-Cal.
3A.	Patient control number. This is an optional field that will help you to easily identify a recipient on <i>Remittance Advices (RAs)</i> . Enter the patient's financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RA. Refer to the <i>Remittance Advice Details (RAD) Examples: Outpatient Services</i> section in this manual for patient control number information.
3B.	Medical record number. Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RA for recipient clarification. The patient control number (Item 3) will appear on the RA.
4.	Type of bill. Enter the appropriate three-character type of bill code as specified in the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> . The type of bill code includes the two-digit facility type code and one-character claim frequency code. This is a required field when billing Medi-Cal. The following facility type codes are a subset of the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> facility type codes commonly used by Medi-Cal. Use one of the following codes as the first two digits of the three-character type of bill code:

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Table of Facility Type Codes

Code	Facility Type
13	Hospital, Outpatient
14	Hospital, Laboratory Services Provided to Non-Patients
23	Skilled Nursing, Outpatient
32	Home Health Services Under a Plan of Treatment
<<33	Home Health, Outpatient>>
34	Home Health Services, Not Under a Plan of Treatment
43	Religious Non-Medical Health Care Institutions, Outpatient Services
71	Clinic, Rural
72	Clinic, Hospital Based or Independent Renal Dialysis Center
73	Clinic, Freestanding
74	Clinic, Outpatient Rehabilitation Facility (ORF)
75	Clinic, Comprehensive Outpatient Rehabilitation Facility (CORF)
76	Clinic, Community Mental Health Center
77	Federally Qualified Health Center (FQHC)
78	Licensed Freestanding Emergency Medical Facility
79	Clinic, Other
81	Specialty Facility, Hospice (non-hospital based)
82	Specialty Facility, Hospice (hospital based)
83	Specialty Facility, Ambulatory Surgery Center
84	Specialty Facility, Freestanding Birthing Center
85	Specialty Facility, Critical Access Hospital
87	Specialty Facility, Freestanding Non-Residential Opioid Treatment Program
89	Specialty Facility, Other

Notes: Only one facility type may be billed on each claim. Outpatient services not logically compatible with the facility type identified on the claim must be billed on a separate claim.

For subacute services, specify the appropriate Place of Service and use modifier U2.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
4.	Type of bill (continued). Clinics and outpatient hospitals use one of the following codes as the first two digits of the three-character type of bill code:

Table of Facility Type Codes by Provider Type

Provider Type	Facility Type
Chronic Dialysis Clinic	72
Community Hospital, Outpatient	13
Community Mental Health Clinic	76
Employer/Employee Clinic	79
Exempt from Licensure Clinic	79
Free Clinic	79
Home Health Agency	32, 34
Local Educational Agency	89
«Medi-Cal Waiver Program (MCWP) Agency»	13, 32, 34 79
Multispecialty Clinic	79
Rehab Clinic	74
Rehab Clinic (Comprehensive)	75
Rural Health Clinic	71
Surgical Clinic	73, 79

Item	Description
5.	Federal tax number. Not required by Medi-Cal.
6.	Statement covers period (From-Through). Not required by Medi-Cal.
7.	Unlabeled. Not required by Medi-Cal.
8A.	Patient name – ID. Not required by Medi-Cal.
8B.	Patient name. Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.

Newborn Infant

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 8B. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.

Enter the infant's date of birth and sex in Boxes 10 and 11. Enter the mother's name in Box 58 (*Insured's Name*) and enter "03" (child) in Box 59 (*Patient's Relationship to Insured*).

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Organ Donors

When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 (*Insured's Name*) and enter "11" (donor) in Box 59 (*Patient's Relationship to Insured*).

Table of Form Items Descriptions (Continued)

Item	Description
9A thru E	Patient address. Not required by Medi-Cal.
10.	Birthdate. Enter the patient's date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors, see Item 8B.)

Item	Description
11.	Sex. Use the capital letter "M" for male, or "F" for female. (For newborns and organ donors, see Item 8B on a previous page.)
12.	Admission date. Not required by Medi-Cal.
13.	Admission hour. Not required by Medi-Cal.
14.	Admission type. «Not required by Medi-Cal.»
15.	Admission source. Not required by Medi-Cal.
16.	Discharge hour. Not required by Medi-Cal.
17.	Status. Not required by Medi-Cal.
18 thru 24.	<p>Condition codes. Condition codes are used to identify conditions relating to this claim that may affect payer processing. Although the Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. <u>The claims processing system ignores all codes not applicable to Medi-Cal.</u></p> <p>Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, "A1", "80" and "82", enter "80" in Box 18, "82" in Box 19 and "A1" in Box 20.</p> <p>Applicable Medi-Cal codes are:</p> <p>Other Coverage: Enter code "80" if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered other coverage and is identified separately.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance prior to billing Medi-Cal. (For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.)</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
18 thru 24.	<p>Condition codes (continued). <u>Emergency Certification:</u> Enter code "81" when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the <i>Remarks</i> field (Box 80). The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required authorization such as emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim.</p> <p>An emergency certification statement is required for medical transportation providers. Please refer to the <i>Medical Transportation – Ground and Medical Transportation – Air</i> sections of the appropriate Part 2 provider manual for additional instructions.</p> <p><u>Outside Laboratory:</u> Enter code "82" if this claim includes charges for laboratory work performed by a licensed laboratory. "Outside" laboratory (facility type "89") refers to a laboratory not affiliated with the billing provider. State in the <i>Remarks</i> field (Box 80) that a specimen was sent to an unaffiliated laboratory.</p> <p><<<u>Family Planning:</u> Enter code "AI" or "A4" if the services rendered are related to Family Planning (FP) Enter code "A1" if the services rendered are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening related. Leave blank if not applicable.>></p>

Table of Condition Codes and Descriptions

Code	Description
A1	<<EPSDT>>
A4	Family Planning
AI	<p>Sterilization/Sterilization <i>Consent</i> Form (PM 330) must be attached if code "AI" is entered</p> <p>See <i>Family Planning and Sterilization</i> sections in the appropriate Part 2 manual for further information.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
18 thru 24.	Condition codes (continued). Medicare Status: Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the <i>Condition Codes</i> fields (Boxes 18 thru 24) blank. The Medicare status codes are:

«Table of Medicare Status Codes and Descriptions»

Code	Description
Y0	Under 65, does not have Medicare coverage
Y1*	Benefits exhausted
Y2*	Utilization committee denial or physician non-certification
Y3*	No prior hospital stay
Y4*	Facility denial
Y5*	Non-eligible provider
Y6*	Non-eligible recipient
Y7*	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9*	PSRO denial
Z1*	Medi/Medi Charpentier: Benefit Limitations
Z2*	Medi/Medi Charpentier: Rates Limitations
Z3*	Medi/Medi Charpentier: Both Rates and Benefit Limitations

«Table of Form Items Descriptions (Continued)»

Item	Description
25 thru 28.	Condition codes. The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 thru 24.
29.	Acadt state. Not required by Medi-Cal.
30.	Unlabeled. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
31 thru 34A thru B.	Occurrence codes and dates. Occurrence codes and dates are used to identify significant events relating to a claim that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. For example, if billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31A and "24" in Box 32A. Refer to <i>Figure 2</i> below.

31 CODE	32 DATE	33 CODE	34 DATE	35 CODE
05	060907	24	060907	

Figure 2. Occurrence Codes Example.

«Table of Form Items Descriptions (Continued)»

Item	Description
31 thru 34A thru B.	Occurrence codes and dates. (continued). Although the Medi-Cal claims processing system will only recognize the following codes, providers may include codes and dates billed to other payers in Boxes 31 thru 34. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u> Applicable Medi-Cal codes are: Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes if the accident or injury was non-employment related:

«Table of Occurrence Codes and Descriptions»

Code	Description
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
35 thru 36A thru B.	Occurrence span codes and dates. Not required by Medi-Cal.
37A.	Unlabeled (Use for delay reason codes). Enter one of the following delay reason codes and include the required documentation if there is an exception to the six-months-from-the-month-of-service billing limit.

«Table of Documentation Descriptions»

Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None ¹
11	Other (theft, sabotage)	Attachment ¹
15	Natural disaster	Attachment

Also refer to the *UB-04 Submission and Timeliness Instructions* section for additional information about codes and documentation requirements.

«Table of Form Items Descriptions (Continued)»

Item	Description
37B.	Unlabeled. Not required by Medi-Cal.
38.	Unlabeled. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
39 thru 41A thru D.	<p>Value codes and amount. Patient's Share of Cost. Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value. For example, if billing for two value codes "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in Box 39A and "30" in Box 40A. (See Figure 3 below.)</p> <p>Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 thru 41. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u></p> <p>Enter code "23" and the amount of the patient's Share of Cost for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about Share of Cost, see the <i>Share of Cost: UB-04 for Outpatient Services</i> section in this manual.</p>

	39	40	41	VAL
	CODE	AMOUNT	CODE	AMOUNT
a	23	5000	30	10000
b				
c				
d				

Figure 3: Value Codes Example.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
39 thru 41A thru D.	Value codes and amount. Patient's Share of Cost (continued).
42.	Revenue code. Revenue codes are required (for instance, for organ procurement) for select outpatient billing. Specific instructions are included in select provider manual sections. Total Charges: Enter "001" on line 23, and enter the total amount on line 23, field 47.
43.	Description. This field will help you separate and identify the descriptions of each service. The description must identify the particular service code indicated in the <i>HCPCS/Rate/HIPPS Code</i> field (Box 44). For more information, refer to the CPT [®] code book. This field is optional except when billing for physician-administered drugs. Entering the National Drug Code (NDC) for Physician-Administered Drugs: Enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). Directly following the last digit of the NDC (no space), enter the two-character unit of measure qualifier followed by the numeric quantity. Refer to the <i>Physician-Administered Drugs – NDC: UB-04 Billing Instructions</i> section in this manual for more information. Notes: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial. If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
44.	<p>HCPCS/rate/HIPPS code. Enter the applicable procedure or drug code (CPT or HCPCS) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claim for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the <i>TAR and Non-Benefit List: Codes (10000 – 99999)</i> sections in the appropriate Part 2 manual. Up to four modifiers may be entered on outpatient <i>UB-04</i> claims. All modifiers must be billed immediately following the HCPCS code in the <i>HCPCS/Rate</i> field (Box 44) with no spaces. (See <i>Figure 4.</i>)</p> <p>Note: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier following the HCPCS code. Section 340B drugs may be billed on the same claim as non-340B drugs.</p> <p>For a listing of modifier codes, refer to the <i>Modifiers: Approved List</i> section in the appropriate Part 2 manual.</p>

42 PREV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	EMERGENCY ROOM USE	Z7501TC90AB21	060207	2	230000
2					
3					
4					

Figure 4: Codes and Modifiers Example for *UB-04* Claim.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
45.	Service date. Enter the date the service was rendered in six-digit, MMDDYY (Month, Day, Year) format, for example, June 24, 2020 = 062420.

'From-Through' Billing

For "From-Through" billing instructions, refer to the *UB-04 Special Billing Instructions for Outpatient Services* section in this manual.

«Table of Form Items Descriptions (Continued)»

Item	Description
46.	Service units. Enter the actual number of times a single procedure or item was provided for the date of service. Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on two or more lines.
47.	<p>Total charges. In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.</p> <p>Note: Medi-Cal cannot process credits or adjustments on the <i>UB-04</i> form. Refer to the <i>CIF Completion</i> and <i>CIF Special Billing Instructions for Outpatient Services</i> sections in the appropriate Part 2 manual for information regarding claim adjustments.</p> <p>Enter the "Total Charge" for all services on line 23. Enter code 001 in <i>Revenue Code</i> field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a preceding page).</p>
48.	Non-covered charges. Not required by Medi-Cal.
49.	<p>Unlabeled. Not required by Medi-Cal.</p> <p>Note: Providers may enter up to 22 lines of detail data (Items 42 thru 49). It is also acceptable to skip lines.</p> <p>To delete a line, mark through the boxes as shown in Figure 5. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.</p>

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / ICD9 CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
1	EMERGENCY ROOM USE	Z7501	060207	2	230000
2	EMERGENCY ROOM USE	Z7502	060207	2	230000
3	PANEL TEST	80018TC	060207	1	8000
4	AMINO ACID NITROGEN	8212690	060207	1	10000

Figure 5: Line Deletion Example for *UB-04* Claim.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
50A thru C.	<p>Payer name. Enter "O/P MEDI-CAL" to indicate the type of claim and payer. Use capital letters only. Refer to <i>Figure 6</i>.</p> <p>When completing Boxes 50 thru 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.</p> <p>When billing other insurance, the other insurance is entered on Line A of Box 50, with the amount paid by Other Coverage on Line A of Box 54 (<i>Prior Payments</i>). All information related to the Medi-Cal billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line.</p> <p>If Medi-Cal is the only payer billed, all information in Boxes 50 thru 65 (excluding Box 56) should be entered on Line A.</p> <p>Reminder: If the recipient has Other Health Coverage, the insurance carrier must be billed prior to billing Medi-Cal.</p>

001	PAGE ____ OF ____
PAYER NAME	
O/P MEDI-CAL	

Figure 6: Payer Name Example for *UB-04* Claim.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
51A thru C.	Health plan ID. Not required by Medi-Cal.
52A thru C.	Release of information certification indicator. Not required by Medi-Cal.
53A thru C.	Assignment of benefits certification indicator. Not required by Medi-Cal.
54A thru B.	Prior payments (other coverage). Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage "payer" (Box 50). Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Leave blank if not applicable. Note: For instructions about completing this field for Medicare/Medi-Cal crossover recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: Outpatient Services</i> section in this manual.
55A thru C.	Estimated amount due (Net amount billed). In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign (\$).

«Table of Total Charges»

Total Charges	(Box 47) Revenue Code 001
(Minus) – Deductions	Share of Cost (Box 39, 40 or 41A – D/ Value code 23) and Other Coverage (Box 54A or B)
(Equals) = Net Billed	(Boxes 55A thru C)

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
56.	NPI. Enter the National Provider Identifier (NPI).
57A thru C.	Other (billing) provider ID (Used by atypical providers only). Enter the Medi-Cal provider number, corresponding to information on lines A, B or C. Note: Required prior to the mandated NPI implementation date when an additional identification number is necessary to identify the provider, or if on and after the mandated NPI implementation, the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.
58A thru C.	Insured's name. If billing for an infant using the mother's ID or for an organ donor, enter the Medi-Cal recipient's name here and the patient's relationship to the Medi-Cal recipient in Box 59 (<i>Patient's Relationship to Insured</i>). See Item 8B on a previous page. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.
59A thru C.	Patient's relationship to insured. If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [child] or "11" [donor]). See Item 8B on a previous page. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.
60A thru C.	Insured's unique ID. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. Note: Medi-Cal does not accept Medicare ID Numbers.

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 8B on a previous page.)

«Table of Form Items Descriptions (Continued)»

Item	Description
61A thru C.	Group name. Not required by Medi-Cal.
62A thru C.	Insurance group number. Not required by Medi-Cal.
63A thru C.	Treatment authorization codes. For services requiring a <i>Treatment Authorization Request</i> (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Note: TAR and non-TAR procedures should not be combined on the same claim.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
64A thru C.	Document control number. Not required by Medi-Cal.
65A thru C.	Employer name. Not required by Medi-Cal.
66.	Diagnosis code header. For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator "0" in the white space below the <i>Diagnosis Code</i> field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
67.	Unlabeled (Use for primary diagnosis code). Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code.
67A.	Unlabeled (Use for secondary diagnosis code). If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. Note: Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 67B thru Q and 68 will not be used for claims processing.
67B thru Q.	Unlabeled. Not required by Medi-Cal.
68.	Unlabeled. Not required by Medi-Cal.
69.	Admitting diagnosis. Not required by Medi-Cal.
70.	Patient reason diagnosis. Not required by Medi-Cal.
71.	PPS code. Not required by Medi-Cal.
72.	External cause of injury code. Not required by Medi-Cal.
73.	Unlabeled. Not required by Medi-Cal.
74.	Principal procedure code and date. Not required by Medi-Cal.
74A thru E.	Other procedure code and date. Not required by Medi-Cal.
75.	Unlabeled. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
76.	Attending. In the first box, enter the provider number of the referring or prescribing physician. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. The referring or prescribing physician's first and last names are not required by Medi-Cal. Note: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.
77.	Operating. In the first box, enter the provider number of the facility in which the recipient resides or of the physician actually providing services. Only one rendering provider number may be entered per claim form. Do not use a group provider number or state license number. The rendering physician's first and last names are not required by Medi-Cal.
78.	Other. Not required by Medi-Cal.
79.	Other. Not required by Medi-Cal.
80.	Remarks. Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim. An emergency certification statement is required for medical transportation providers. Please refer to the <i>Medical Transportation – Ground and Medical Transportation – Air</i> sections of the appropriate Part 2 provider manual for additional instructions.
81A thru D.	Code-code. Not required by Medi-Cal.

Inpatient:

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
1.	<p>Unlabeled (Use for hospital information). Enter the hospital name. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. A telephone number is optional in this field.</p> <p>Note: The nine-digit zip code entered in this box must match the billing provider's zip code on file for claims to be reimbursed correctly.</p>
2.	<p>Unlabeled. For FI use only. This field <u>must</u> be left blank on all claims submitted to Medi-Cal.</p>
3A.	<p>Patient control number. This is an optional field that will help you to easily identify a recipient on <i>Remittance Advices</i> (RAs). Enter the patient's financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RA. Refer to the <i>Remittance Advice Details (RAD) Examples: Inpatient Services</i> section in this manual for patient control number information.</p>
3B.	<p>Medical record number. Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RAD for recipient clarification. The patient control number (Item 3) will appear on the RAD.</p>
4.	<p>Type of bill. Enter the appropriate three-character type of bill code as specified in the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i>. This is a required field when billing Medi-Cal.</p> <p>The following facility type codes are a subset of the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> facility type codes commonly used by Medi-Cal.</p> <p>Use one of the following codes «in the table below» as the first two digits of the three-character type of bill code.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Code	Facility Type
11	Hospital – Inpatient (when billing for a recipient with Medicare Part A)
12	Hospital – Inpatient (when billing for a recipient with Part A Exhaust or Inpatient Medicare Part B only)
18	Hospital – Swing Beds
21	Skilled Nursing – Inpatient (when billing for a recipient with Medicare Part A)
22	Skilled Nursing – Inpatient (when billing for a recipient with Part A Exhaust or Inpatient Medicare Part B only)
28	Skilled Nursing – Swing Beds
41	Religious Non-Medical Health Care Institutions – Hospital Inpatient
65	Intermediate Care – Intermediate Care Level I
66	Intermediate Care – Level II
86	Special Facility – Residential Facility

«Table of Form Items Descriptions (continued)»

Item	Description
5.	Federal tax number. Not required by Medi-Cal.
6.	Statement covers period (from –through). In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. The date of discharge should be entered in the <i>through</i> Box, even though this date is not reimbursable (unless the day of discharge is the date of admission). For "From-Through" billing instructions, refer to the <i>UB-04 Special Billing Instructions for Inpatient Services</i> section in this manual.
7.	Unlabeled. Not required by Medi-Cal.
8A.	Patient name – ID. Not required by Medi-Cal.
8B.	Patient name. Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.

Newborn Infant

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 8B. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Organ Donors

When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 (*Insured's Name*) and enter "11" (donor) in Box 59 (*Patient's Relationship to Insured*).

Table of Form Items Descriptions (continued)

Item	Description
9A thru E.	Patient address. Not required by Medi-Cal.
10.	Birthdate. Enter the patient's date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors, see Item 8B on a previous page.)
11.	Sex. Use the capital letter "M" for male, or "F" for female. (For newborns and organ donors, see Item 8B on a previous page.)
12 thru 13.	Admission date and hour. In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows: <ul style="list-style-type: none"> • Eliminate the minutes • Convert the hour of admission/discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15)

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
14.	<p>Admission type. Enter the numeric code indicating the necessity for admission to the hospital:</p> <ul style="list-style-type: none"> • Emergency – 1 • Elective – 3 • Newborn – 4 <p>If the delivery was outside the hospital, use admit type code “1” (emergency) in the Type of Admission, and admission source code “4” (extramural birth) in the Source of Admission field (Box 15).</p>
15.	<p>Admission source. If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code “1” or “3” must be entered in Box 14 to indicate whether the transfer was an emergency or elective.</p> <p>A baby born outside the hospital: In cases where the type of admission code in Box 14 is “4” (newborn [used by Medi-Cal only when a baby is born outside the hospital]), submit the claim with source of admission code “4” (extramural birth) in Box 15 and the appropriate revenue code in Box 42.</p>

«Table of Admission Code Source Descriptions (Item 15)»

Admission Code Source	Description
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility

«Table of Form Items Descriptions (continued)»

Item	Description
16.	<p>Discharge hour. Enter the discharge hour as follows:</p> <ul style="list-style-type: none"> • Eliminate the minutes • Convert the hour of discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15) <p>If the patient has not been discharged, leave this box blank.</p>
17.	<p>Status. Enter one of the following numeric codes «from the table below» to explain patient status as of the “Through” date indicated in (Box 6) under “Statement Covers Period.”</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Code	Explanation
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an Intermediate Care Facility
05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
09	Admitted as inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified Long Term Care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this code list

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

«Table of Code Descriptions (Item 17) (continued)»

Code	Explanation
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/transferred to a Skilled Nursing Facility with Medicare certification with a planned acute care hospital inpatient readmission
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
90	Discharged/transferred to an Inpatient Rehabilitation Facility including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
91	Discharged/transferred to a Medicare certified Long Term Care Hospital with a planned acute care hospital inpatient readmission
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/transferred to a Critical Access Hospital with a planned acute care hospital inpatient readmission
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
18 thru 24.	<p>Condition codes. Condition codes are used to identify conditions relating to this claim that may affect payer processing.</p> <p>Although the Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. <u>The claims processing system ignores all codes not applicable to Medi-Cal.</u></p> <p>Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, "A1", "80" and "82", enter "80" in Box 18, "82" in Box 19 and "A1" in Box 20.</p> <p>Applicable Medi-Cal codes are:</p> <p><u>Other Coverage:</u> Enter code "80" if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
18 thru 24.	<p>Condition codes (continued).</p> <p><u>Emergency Certification:</u> Enter code "81" when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the <i>Remarks</i> field (Box 80). The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required authorization, such as emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim.</p> <p>An emergency certification statement is required for medical transportation providers. Please refer to the <i>Medical Transportation – Ground and Medical Transportation – Air</i> sections of the appropriate Part 2 provider manual for additional instructions.</p> <p>«<u>Family Planning:</u> Enter code "AI" or "A4" if the services rendered are related to Family Planning (FP). Enter code "A1" if the services rendered are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening related. Leave blank if not applicable.</p> <p>Submit a separate claim form for bills that contain more than one FP code.»</p>

Table of Code Descriptions (Items 18 thru 24)

Code	Description
A1	«EPSDT»
A4	Family Planning
AI	Sterilization/Sterilization <i>Consent Form</i> (PM 330) must be attached if code "AI" is entered

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
18 thru 24.	Condition Codes (continued). <u>Medicare Status:</u> Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the <i>Condition Codes</i> fields (Boxes 18 thru 24) blank on the <i>UB-04</i> claim. The Medicare status codes are:

«Table of Code Descriptions (Items 18 thru 24)»

Code	Description
Y0	Under 65, does not have Medicare coverage
Y1 *	Benefits exhausted
Y2 *	Utilization committee denial or physician non-certification
Y3 *	No prior hospital stay
Y4 *	Facility denial
Y5 *	Non-eligible provider
Y6 *	Non-eligible recipient
Y7 *	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9 *	PSRO denial
Z1 *	Medi/Medi Charpentier: Benefit Limitations
Z2 *	Medi/Medi Charpentier: Rates Limitations
Z3 *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

«Table of Form Items Descriptions (continued)»

Item	Description
25 thru 28.	Condition Codes. The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 thru 24.
29.	ACDT state. Not required by Medi-Cal.
30.	Unlabeled. Not required by Medi-Cal.
31 thru 34A thru B.	Occurrence Codes and Dates. Occurrence codes and dates are used to identify significant events relating to a claim that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. For example, if billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31A and "24" in Box 32A. Refer to <i>Figure 2</i> below.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

31	OC	05	060907	32	OC	24	060907	33	OC			34	OC			35	OC		
	CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE		CODE		DATE

Figure 2: Occurrence Codes Example.

Item	Description
31 thru 34A thru B.	<p>Occurrence Codes and Dates (continued). Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers may include codes and dates billed to other payers in Boxes 31 thru 34. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u></p> <p>Applicable Medi-Cal codes are:</p> <p>Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes <<from the table below>> if the accident or injury was non-employment related:</p>

<<Table of Code Descriptions (Items 31 thru 34A thru B)>>

Code	Description
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

Item	Description
31 thru 34A thru B.	<p>Occurrence Codes and Dates (continued).</p> <p>Discharge Date. In six-digit MMDDYY (Month, Day, Year) format, enter code "42" and the date of hospital discharge when the date of discharge is different than the "Through" date in Box 6.</p>
35 thru 36A thru B.	<p>Occurrence Span Codes and Dates. Not required by Medi-Cal.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
37A.	Unlabeled (Use for delay reason codes). Enter one of the following delay reason codes «in the following table», and include the required documentation, if there is an exception to the six-month from the month of service billing limit.

«Table of Code Description Documentation (Item 37A)»

Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None ¥
11	Other (theft, sabotage)	Attachment ¥
15	Natural disaster	Attachment

«Table of Form Items Descriptions (continued)»

Item	Description
37A.	Unlabeled (Use for delay reason codes) (continued). <u>For hospitals that are not reimbursed according to the diagnosis-related group (DRG) model:</u> Providers must use claim frequency code "5" in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay and the original stay was already billed. Refer to the <i>UB-04 Submission and Timeliness Instructions</i> section in this manual for detailed information about codes and documentation requirements.
37B.	Unlabeled. Not required by Medi-Cal.
38.	Unlabeled. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
39 thru 41A thru D.	<p>Value Codes and Amount. Patient's Share of Cost. Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value. For example, if billing for two value codes "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in Box 39A and "30" in Box 40A. (See Figure 3 below.)</p> <p>Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 thru 41. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u></p> <p>Enter code "23" and the amount of the patient's Share of Cost for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about Share of Cost, see <i>the Share of Cost: UB-04 for Inpatient Services</i> section in this manual.</p>

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VAL
a	23	5000	30	10000		
b						
c						
d						

Figure 3: Value Codes Example

«Table of Form Items Descriptions (continued)»

Item	Description
42.	<p>Revenue Code. Enter the appropriate revenue or ancillary code. Refer to the <i>Revenue Codes for Inpatient Services</i> section in this manual. Ancillary codes are listed in the <i>Ancillary Codes</i> section in this manual.</p> <p>Total Charges: Enter "001" on line 23, and enter the total amount on line 23, field 47.</p>
43.	<p>Description. Enter the description of the revenue or ancillary code used in Box 42. Refer to <i>the Revenue Codes for Inpatient Services</i> and <i>Ancillary Codes</i> sections in this manual for the appropriate description.</p> <p>Note: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
44.	HCP/CS/rate/HIPPS code. Not required by Medi-Cal.
45.	Service Date. Not required by Medi-Cal.
46.	Service Units (Accommodation Days). Enter the number of days of care by revenue code. Units of service are not required for ancillary services. Note: Although this is a seven-digit field, Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on two or more lines.
47.	Total charges. In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). Note: Medi-Cal cannot process credits or adjustments on the UB-04 claim form. Refer to the <i>CIF Completion</i> and <i>CIF Special Billing Instructions for Inpatient Services</i> sections in this manual for information regarding claim adjustments. Enter the "Total Charge" for all services on Line 23. Enter code 001 in <i>Revenue Code</i> field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a preceding page).
48.	Non-covered charges. Not required by Medi-Cal.
49.	Unlabeled. Not required by Medi-Cal. Note: Providers may enter up to 22 lines of detail data (Items 42 thru 49). It is also acceptable to skip lines. To delete a line, mark through the boxes as shown in Figure 4. Be sure to draw a thin line through the <u>entire</u> detail line using a blue or black ballpoint pen.

42 REV. CD	43 DESCRIPTION	44 HCP/CS / RATE / HIPPS CODE	45 SEPRV. DATE	46 SEPRV. UNITS	47 TOTAL CHARGES
205	INTENS CARE PEDIATRIC			12	1800000
203	INTENS CARE PEDIATRIC			15	2300000
272	MEDICAL/SURGICAL SUPPLY			1	80000

Figure 4: UB-04 Claim Line Deletion Example.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
50A thru C.	<p>Payer name. Enter "I/P MEDI-CAL" to indicate type of claim and payer. Use capital letters only. Refer to Figure 5 below.</p> <p>When completing Boxes 50 thru 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.</p> <p>If Medi-Cal is the only payer billed, all information in Boxes 50 thru 65 (excluding Box 56) should be entered on Line A.</p> <p>Reminder: If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.</p>

Figure 5: UB-04 Payer Name Example

«Table of Form Items Descriptions (continued)»

Item	Description
51A thru C.	Health plan ID. Not required by Medi-Cal.
52A thru C.	Release of Information Certification Indicator. Not required by Medi-Cal.
53A thru C.	Assignment of Benefits Certification Indicator. Not required by Medi-Cal.
54A thru B.	<p>Prior Payment (Other Coverage). Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage "payer" (Box 50). Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Leave blank if not applicable.</p> <p>Note: For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: Inpatient Services</i> section in this manual.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
55A thru C.	Estimated amount due (net amount billed). In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign (\$).

«Table of Estimated Amounts (Item 55A thru C)»

Dollar Amount	Location on Form
Total Charges	(Box 47) Revenue code 001
Deductions (Minus) –	Share of Cost (Box 39, 40 or 41A thru D/ Value code 23) and Other Coverage (Box 54A or B)
Net Billed (Equals) =	(Boxes 55A thru C)

«Table of Form Items Descriptions (continued)»

Item	Description
56.	NPI. Enter the National Provider Identifier (NPI).
57A thru C.	Other (billing) provider ID (used by atypical providers only). Not required by Medi-Cal for inpatient providers. Note: Required prior to the mandated NPI implementation date when an additional identification number is necessary to identify the provider, or if on and after the mandated NPI implementation, the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.
58A thru C.	Insured's Name. If billing for an infant using the mother's ID or for an organ donor, enter the Medi-Cal recipient's name here and the patient's relationship to the Medi-Cal recipient in Box 59 (<i>Patient's Relationship to Insured</i>). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
59A thru C.	Patient's Relationship to Insured. If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [child] or "11" [donor]). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.
60A thru C.	Insured's Unique ID. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. Note: Medi-Cal does not accept Medicare ID numbers.

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 8B on a previous page.)

«Table of Form Items Descriptions (continued)»

Item	Description
61A thru C.	Group Name. Not required by Medi-Cal.
62A thru C.	Insurance Group Number. Not required by Medi-Cal.
63A thru C.	Treatment Authorization Codes. For services requiring a <i>Treatment Authorization Request (TAR)</i> , enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
64A thru C.	Document Control Number. Not required by Medi-Cal.
65A thru C.	Employer Name. Not required by Medi-Cal.
66.	Diagnosis Code Header. For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator "0" in the white space below the <i>Diagnosis Code</i> field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
67.	<p>Unlabeled (Use for primary diagnosis code). Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code.</p> <p><u>Present on admission (POA) indicator:</u> Each diagnosis code may require a POA indicator that meets Centers for Medicare & Medicaid Services (CMS) standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67Q. See Figure 6 in Item 67A.</p> <p>Note: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A.</p> <p>However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 thru 67Q) so the claim is reimbursed at the appropriate level.</p> <p>Paper claims accommodate up to 18 diagnosis codes.</p>
67A.	<p>Unlabeled (Use for secondary diagnosis code). If applicable, enter all letters and/or numbers of the ICD-10-CM code for the secondary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code.</p> <p><u>Present on admission (POA) indicator:</u> Each diagnosis code may require a POA indicator that meets CMS standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67Q.</p>

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

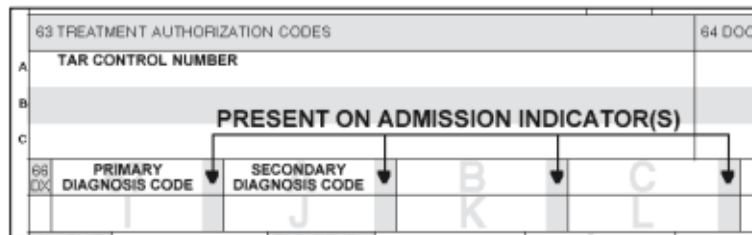


Figure 6: Arrows show shaded areas where present on admission (POA) indicators are placed; next to their associated diagnosis codes.

Item	Description
67A.	Unlabeled (Use for secondary diagnosis code) (continued). Note: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A. However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 thru 67Q) so the claim is reimbursed at the appropriate level. Paper claims accommodate up to 18 diagnosis codes.
67B thru Q.	Unlabeled. Not required by Medi-Cal. See "Note" in Item 67A.
68.	Unlabeled. Not required by Medi-Cal.
69.	Admitting Diagnosis. Not required by Medi-Cal.
70.	Patient Reason Diagnosis. Not required by Medi-Cal.
71.	PPS code. Not required by Medi-Cal.
72.	External Cause of Injury Code. Not required by Medi-Cal.
73.	Unlabeled. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
74.	<p>Principal Procedure Code and Date. Enter the appropriate ICD-10-CM PCS code identifying the primary medical or surgical procedure. In six-digit MMDDYY (Month, Day, Year) format, enter the date the surgery or delivery was performed. Enter the ICD-10-CM PCS code, without periods or spaces between the numbers.</p> <p>Note: The Medi-Cal claims processing system only scans the primary and secondary procedure codes entered in Boxes 74 and 74A.</p> <p>However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all procedure code fields (Boxes 74 thru 74E) so the claim is reimbursed at the appropriate level.</p> <p>Paper claims accommodate up to six procedure codes.</p>
74A thru E.	<p>Other procedure codes and dates. Enter the appropriate ICD-10-PCS code identifying the secondary medical or surgical procedure. Enter the ICD-10-PCS code, without periods or spaces between the numbers or characters.</p> <p>Note: For OB vaginal or cesarean delivery and transplants, enter the appropriate ICD-10-PCS code in either Box 74 or 74A thru E.</p> <p>Also see the "Note" in Item 74.</p>
75.	Unlabeled. Not required by Medi-Cal.
76.	Attending. In the first box, enter the attending physician's NPI. Do not use a group provider number. The attending physician's first and last name are not required by Medi-Cal.
77.	Operating. In the first box, enter the operating physician's NPI. Do not use a group provider number. The operating physician's first and last name are not required by Medi-Cal.
78.	Other (Use for admitting physician provider number). In the first box, enter the admitting physician's NPI. Do not use a group provider number. The admitting physician's first and last name is not required by Medi-Cal.
79.	Other. Not required by Medi-Cal.

Policy/Procedure Number: CLPM-03		Lead Department: Claims
Policy/Procedure Title: Required Billing Forms and Completion Requirements		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy
Original Date: 9/1/25	Next Review Date: 1/1/26 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees

Item	Description
80.	<p>Remarks. Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim.</p> <p>An emergency certification statement is required for medical transportation providers. Please refer to the <i>Medical Transportation – Ground and Medical Transportation – Air</i> sections of the appropriate Part 2 provider manual for additional instructions.</p>
81A thru D.	Code-Code. Not required by Medi-Cal.

VII. REFERENCES:

A. State of California Merdi-Cal Provider Manual

VIII. DISTRIBUTION:

A. PARTNERSHIP4ME PowerDMS Policies & Procedures

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

X. REVISION DATES: 9/1/25