HCAM Billers Forum

Mastering SNF Billing:
Don’t Leave Money on the Table

April 2024

Presented by:

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Tina Simmons, Healthcare Consultant

ECS SOLUTIONS™
A division of HW&Co.

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information _____

  _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

Form Instructions for the Detailed Explanation of Non-Coverage (DENC)
CMS-10124

A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the termination of services in these settings. The DENC must be provided no later than close of business of the day of the QIO's notification.

Alterations to the DENC

Providers may include their business logo and contact information on the top of the DENC. Text may not be moved to a second page to accommodate large logos, address headers, etc.

Heading

Insert contact information here: The name, address and telephone number of the provider or plan that delivers the notice must appear above the title of the form. The entity's registered logo is not required, but may be used.

Date: Fill in the date the notice is generated by the provider or plan.

Patient Name: Fill in the beneficiary's/enrollee's first and last name.

Member number: Fill in the beneficiary's/enrollee's medical record or identification number. The beneficiary's/enrollee's HIC number must not be used.

{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice.

Bullet # 1 The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain English.

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the

Medicare guidelines. Describe how the beneficiary/enrollee does not meet these guidelines.

Bullet # 3 (Plans only) The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan's policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please explain that here.

If you would like a copy of the policy: If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents sent to the QIO.

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

Form Instructions for the Detailed Explanation of Non-Coverage (DENC)
CMS-10124

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Date: Fill in the date the notice is generated by the provider or plan.

Patient Name: Fill in the beneficiary's/enrollee's first and last name.

Member number: Fill in the beneficiary's/enrollee's medical record or identification number. The beneficiary's/enrollee's HIC number must not be used.

{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice.

Bullet # 1 The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain English.

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the

Medicare guidelines. Describe how the beneficiary/enrollee does not meet these guidelines.

Bullet # 3 (Plans only) The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan's policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please explain that here.

If you would like a copy of the policy: If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents sent to the QIO.

Skilled Nursing Facility:

Beneficiary's Name: **Identification Number:**

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Date

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)
Form CMS-10055 (2018)

Overview

These abbreviated instructions explain when and how the SNFABN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30 for general notice requirements and detailed information on the SNFABN. Information on the ABN (Form CMS-R-131) can be found on the ABN webpage: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:

- not medically reasonable and necessary; or
- considered custodial.

The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services.

Completing the SNFABN

The SNFABN is available for download by selecting the "FFS SNFABN" link from the menu on the webpage http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. The SNFABN is a CMS-approved model notice and should be replicated as closely as possible when used as a mandatory notice. Failure to use this notice or significant alterations of the SNFABN could result in the notice being invalidated and/or the SNF being held liable for the care in question.

The SNFABN has the following 5 sections for completion:

1. Header
2. Body
3. Option Boxes
4. Additional Information
5. Signature and Date

Entries in the blanks may be typed or legibly hand-written and should be large enough for easy reading (approximately 12 point font).

1. Header

A. SNF Information

The first blank above the title "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)" is labeled "Skilled Nursing Facility:" The SNF must include the SNF's name, address, and phone number, at a minimum. A TTY number should be included when necessary to meet a beneficiary's needs. Adding the SNF's email address, additional contact information, and/or corporate logo is optional.

B. Patient's Name

SNFs must enter the first and last name of the beneficiary receiving the notice, and a middle initial should be entered if there is one on the beneficiary's Medicare card. The SNFABN will still be valid if there's a misspelling or missing initial, as long as the beneficiary or their authorized representative recognizes the name listed on the notice.

C. Identification Number

Entering an identification number is optional, and the SNFABN is valid if this space is left blank. SNFs may insert an internal filing number (such as a medical record number) that might help link the notice with a related claim. Medicare numbers (i.e., Health Insurance Claim Numbers) or Social Security numbers **must not** be listed on the notice.

2. Body

A. "Beginning On" Blank/ Effective Date of Potential Non-coverage

In the blank that follows "Beginning on…," the SNF enters the date on which the beneficiary may be responsible for paying for care that Medicare isn't expected to cover.

B. "Care" Section

In this section, the SNF lists the care that it believes may not or won't be covered by Medicare. The description must be written in plain language that the beneficiary can understand. The care can be listed as "inpatient stay at this facility," for example.

C. "Reason Medicare May Not Pay" Section

The SNF must give the applicable Medicare coverage guideline(s) and a brief explanation of why the beneficiary's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment.

Below are examples of denial statements that explain some of the common reasons why an extended care stay or services may not be covered under Medicare. These denial statements are not mandatory language and can be modified to meet individual scenarios. The SNF may also develop language different from these examples to explain why an extended care stay, or services may not be paid for by Medicare.

Example 1: Beneficiary no longer requires skilled care but wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay
Reason Medicare May Not Pay: You need only assistive or supportive care. You don't require daily skilled care by a professional nurse or therapist. Medicare won't pay for your stay at this facility unless you require daily skilled care.

Example 2: Beneficiary no longer requires daily skilled care but wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay
Reason Medicare May Not Pay: You don't require skilled care on a daily basis. Medicare won't pay for your stay at this facility unless you need daily skilled care for your medical condition.

Example 3: Beneficiary no longer requires skilled therapy services and wants to continue residing in the SNF.

Care: Inpatient Skilled Nursing Facility Stay
Reason Medicare May Not Pay: You need help with repetitive exercises and walking, and you don't require skilled care. Medicare won't pay for your stay at this facility unless you need daily skilled care.

D. "Estimated Cost" Section

In this section, the SNF enters the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimated total cost or a daily, per item, or per service cost estimate. SNFs must make a good faith effort to insert a reasonable cost estimate for the care. The lack of a cost estimate entry on the SNFABN or an amount that is different than the final actual cost charged to the beneficiary does not invalidate the SNFABN.

If for some reason the SNF is unable to provide a good faith estimate of projected costs of care at the time of SNFABN delivery, the SNF should indicate in the cost estimate area that no cost estimate is available. This should not be a routine or frequent practice but allows timely issuance of the SNFABN during rare instances when a cost estimate is not available.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the SNFABN, in general. SNFs should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated a SNFABN.

3. Option Boxes

There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary's selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice.

Option 1:

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

When the beneficiary selects Option 1, the care is provided, and the SNF must submit a claim to Medicare. The SNF must notify the beneficiary when the claim is submitted. This will result in a payment decision, and if Medicare denies payment, the decision can be appealed. SNFs aren't permitted to collect money for Part A services until Medicare makes an official payment decision on the claim.

Note: Beneficiaries who need an official Medicare decision (Medicare denial) for a secondary insurance claim should choose Option 1.

Option 2:

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

When the beneficiary selects Option 2, the care is provided, and the beneficiary pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the beneficiary has no appeal rights.

Note: Although Option 2 indicates that Medicare will not be billed, SNFs must still adhere to the Medicare requirements for submitting no pay bills. See Chapter 6 of the Medicare Claims Processing manual for SNF claim submission guidance.

Option 3:

☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

When the beneficiary selects Option 3, the care is not provided, and there is no charge to the beneficiary. Since no care is given, the SNF doesn't submit a claim, and there are no appeal rights.

4. Additional Information

SNFs may use this space to clarify and/or provide any additional information they think might be helpful to the beneficiary. For example, SNFs may use this space to include:

- information on other insurance coverage, such as a Medigap policy, if applicable;
- an additional dated witness signature; or
- other necessary notes.

Information in this section will be assumed to have been made on the same date the SNFABN is issued. If the notes are made on different dates, include those dates in the notes.

5. Signature and Date

The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF may fill in the date if the beneficiary needs help. This date should reflect the date that the SNF gave the notice to the beneficiary in-person, or when appropriate, the date contact was made with the beneficiary's authorized representative by phone. If an authorized representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the authorized representative's signature is not clearly legible, the authorized representative's name must be printed. If the beneficiary refuses to choose an option and/or refuses to sign the SNFABN when required, the SNF should annotate the original copy of the SNFABN indicating the refusal to sign and may list a witness to the refusal. The SNF should consider not furnishing the care.

Completing the SNFABN as a voluntary notice

The SNFABN can be used as a voluntary notice and replaces the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF). There are no specific requirements for notice completion when the SNFABN is issued voluntarily, and alternatively, SNFs may develop their own written notice for care that is never covered. When the SNFABN is being issued as a voluntary notice, the beneficiary doesn't need to select an option box or provide a signature.

SNFs are not required to give written notice prior to providing care that Medicare never covers, such as care that is statutorily excluded or care that fails to meet a benefit requirement; however, as a courtesy to the beneficiary and to forewarn him/her of impending financial obligation, SNFs are encouraged to give notice.

The following are examples of statements of non-coverage that can be inserted into the "Reason Medicare may not pay" section of the voluntary SNFABN.

Example 1

Care: Inpatient Skilled Nursing Facility Stay

Reason Medicare May Not Pay:

- Medicare won't pay for your stay at this facility because you don't have a qualifying 3-day inpatient hospital stay;

- Medicare won't pay for your stay at this facility because more than 30 days have passed since your hospital discharge; or
- Medicare only pays for a certain number of days of inpatient care. You have used up all your days of inpatient care for this benefit period, and Medicare will no longer pay for your stay.

Example 2

Care: Barber services
Reason Medicare May Not Pay: Medicare never pays for barber or beauty services.

Example 3

Care: Routine foot care
Reason Medicare May Not Pay: Medicare never pays for routine foot care.

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Skilled Nursing Facility:

Beneficiary's Name: **Identification Number:**

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: Check only one box. We can't choose a box for you.

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

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Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Date

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

1 RESTHAVEN GARDENS NH 123 ANYWHERE ST ANYPLACE OH 432221234	2	3a PAT CNTL # 000123456 b. MED. REC # 123456	4 TYPE OF BILL 212
		5 FED TAX I.D. 111222333	6 STATEMENT COVERS PERIOD FROM 07/01/2023 THROUGH 07/31/2023

8 PATIENT NAME		9 PATIENT ADDRESS				
b FLINTSTONE FRED		a 123 ANYWHERE ST				
		b ANYPLACE	c OH	d 43222	e	

10 BIRTH DATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
07/11/1914	M	07/01/2023	10	3	4		30													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
50	07/07/2023							70	06/20/2023	07/01/2023				

39	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	80	31.00	82	31.00	09	1.00
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	KAPD1		14	0.00		
0022	SNF HIPPS RATE CODE	ZZZZZ		17	0.00		
0120	ROOM-BOARD/SEMI			31	6200.00		
0250	PHARMACY			1	300.00		
0420	PHYSICAL THERAPY			14	1500.00		
0430	OCCUPATIONAL THERAPY			14	1600.00		
0001	PAGE 1 OF 1	CREATION DATE	10/28/2020	TOTALS	9600.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
OH MEDICARE SNF - IP		Y	Y			0001112223	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE FRED	18	1XX1XX1XX11		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX											68
	J449	Z03818	I6381								
0											

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE		72 ECI			73	
	J449										

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0001112224	QUAL	
LAST SMITH	FIRST J		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS	81CC
PARTIAL BENEFIT EXHAUST	a
	b
	c
	d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 RESTHAVEN GARDENS NH
123 ANYWHERE ST
ANYPLACE OH 432221234

2

3a PAT CNTL # 000123456
b. MED. REC # 123456
4 TYPE OF BILL 213
5 FED TAX I.D. 111222333
6 STATEMENT COVERS PERIOD FROM 09/01/2023 THROUGH 09/04/2023
7

8 PATIENT NAME a
b FLINTSTONE FRED
9 PATIENT ADDRESS a 123 ANYWHERE ST
b ANYPLACE c OH d 43222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
07/11/1914	M	07/01/2023	10	3	4		30													

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
22	9042023							70	06/20/2023	07/01/2023				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	4.00	82	4.00	09	1.00
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	ZZZZZ		4	0.00		
0120	ROOM-BOARD/SEMI				800.00		
0001	PAGE 1 OF 1	CREATION DATE	09/30/2023	TOTALS	800.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
OH MEDICARE SNF - IP		Y	Y			0001112223

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE FRED	18	1XX1XX1XX11		

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX J449 Z03818 I6381 | 67 | 68
0

69 ADMIT DX J449 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 0001112224 QUAL
LAST SMITH FIRST J

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS BENEFIT EXHAUST

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 RESTHAVEN GARDENS NH
123 ANYWHERE ST
ANYPLACE OH 432221234

2

3a PAT CNTL # 000123456
b. MED. REC # 123456
4 TYPE OF BILL 210
5 FED TAX I.D. 111222333
6 STATEMENT COVERS PERIOD FROM 09/05/2023 THROUGH 09/30/2023
7

8 PATIENT NAME a
b FLINTSTONE FRED
9 PATIENT ADDRESS a 123 ANYWHERE ST
b ANYPLACE c OH d 43222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07/11/1944	M	04/06/2023	10	3	4		30	21												

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	04/01/2023	04/06/2023				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	81	26.00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	AAA00		26	0.00		
0120	ROOM-BOARD/SEMI			26	5200.00	5200.00	
0001	PAGE 1 OF 1	CREATION DATE		TOTALS	5200.00	5200.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
OH Medicare SNF - IP		Y	Y		
OH Medicaid - IP (clm tab		Y	Y		

56 NPI 0001112223
57 OTHER PRV ID

58 INSURED'S NAME		59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE	FRED	18	3J99QT2EW21		
FLINTSTONE	FRED	18	102234567899		

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX J9601 J439 I509
0
67 68

69 ADMIT DX J9601
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 0001112224 QUAL 1G
LAST SMITH FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS NO PAY CLAIM
EXAMPLE 4
81CC a
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 RESTHAVEN GARDENS NH
123 ANYWHERE ST
ANYPLACE OH 432221234

2

3a PAT CNTL # 000123456
b. MED. REC. # 123456
4 TYPE OF BILL 210
5 FED. TAX I.D. 111222333
6 STATEMENT COVERS PERIOD FROM 10/01/2023 THROUGH 12/01/2023
7

8 PATIENT NAME a
b FLINTSTONE FRED

9 PATIENT ADDRESS a 123 ANYWHERE ST
b ANYPLACE c OH d 43222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07/11/1944	M	04/06/2023	10	3	4	09	02	21												

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	04/01/2023	04/06/2023				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	81	61.00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	AAA00		61	0.00		
0120	ROOM-BOARD/SEMI			61	12200.00	12200.00	
0001	PAGE 1 OF 1	CREATION DATE		TOTALS	12200.00	12200.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
OH Medicare SNF - IP		Y	Y		
OH Medicaid - IP (clm tab		Y	Y		

56 NPI 0001112223
57 OTHER PRV ID 1234567

58 INSURED'S NAME		59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE	FRED	18	3J99QT2EW21		
FLINTSTONE	FRED	18	102234567899		

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX J9601 J439 I509
0
67 68

69 ADMIT DX J9601
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 0001112224 QUAL 1G
LAST SMITH FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS NO PAY CLAIM
EXAMPLE 5

81CC a
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 RESTHAVEN GARDENS NH
123 ANYWHERE ST
ANYPLACE OH 432221234

2

3a PAT CNTL # 000123456
b. MED. REC # 123456

4 TYPE OF BILL 213

5 FED TAX I.D. 111222333

6 STATEMENT COVERS PERIOD FROM 10/01/2023 THROUGH 10/31/2023

7

8 PATIENT NAME a
b FLINTSTONE FRED

9 PATIENT ADDRESS a 123 ANYWHERE ST
b ANYPLACE c OH d 43222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
07/11/1944	M	04/06/2023	10	3	4	09	02	04												

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	04/01/2023	04/06/2023				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	81	61.00				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	AAA00		31	0.00		
0120	ROOM-BOARD/SEMI			31	12200.00		
0420	PHYSICAL THERAPY			18	2400.00		
0430	OCCUPATIONAL THERAPY			18	2700.00		
0250	PHARMACY			1	1000.00		
0001	PAGE 1 OF 1	CREATION DATE		TOTALS	18300.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
OH MEDICARE SNF - IP		Y	Y		
OH MEDICAID - IP (CLM TAB		Y	Y		

56 NPI 0001112223

57 OTHER PRV ID 1234567

58 INSURED'S NAME		59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE	FRED	18	3J99QT2EW21		
FLINTSTONE	FRED	18	102234567899		

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX J9601 J439 I509

0

67

68

69 ADMIT DX J9601

70 PATIENT REASON DX

71 PPS CODE

72 ECI

73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

75

76 ATTENDING NPI 0001112224 QUAL 1G
LAST SMITH FIRST J

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
ADVANTAGE INFORMATIONAL CLAIM

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

1 RESTHAVEN GARDENS NH
123 ANYWHERE ST
ANYPLACE OH 432221234

2

3a PAT CNTL # 000123456
b. MED. REC # 123456

4 TYPE OF BILL 210

5 FED TAX I.D. 111222333

6 STATEMENT COVERS PERIOD FROM 10/01/2023 THROUGH 12/01/2023

7

8 PATIENT NAME a
b FLINTSTONE FRED

9 PATIENT ADDRESS a 123 ANYWHERE ST
b ANYPLACE c OH d 43222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
07/11/1944	M	04/06/2023	10	3	4	09	02	20												

CONDITION CODES (18–28)

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	04/01/2023	04/06/2023				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	81	61.00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022	SNF HIPPS RATE CODE	AAA00		61	0.00		
0120	ROOM-BOARD/SEMI			61	12200.00	12200.00	
0001	PAGE 1 OF 1	CREATION DATE		TOTALS	12200.00	12200.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
OH Medicare SNF - IP		Y	Y		
OH Medicaid - IP (clm tab		Y	Y		

56 NPI 0001112223

57 OTHER PRV ID 1234567

58 INSURED'S NAME		59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FLINTSTONE	FRED	18	3J99QT2EW21		
FLINTSTONE	FRED	18	102234567899		

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX 0 — 67 J9601 | J439 | I509

68

69 ADMIT DX J9601

70 PATIENT REASON DX

71 PPS CODE

72 ECI

73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

75

76 ATTENDING NPI 0001112224 QUAL 1G
LAST SMITH FIRST J

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS DEMAND BILL

81CC a
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997