CHAPTER 6: BILLING AND PAYMENT

UNIT 3: FACILITY (UB-04/837I) BILLING

IN THIS UNIT

What Is My Service Area?

OBSOLETE

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. Where no symbol is present, the information is relevant to all states.

PA ONLY | The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

DE ONLY | The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

WV ONLY | The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

6.3 FACILTY BILLING OVERVIEW

Introduction

Highmark requires facility providers to bill electronically via 837 Institutional (837I) electronic transactions. HIPAA-compliant UB Claim Submission is also available in NaviNet®. In some cases, claim submission may be necessary on UB-04 paper claim forms.

Facility Bulletins

In the past, Highmark published Facility Bulletins to communicate policies and procedures to facilities. Although the publication of newly created Facility Bulletins was discontinued in 2015, Highmark has reviewed previously published bulletins in Pennsylvania to evaluate their content. As the bulletins were evaluated, Highmark determined if the information was still current and valid, or if the information was outdated and/or superseded in a more recent bulletin (or communication). Those bulletins deemed to be outdated, or superseded in a more recent communication, were marked as obsolete and added to the Facility Bulletin Archive.

Facility Bulletins continue to be available online to providers as resources and for historical reference in all service areas. The *Highmark Provider Manual*, provider newsletters, Special Bulletins, and other communications (e.g., Plan Central Messages) should be referenced for the most up-to-date information.

Facility Bulletins can be accessed from the Provider Resource Center by selecting **NEWLETTERS/NOTICES** from the main menu.

What Is My Service Area?

Billing Highlights

Billing Highlights are available in Pennsylvania to help facilities identify the information from the UB-04 locator fields that are required when billing specific facility type claims. In addition, helpful tips are offered to assist facilities with providing the needed information for each facility type claim submitted to Highmark.

The Billing Highlights are available on the NaviNet® Provider Resource Centers in Pennsylvania -- select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

FOR MORE INFORMATION

Please see also **Chapter 4.3: Facility-Specific Guidelines** that contains information and guidelines specifically for facilities that may also include reporting guidelines (e.g., Observation Services).

6.3 PRESENT ON ADMISSION/ADVERSE EVENTS

Present on Admission (POA)	Highmark requires the submission of Present on Admission (POA) information on inpatient claims for all hospital providers. This is for **all inpatient acute care hospitals, including critical access hospitals**, for all claims.
Potential reduction in payment for Hospital Acquired Conditions (HAC)	Medicare Grouper for all DRG-reimbursed inpatient acute care hospitals, including critical access hospitals for commercial business, features logic that prevents the assignment of a higher MS-DRG to a claim reporting certain conditions not present on admission (when no other condition on the claim would otherwise trigger a higher MS-DRG). Highmark will also apply a separate methodology and process to potentially **reduce payment to non-DRG reimbursed hospitals** for claims reporting any of the following conditions if not identified as present on admission (in the absence of other complications or major complications on the claims): • Foreign object retained after surgery • Air embolism • Blood incompatibility • Pressure ulcer stages III and IV • Falls and trauma • Catheter-associated urinary tract infection • Vascular catheter-associated infection • Manifestations of poor glycemic control • Surgical site infection, mediastinitis, following coronary artery bypass graft • Surgical site infection following certain orthopedic procedures • Surgical site infections following bariatric surgery for obesity • Surgical site infection following cardiac implantable electronic device (CIED) procedures • Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures • Iatrogenic pneumothorax with venous catheterization
Non-payment for "wrong" surgical events for all hospital providers	Consistent with Centers for Medicare & Medicaid Services (CMS) policy, Highmark will not make payment for the following three "wrong" surgical events: • The **wrong surgical procedure** was performed • Surgery was performed on the **wrong body part** • Surgery was performed on the **wrong patient**

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6.3 PRESENT ON ADMISSION/ADVERSE EVENTS, Continued

Facility Bulletins available

For additional information, Facility Bulletins are available in Pennsylvania and West Virginia. To access these Facility Bulletins, select **NEWSLETTERS/NOTICES** from the Provider Resource Center main menu, and then **Facility Bulletins**.

Click on the **Facility Bulletin Search** to search for all related bulletins by the following Bulletin Numbers (ordered from most recent to oldest):

- **Pennsylvania:**
  - Western Region:
    - HOSP-2012-023-W; MPC-2012-018-W
    - PROV-2012-002-W
    - PROV-2011-004-W
    - HOSP-2009-010-W
    - HOSP-2009-001-W
    - HOSP-2008-008-W; MPC-2008-003-W
    - HOSP-2008-001-W; MPC-2008-001-W
  - Central & Northeastern Regions:
    - HOSP-2012-023-C; MAHOSP-2012-009-C
    - PROV-2012-002-C
    - PROV-2011-004-C
    - HOSP-2009-003-C
    - HOSP-2009-002-C
    - HOSP-2008-007-C; MAHOSP-2008-005-C
    - HOSP-2008-003-C
    - HOSP-2008-002-C; MAHOSP-2008-001-C

- **West Virginia:**
  - HWV-HOSP-2012-018; HHIC-HOSP-2012-005
  - HWC-PROV-2012-001; HHIC-PROV-2012-001
  - MS-HOSP-2009-003; HHIC-HOSP-2009-003
  - MS-HOSP-2009-002; HHIC-HOSP-2009-002

What Is My Service Area?

6.3 NATIONAL CORRECT CODING INITIATIVE (NCCI) EDITS

Introduction

The National Correct Coding Initiative (NCCI) edits were developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and reduce paid claim errors resulting from improper coding and inappropriate payments. Highmark began to systematically follow CMS guidelines and apply Medically Unlikely Edits (MUEs), a subset of these edits, effective January 1, 2012.

Highmark applies the NCCI edits on a systematic basis to outpatient facility claims rendered in an acute-care hospital for both commercial and Medicare Advantage business.

Systematic application of NCCI edits

Although Highmark has always required contracted facilities to comply with industry coding standards such as those incorporated in the NCCI edits, it has not systematically applied this logic via claims edits under all reimbursement methods. Effective October 1, 2013, Highmark expanded the application of the NCCI edits to all acute care hospitals for outpatient Commercial and Medicare Advantage facility claims in order to produce more accurate payments and reduce the need for claim adjustments due to clerical or coding errors.

The systematic edits will be applied based on the date of service of the claim submitted.

Quarterly updates

Highmark is unable to implement CMS-driven reimbursement changes (such as changes to the NCCI edits) on the CMS effective date. In some cases, the changes are transmitted to Highmark via its software vendor and cannot be implemented until the vendor has distributed the updated software. Even when a software vendor is not involved, all such changes must be evaluated in light of Highmark contracts and system constraints prior to implementation.

Highmark's implementation of CMS-driven changes to the quarterly version updates to the NCCI edits will therefore occur after CMS's implementation and after appropriate evaluation.

6.3 CLAIM ADJUSTMENTS

Overview To make changes to claims that have already been submitted to Highmark, facility providers are to use Adjustment Bill Types XX7, XX8, or XX5 for claims previously submitted by paper and electronically.

Corrected / adjustment bill types

Please follow the specific guidelines provided in the table below for Adjustment Bill Types XX8, XX7, and XX5:

ADJUSTMENT BILL TYPE	WHEN TO UTILIZE	HIGHMARK ACTION
XX5 Late Charges Only	This code is to be used for submitting additional new charges or lines which were identified by the facility after the original claim was submitted (use XX7 for BlueCard®).	Adjust the original claim to include the additional charges.
XX7 Replacement of prior claim	This code is to be used when a specific bill or line has been issued and needs to be restated in its entirety. When this code is used, Highmark will operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.	Adjust the original claim by overlaying data from XX7 claim onto original claim. The new payment amount or retraction will be processed on the original claim.
XX8 Void/Cancel Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill. Use of XX8 will cause the bill to be completely canceled from the Highmark system.	Void the original claim on the remittance.

Codes used to report adjustment claims on 835

Highmark uses the following codes to report adjustment claims on the 835:
- Claim Adjustment Group and Reason Code **CO129** ("Prior processing information appears incorrect") will be used to deny the claim.
- Remark Code **N770** ("The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.") will also be used on these claims.

6.3 CLAIM ADJUSTMENTS, Continued

Original claim number required

The original claim number is required when submitting adjustment bill types XX5, XX7, and XX8 on claims via NaviNet® UB Claim Submission and HIPAA 837I batch and real-time submissions.

The original claim number should be reported in the **Adjustment Claim Link (ACL)** field.

Exceptions

Although the automated process handles the majority of electronically submitted adjustments, there are certain categories of adjustments that still require manual intervention. Among these are adjustments to previously adjusted claims.

Highmark will make every effort to avoid separation between the retraction and repayment components of these adjustments.

Remittance Advice

The Highmark Remittance Advice informs providers of the amount Highmark will pay for a specific claim. It will also detail both paid and denied claims.

Please refer to **Chapter 6.7: Payment/EOBs/Remittances** for specific and detailed information pertaining to the Remittance Advice.

6.3 GUIDELINES FOR HIPPS REPORTING

Background

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types.

The Centers for Medicare & Medicaid Services (CMS) requires Health Insurance Prospective Payment System (HIPPS) codes on all Medicare Advantage claims for home health agency and skilled nursing facility providers, effective July 1, 2014.

Requirement

Highmark follows the CMS HIPPS reporting guidelines for **both commercial and Medicare Advantage** business. Home health and skilled nursing facility providers are required to submit the applicable HIPPS codes on claims for all commercial and Medicare Advantage Highmark members for dates of services on and after July 1, 2014.

Providers are required to report codes that are valid as of the date of service. Always consult the most current national UB Data Specifications Manual for the most updated list of codes.

This requirement does not change your current reimbursement method. Providers should continue to submit claims according to your contract.

Revenue codes

Please report applicable revenue code that represent the prospective payment mechanism as follows:

PROVIDER TYPE	REVENUE CODE	GUIDELINES
Home Health	**0023**	This revenue code (and the corresponding HIPPS codes) should be reported **in addition to** the revenue lines representing the home health service billed by the facility.
Skilled Nursing Facility	**0022**	This revenue code (and the corresponding HIPPS codes) should be reported **in addition to** the revenue lines representing the skilled nursing service billed by the facility. Bill the revenue line of 0022 with the appropriate Resource Utilization Group (RUG) code and the Assessment Reference Date (ARD).

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6.3 GUIDELINES FOR HIPPS REPORTING, Continued

HIPPS codes	Ensure the appropriate HIPPS code is reported on all Commercial and Medicare Advantage claim submissions. Generate a new HIPPS code for each home health or skilled nursing episode according to CMS guidelines.

Special considerations when naviHealth assigns the RUG level

(PA ONLY) (WV ONLY)

naviHealth assigns the appropriate RUG code level for Highmark's Medicare Advantage members receiving skilled rehabilitation therapy. In these scenarios, skilled nursing facilities will not complete the typical Medicare Prospective Payment System (PPS) Assessments.

Skilled nursing facilities should follow the guidelines outlined below when naviHealth assigns the RUG Code level:

- **HIPPS code**: naviHealth will only provide the RUG code level, which should be the first three digits of the HIPPS code.
- **Assessment Indicator (AI):** Skilled nursing facilities should report **60** as the AI for members receiving therapy.
- **Assessment Reference Date (ARD):** When using revenue code 0022, the ARD is reported in locator 31-34 with Occurrence Code 50.
- **Admission Date:** The admission date should be entered for Medicare Advantage members receiving skilled rehabilitation services when naviHealth has assigned the RUG level.

For information on Highmark's partnership with naviHealth for post-acute care management for Highmark Medicare Advantage members, please visit the Provider Resource Center (in Pennsylvania and West Virginia). Select **Care Management Programs** from the main menu on the left, and then click on **Post-Acute Care Management for Medicare Advantage Members**.

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Service date	For revenue code 0023, the date of service should equal the date of the first billable service on the claim.

What Is My Service Area?

Units of service

Units of service are required on each separate HIPPS revenue line.

- **For each revenue code 0023:** Units should always equal 1.
- **For each revenue code 0022:** The units for the multiple lines should equal the number of room and board days falling under that HIPPS code.

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6.3 GUIDELINES FOR HIPPS REPORTING, Continued

Billing scenarios

The table below illustrates several billing scenarios that may occur when reporting Revenue code 0023:

If the provider reports...	Along with…	Then…
Home health Revenue code 0023	The corresponding HIPPS (HHRG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).
Skilled nursing Revenue code 0022	The corresponding HIPPS (RUG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).
Revenue code 0022 or 0023	A HIPPS code not valid as of the date of service, or in the incorrect format.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
Revenue code 0022 or 0023	A HIPPS code that does not correspond to the revenue submitted.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
Revenue code 0022 or 0023	A HCPCS/CPT code instead of a HIPPS code.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
No revenue code 0022 or 0023	A HIPPS code.	This is nnot an acceptable combination in NaviNet, and the provider will be prompted to correct the code.

REMINDER: Check your Claims Log

Providers who submit claims electronically via NaviNet® are reminded to check their NaviNet Claims Log regularly to ensure that any claims rejected for these reasons are addressed in a timely fashion.

6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY

Introduction   This section outlines Highmark's longstanding billing guidelines for outpatient services -- Emergency Department (ED), observation, pre-admission testing, etc. -- rendered prior to an inpatient admission.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the forty-eight (48) hour period or leaves the facility and returns to be admitted within the forty-eight (48) hour time frame. Information is included for both Commercial and Medicare Advantage members.

Commercial members   Please refer to the table below for guidelines on when outpatient services should be billed on the inpatient claim for commercial members (see next page for excluded services):

SCENARIO	If…	Then…
Member Seeking Emergency Department (ED) Services	A member receives ED services within a 48-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.
Member Receiving Observation Services	A member receives observation services within a 48-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.
Member Receiving Pre-Admission and Other Outpatient Services	A member receives pre-admission or other outpatient services within a 48-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.

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6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY, Continued

Medicare Advantage members

Please refer to the table below for guidelines on when outpatient services should be billed on the inpatient claim for Medicare Advantage members:

SCENARIO	If ...	Then ...
Member Seeking Emergency Department (ED) Services	a member receives ED services within a 24-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.
Member Receiving Observation Services	a member receives observation services within a 48-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.
Member Receiving Pre-Admission and Other Outpatient Services	a member receives pre-admission or other outpatient services within a 72-hour period prior to an inpatient admission to the **same** facility for a related diagnosis…	**all** services need to be billed on the inpatient claim.

What Is My Service Area?

Unrelated diagnosis

Please note that when outpatient services have been performed within the designated period prior to an inpatient admission **for an unrelated diagnosis**, those services are not to be included on the inpatient claim. These services should be billed independently.

Excluded services

There are certain outpatient services that are excluded from this policy when performed within the designated period prior to an inpatient admission.

These services are **not to be included on the inpatient claim** and should be billed independently. They are as follows:

- **Chemotherapy and/or Outpatient Surgery:** These services should not be included on the inpatient claim as long as they are **not performed on the same day** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they are to be included on the inpatient claim.
- **Maternity Services:** Outpatient diagnostic and/or Emergency Department services **provided in conjunction with a maternity-related diagnosis prior to the inpatient admission** should not be included on the inpatient claim.

6.3 MODIFIER REQUIRED FOR OFF-CAMPUS OUTPATIENT SERVICES

Requirement

Hospitals are required to report **modifier PO** ("Services, procedures, tests and/or surgeries furnished at off-campus provider-based outpatient department") with every Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code for all outpatient items and services furnished in an off-campus provider-based department of a hospital.

This mandatory billing requirement will help the Centers for Medicare & Medicaid Services (CMS) collect data on the frequency of, type of, and payment for services provided in off-campus provider-based hospital departments. Highmark has adopted this requirement for all lines of business, Commercial and Medicare Advantage, for similar reasons.

Main campus & off-campus defined

The main campus of a provider is defined as "the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings."

"Off campus" references all other facilities or locations not meeting this requirement that are deemed to be provider based.

Where to report on claims

The PO modifier must be reported on your 837I electronic submissions (Loop 2400, SV2 Segment) and on any paper claim submissions (UB-04/CMS 1450 – Locator 44) for services performed at an off-campus provider-based outpatient department.

Reminder: Providers are required to provide the "Service Facility Location" information if it is different than the billing address (Loop 2310 E NM1, N3, and N4 on the 837I version 5010). For more information, see **Chapter 6.1: General Claim Submission Guidelines**.

6.3 HOME HEALTH AGENCY BILLING HOME INFUSION SERVICES FOR MEDICARE ADVANTAGE

What Is My Service Area?

Billing guidelines

When a Medicare Advantage member is being treated under 60-day Episode of Care and concurrently receiving home infusion services, the proper billing methodology must be used by the home health agency.

If home infusion services are being provided, the existing 60-day Episode of Care must be closed and a new claim for a Partial Episodic Payment (PEP) with a discharge status of "**06**" must be submitted to Highmark.

Unrelated services

If additional services are provided to the member that are unrelated to the home infusion services, a claim will need to be submitted for these services using the per visit reimbursement methodology.

Note: These additional services will need to be authorized by Highmark Clinical Services.

Infusion services completed

After the home infusion services have been completed, another 60-day Episode of Care can be submitted if the member requires additional home health services.

Note: An additional 60-day Episode of Care will need to be authorized by Highmark Clinical Services.

6.3 REIMBURSEMENT FOR INPATIENT HOSPICE WHEN DISCHARGE STATUS INDICATES EXPIRED

Overview

Inpatient hospice facilities will receive reimbursement when the member's discharge status indicates expired. This policy applies to commercial products effective with discharge dates on or after August 1, 2014.

Requirement for claim submission

Highmark requires hospice providers to submit the eligible dates of service and the total number of units for inpatient hospice services, including the date of death. Hospice providers must use discharge status codes when submitting claims:

- 40 – Expired at home
- 41 – Expired in a medical facility
- 42 – Expired (place unknown)

Extending the authorization to include date of death

If the member has expired and the date of death is not covered by the existing authorization period, the facility must notify Highmark Clinical Services. This is to extend the authorization and enable the payment to be made for the member's expiration date.

Quick Reference

6.3 DIAGNOSTIC VS. ROUTINE PAP SMEARS

Introduction

These guidelines clarify billing for both outpatient diagnostic pap smears and routine pap smears.

Billing for routine pap smears

If billing for a **routine pap smear**, only report a **routine** diagnosis on the claim to ensure that the claim will process correctly.

Billing for diagnostic pap smears

If billing for a **diagnostic pap smear** as a follow-up to a routine pap smear, and **no other services are being reported** on the claim, the diagnosis code reported should only be **diagnostic** and related to the symptom or chief complaint of the patient.

Note: If a routine diagnosis code is reported on a claim where the only service being billed is diagnostic, the claim will be viewed as routine and it may be rejected for benefit limitations.

Diagnostic pap smears with routine services

If billing for a diagnostic pap smear **and** a routine service:
- Report the diagnosis related to the symptom or chief complaint of the patient for the diagnostic pap smear, and
- Also report the routine diagnosis for the routine service provided.

6.3 REVISED AND DISCONTINUED BILL TYPES FOR HOME HEALTH

Overview On October 1, 2013, Highmark aligned with the National Uniform Billing Committee's (NUBC) decision to simplify code sets by revising and discontinuing certain bill types for Home Health providers.

Bill types revised or discontinued The following bill types have been revised and and/or discontinued:

BILL TYPE	Description of outpatient bill types prior to October 1, 2013	Description of outpatient bill types effective October 1, 2013
032X	Inpatient (plan of treatment under Part B only)	Home Health Services under a Plan of Treatment
033X	Outpatient (plan of treatment under Part A, including DME under Part A)	Discontinued
034X	Other (for medical and surgical services not under a plan of treatment)	Home Health Services **not** under a Plan of Treatment

IMPORTANT! This requirement does not affect your reimbursement method. Providers should continue to submit claims according to your contract.

OBSOLETE

6.3 GUIDELINES FOR SUBMITTING PAPER CLAIMS

Optical Character Recognition (OCR)

Although electronic claim submission is required, you may encounter a situation in which the submission of a paper claim is necessary. If this occurs, **you must always print or type all information on the claim form.** Clear, concise reporting on the form helps us to interpret the information correctly.

Highmark uses an Optical Character Recognition (OCR) scanner for direct entry of claims into its claims processing system. OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and "reads" the printed data, then stores the image for audit purposes. The scanner can read both computer-prepared and typewritten claim forms.

Tips for submitting paper claims

To ensure that your facility's claims are submitted in a format that allows for clear scanning, please observe the guidelines below so that the scanner can "read" and "interpret" the claim data correctly:

- Only use the approved red UB-04 paper claim form (see next page for sample).
- Always send the **original** claim form to Highmark, since photocopies cannot be scanned. If your facility is using a multi-part form, please submit the top sheet, not one of the copies.
- Print the data on the form via computer, or type it within the boundaries of the fields provided on the form. **DO NOT HAND WRITE.**
- Use a print range of 10 or 12 characters per inch (CPI).
- Use black ink only. The scanner cannot read red ink.
- Do not use excessive amounts of correction fluid on the claims.
- Change the print ribbon or cartridge regularly to ensure print readability; light print cannot be read by the scanner.
- Do not use a rubber stamp to print data in any fields of the UB claim form.
- Do not highlight anything on the claim form or any necessary attachments; highlighted information becomes blackened out and is not legible.

Required information

In order to avoid processing and payment delays, please complete the claim form in its entirety. If required information is not present on the claim, Highmark will return the claim to your facility for completion. Under certain circumstances, Highmark may contact the facility to obtain the missing data.

Exception: Major Medical claims

Pennsylvania Western Region facilities are required to submit Major Medical claims via a red UB-04 paper claim (available at **nubc.org**), rather than electronically.

What Is My Service Area?

6.3 SAMPLE UB-04 CLAIM FORM

TIP SHEET

Sample UB-04   Click on the Tip Sheet icon for a full-size version of the sample UB-04 claim form.