
Section 9: Claims

What is a Claim?

A claim is a request for payment. DCHP uses the standard CMS-1500 (professional) and CMS-1450 (UB92 institutional) paper claim forms **OR** the ANSI-837 format for electronic claims submission for medical and behavioral health claims.

What is an Encounter?

An encounter is informational claim submitted for statistical purposes where the services provided were capitated to the provider or were otherwise not eligible for reimbursement. Capitated providers are required to submit encounter claims using the CMS-1500 or CMS-1450 claim forms **OR** via an ANSI-837 electronic format transmission.

Electronic Claims Submission: ANSI-837

DCHP accepts claims via 837 electronic claims submission. For compatible Companion Guides and/or information relating to current clearinghouses, please contact Provider Services.

Submitting Paper Claims to DCHP

Paper claim forms are mailed to:

**Driscoll Children's Health Plan
ATTN: CLAIMS
P. O. Box 3668
Corpus Christi, TX 78463-3668**

DCHP Provider Services 1-877-DCH-DOCS (324-3627)
Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)
Case Management: 1-877-222-2759 (FAX: 1-866-741-5650)
CHIP Member Services: 1-877-451-5598 STAR Member Services: 1-877-220-6376
Member Services FAX: 361-904-0187

Timeliness of Billing

Claims and/or encounters must be submitted as follows:

Type of Claim	Timely Billing Parameter
<i>Professional Claims</i> submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	95 days from DATE OF SERVICE
<i>Ancillary Services Claims</i> submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	95 days from DATE OF SERVICE
<i>Ancillary Services Claims</i> for services that are billed on a monthly basis submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format (e.g. home health or rehabilitation therapy)	95 days from the LAST DAY OF THE MONTH for which services are being billed
<i>Outpatient Hospital Services</i> billed on the CMS-1450 (UB92 institutional claim form) or using the institutional ANSI-837 electronic claim format	95 days from the DATE OF SERVICE on the claim
<i>Inpatient Hospital Services</i> claims billed on the CMS-1450 (UB92 institutional claim form) or using the institutional ANSI-837 electronic claim format	95 days from the DATE OF DISCHARGE

Timeliness of Payment

DCHP will pay all clean claims submitted in the acceptable formats as previously detailed within thirty (30) days from the date of receipt or the date that the claim is deemed “clean”. Should DCHP fail to pay the provider within the thirty days, the provider will be reimbursed the interest on the unpaid claim at a rate of 1.5% per month (18% annum) for every month the claim remain unpaid.

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Coding Requirements: ICD9 and CPT4/HCPCS Codes

Professional Medical Claims: DCHP requires the use of ICD9 diagnosis codes and CPT4 or HCPCS procedure codes.

Emergency Professional Services Claims: DCHP requires the use of ICD9 diagnosis codes and CPT4 or HCPCS procedure codes.

Inpatient Institutional Claims: DCHP requires the use of ICD9 diagnosis codes and either ICD9 or CPT4 surgical procedure codes. Line item charges must be coded with UB92 Revenue Codes.

Outpatient Institutional Claims: DCHP requires the use of ICD9 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB92 Revenue Code, and either ICD9 or CPT4 surgical procedure codes.

Emergency Institutional Claims: DCHP requires the use of ICD9 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB92 Revenue Code, and either ICD9 or CPT4 surgical procedure codes.

Dental Claims: DCHP does not process dental claims. Dental services are provided through a Dental Management Organization (DMO). Providers should contact the State's DMO by calling **1-866-561-5891** for questions concerning benefits and billing.

Prescription Drug Claims: DCHP does not process prescription drug claims. Prescription drug services are provided for STAR and CHIP members through the State of Texas Vendor Drug Program. Inquiries regarding services should be directed to **1-800-435-4165**.

E&M Office Visits Billing Requirements

DCHP follows standard E&M coding guidelines as promulgated by the Centers for Medicare and Medicaid Services (CMS).

E&M Consult Billing Requirements

DCHP follows standard coding and billing requirements for consults (CPT4 codes 99241-99275).

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Use of Modifier 25

Effective with dates of service on and after June 1, 2006, DCHP will accept modifier 25 codes when submitted in accordance with the following requirements.

- Modifier 25 is used on a valid CPT4 or HCPCS procedure code to indicate that the identified service was provided as a distinctly separate service from other similar services furnished on the same date of service.

EXAMPLE: Providing an age-appropriate health screening on the same day as a sick visit.

Sick Visit	Select the appropriate E&M Office Visit Code
Preventive Screen	Select the age-appropriate preventive E&M Code and affix the 25 modifier.

- Providers may use the modifier 25 when billing an E&M code with another significant procedure on the same day. The modifier 25 should be affixed to the E&M code only. The medical record should clearly support the significance and distinctiveness of the associated procedure.
- The modifier 25 may also be used to bill a preventive health screen, or THSteps exam, performed on the same day as a sick visit. The modifier 25 should be affixed to the preventive screen code.

The DCHP Waste, Abuse and Fraud (WAF) special investigative unit monitors modifier 25 billings. Occasional chart audits are performed to comply with our WAF program requirements.

Billing for Assistant Surgeon Services

DCHP provides coverage for Assistant Surgeon services authorized in accordance with DCHP policies for certain CPT4 codes. For further information on Assistant Surgeon allowable, please contact the UM Department for authorization.

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Billing for Capitated Services

Capitated providers are required to submit encounter claims for all capitated services. DCHP accepts encounter data on the CMS-1500 form or the professional ANSI-837 electronic format. The forms should be completed in the same manner as a claim.

For a complete list of capitated services along with applicable carve outs and allowables please refer to your Provider Contract.

Billing for Immunization and Vaccine Services

Childhood Immunizations: Primary Care Physicians who furnish immunization services for children are required to enroll with the Texas Vaccine for Children (VFC) program. The program provides vaccines for childhood immunization. DCHP does not reimburse for vaccines, but will reimburse PCPs for the administration of vaccine.

Adult Immunizations: DCHP covers adult immunization services. Providers may bill for both the vaccine (using the appropriate HCPCS code) and for vaccine administration.

Billing for THSteps Services

THSteps Providers are required to submit claims for all THSteps services in the acceptable formats previously detailed. Additionally, THSteps providers must send all THSteps newborn screen to the Texas Department of State Health Services (DSHS), Bureau of Laboratories or a DSHS certified lab. THSteps Providers must include detailed identifying information for all screened newborn members and the member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up. Billing for services outside of the Periodicity schedule listed in Section 5 of this manual will only be paid for exceptions listed in that section.

Billing for Deliveries and Newborn Services

DCHP requires separate claim forms for mothers and babies. Since there may be a delay in obtaining a Medicaid number for a newborn, DCHP accepts billing for newborns using the

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mother's DCHP ID # affixed with an "A" at the end. If the mother gave birth to multiple newborns, sequentially use "A", "B", "C", etc and submit a separate claim for each newborn.

EXAMPLE 1: Mother gives birth a single live child.

Mother = 12345678
Newborn = 12345678A

EXAMPLE 2: Mother gives birth to twins.

Mother = 87654321
Newborn 1 = 87654321A
Newborn 2 = 87654321B

Claim forms that reflect combined charges for both a mother and a newborn will be rejected.

Billing for Outpatient Surgery Services

Physician Claims: Submit the claim on the standard CMS-1500 or using the acceptable ANSI-837 professional electronic format. The applicable CPT4-coded surgical procedure code(s) must be identified.

Facility Claims: Claims from hospitals, ambulatory surgery centers or other facilities where outpatient surgery may be performed, must be submitted on the CMS-1450 (UB92) form of using the acceptable ANSI-837 institutional electronic format, with the applicable ICD9 surgical procedures code(s), date of the surgery, itemized charges, and associated CPT4/HCPCS procedure codes.

Billing for Hospital Observation Services

Facilities are eligible to receive reimbursement for authorized Observation Admissions. DCHP considers an observation claim to be an outpatient claim. In the itemized charges section of the claim form a line showing the UB Revenue Code should be shown with a number of hours of observation. Observation cannot exceed 23 hours. If the patient requires observation for longer than 23 hours, the facility must convert the claim to an inpatient and bill the services as an inpatient admission. In cases where an observation stay is converted to inpatient, the facility should notify the DCHP Utilization Management Department.

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Coordination of Benefits (COB) Requirements

DCHP is usually the payer of last resort. Providers must bill all other carriers and receive payment or denial prior to billing DCHP.

Other Payer Makes Payment: In cases where the other payer makes payment, the CMS-1500, CMS-1450, or applicable ANSI-837 electronic format claim must reflect the other payer information and the amount of the payment received.

Other Payer Denies Payment: In cases where the other payer denies payment, or applies their payment to the member’s deductible, a copy of the applicable denial letter or EOB must be attached with the claim that is submitted to DCHP.

Billing Members

Providers are not allowed to “balance bill” DCHP members. All covered services are included within the payment made by DCHP and the residual balance of covered charges must be written off as a contractual allowance. The following table illustrates circumstances concerning billing members.

Member Billing Situations

SERVICE	PLAN PAYS NOTHING	PLAN PAYS CONTRACTED RATE	PLAN PAYS USUAL & CUSTOMARY	PROVIDER CAN BILL MEMBER if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services	PROVIDER CANNOT BALANCE BILL MEMBER
IN NETWORK					
Authorized		✓			✓
Not Authorized	✓				✓
OUT-OF-NETWORK					
Authorized			✓		✓
Not Authorized	✓			✓	
EMERGENCY CARE					
In Network		✓			✓
Out-Of-Network			✓		✓

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SERVICE	PLAN PAYS NOTHING	PLAN PAYS CONTRACTED RATE	PLAN PAYS USUAL & CUSTOMARY	PROVIDER CAN BILL MEMBER if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services	PROVIDER CANNOT BALANCE BILL MEMBER
Non-Covered Services	✓			✓ See Section 2 of this manual	

Providers are prohibited from billing or collecting any amount from a Medicaid Member for Health Care Services. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.

Co-pay Amounts on CHIP Members: Providers may collect copay amounts from CHIP members as outlined below or on the member’s CHIP identification card.

Collecting from or Billing CHIP Members for Co-pay Amounts

Some CHIP members have co-pay for some services. The members’ DCHP identification card will indicate the applicable levels of co-pay for each member. Only valid co-pay amounts can be collected from CHIP members.

For a list of co-pay amounts refer to Chapter 4.0 of this Provider Manual.

Billing Members for Non-covered Services

Providers may not bill members for non-covered services **UNLESS** the provider has obtained a signed *Advance Beneficiary Notice and Private Pay Form* (see Appendix A) from the member or guarantor prior to furnishing the non-covered service. ABN forms must be maintained in the provider’s records and made available to DCHP, HHSC, or agents of HHSC upon request.

Providers Required to Report Credit Balances

Providers are required to report credit balances on accounts of DCHP members within 60 days of the credit balance occurring on the account, if the credit balance was caused by:

- (a) having received payment from both DCHP and another payer, or
- (b) duplicate payment from DCHP.

Claims Questions & Appeals

For questions regarding claims, please contact DCHP Provider Services. You may also contact Provider Services for additional information. All claim appeals must be filed within 60 days of the date of the EOB. To submit an appeal regarding claim payment, please submit a completed claim form, a copy of the EOB with the claim in question, and a written explanation of your appeal to:

**Driscoll Children's Health Plan
ATTN: APPEALS
615 N Upper Broadway, Suite 1070
Corpus Christi, TX 78401**

Field Requirements for Paper CMS-1500 Forms

For a complete listing of all field requirements for CMS-1500 forms, see the table below on pages 10 through 15.

Field Requirements for Paper CMS-1450 (UB92) Forms

For a complete listing of all field requirements for CMS-1450 forms, see the pages below on pages 16 through 20.

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**Field Requirements for CMS-1500 Form
For Driscoll Children’s Health Plan STAR and CHIP Members**

Field	Description	Required/Optional	Remarks
1	Payer Designation	Required	Select “Other” or “Medicaid”
1a	Insured I.D. Number	Required	Member’s DCHP ID #
2	Patient Name (Last, First, MI)	Required	Enter the name of the patient
3	Patient’s Birth Date and Sex	Required	Enter patient’s date of birth
4	Insured’s Name	Required	Enter the name of the insured person – for STAR and CHIP this will be the same as the patient
5 line 1	Patient’s Address	Required	Enter the patient’s address
5 line 2	Patient’s City and State	Required	Enter the City and State of the patient
5 line 3	Patient’s Zip Code and Phone	Required	Enter the patient’s zip code and telephone number
6	Patient Relationship to Insured	Required	
7 line 1	Insured’s Address	Required	For STAR And CHIP this is same as field 5 line 1
7 line 2	Insured’s City and State	Required	For STAR And CHIP this is same as field 5 line 2
7 line 3	Insured’s Zip Code and Phone	Required	For STAR And CHIP this is same as field 5 line 3
8	Patient Status	Required	Place an X in the appropriate boxes that describe the patient’s marital status and the patients employment or student status.
9	Other Insured’s Name	Situational	If there is other insurance for this claim, enter the name of the insured person.
9a	Other Insured’s Policy/Group #	Situational	If there is other insurance for this claim, enter the policy and group number.
9b	Other Insured’s DOB and Sex	Situational	If there is other insurance for this claim, enter the date of birth and sex of the insured person.
9c	Other Insured’s Employer or School	Situational	If there is other insurance for this claim, enter the name of the employer or school sponsoring the insurance.
9d	Other Insured’s Insurance Plan Name	Situational	If there is other insurance for this claim, enter the name of the insurance carrier.
10a	Condition Related to	Required	Check YES or NO if condition

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Field	Description	Required/Optional	Remarks
	Employment		treated is related to employment.
10b	Condition Related to Auto Accident	Required	Check YES or NOT if the condition treated is related to an automobile accident. NOTE: If this is YES, an E-level ICD9 code should be shown in field 21.
10c	Condition Related to Other Accident	Required	Check YES or NO if the condition treated is related to another type of accident other than an automobile accident. NOTE: If this is YES, an E-level ICD9 code should be shown in field 21.
10d	RESERVED FOR LOCAL USE	Not Required	
11	Insured's Policy/Group Number	Not Required	
11a	Insured's DOB and Sex	Required	Enter the date of birth and sex code of the insured person. For STAR and CHIP this will be the same as field 3.
11b	Insured's Employer or School	Not Required	
11c	Insurance Plan Name	Not Required	
11d	Is There Another Health Benefit Plan?	Situational	Check YES or NO with regard to other insurance. If YES is entered, fields 9 through 9d must be completed.
12	Patient's or Authorized Person's Signature and Date Signed	Situational	If the patient or authorized guardian/person has authorized release of medical records related to this claim, enter "Signature on File" and the date such signature was obtained.
13	Insured's Signature	Situational	If the insured assigned benefits to the provider or supplier submitting this claim, enter "Signature of File" in this space. A blank in this field, may result in payment rejection.
14	Date of Illness, Injury or LMP	Situational	If the services are related to an illness or injury, enter the date of onset.

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Field	Description	Required/Optional	Remarks
			If the services are related to pregnancy, enter the date of the last menstrual period (LMP).
15	Date of Similar or Same Illness	Situational	If the patient was treated previously for the same or similar symptoms, enter the last date of such service.
16	Dates Patient Unable to Work	Not Required	
17	Name of Referring Physician	Situational	If the services are being provided as a result of a referral from another provider, enter the name of the referring provider.
17a	ID Number of Referring Physician	Situational	Enter the UPIN of the referring physician
18	Hospitalization Dates		
19	RESERVED FOR LOCAL USE	Not Required	
20	Outside Lab? and Charges	Situational	Check YES or NO if lab specimens related to this visit were drawn and sent to an outside lab. If YES is selected, enter the amount of charges, if known.
21	Diagnosis Codes	Required	Enter up to four (4) ICD9 diagnosis codes applicable to this claim
22	Medicaid Resubmission Code and ICN	Not Required	
23	Prior Authorization Number	Required	If a DCHP prior authorization or referral number was given for the services, enter that number in this space.
24	Itemized Charges Segment		Enter up to 6 service lines
24A	Dates of Service	Required	Enter the FROM and THRU dates of service represented by the line item. If the FROM and THRU are the same, only the FROM date is required.
24B	Place of Service	Required	Enter the Place of Service Code (see taxonomy in table below)
24C	Type of Service	Required	Enter the Type of Service Code (see taxonomy in table below)
24D	Procedure Code and Modifier	Required	Enter the applicable CPT4 or HCPCS code that best describes the service that was furnished.

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Field	Description	Required/Optional	Remarks
			Enter a modifier is appropriate.
24E	Diagnosis Code	Required	Enter the diagnosis code from box 21 that is related the service provided
24F	Charges	Required	Enter the dollar amount of the charge
24G	Days or Units	Required	Enter the quantity of service
24H	EPSDT or Family Planning Indicator	Situational	* Enter "E" if services are related to an EPSDT or THSteps exam. * Enter "F" if services are related to Family Planning.
24I	EMG	Optional	Enter an "X" if service was an EMG
24J	COB	Situational	Enter "Y" is other insurance is involved for this line item
24K	RESERVED FOR LOCAL USE	Not Required	
25	Federal Tax ID Number	Required	Enter the federal tax identification number of the provider furnishing the service or supply
26	Patient Account Number	Optional	Enter provider's internal account number. If present, this number will be reported back to the provider on the EOB.
27	Accept Assignment	Required	Check YES or NO for whether benefits are assigned to the provider
28	Total Charges	Required	Total amount of charges represented on the claim
29	Amount Paid	Situational	Amount paid by the patient and/or other insurance
30	Balance Due	Situational	Difference between field 28 and field 29
31	Physician or Supplier Signature and Date	Required	Physician Name or Date
32	Facility Where Services Provided	Required	Enter address where services were provided
33	Physician or Supplier Address	Required	Enter Physician or Supplier's physical address
33 Grp#	Group #	Required	Enter DCHP Provider Number

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PLACE OF SERVICE CODES: Field 24B of CMS-1500 Form

POS Code	Description	Detailed Description
00-10	Unassigned	
11	Office	Location other than hospital, skilled nursing facility, military treatment facility, community health center, public health clinic, or intermediate care facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis
12	Home	
13-20	Unassigned	
21	Inpatient Hospital	Inpatient hospital other than an inpatient psychiatric hospital.
22	Outpatient Hospital	
23	Emergency Room Hospital	
24	Ambulatory Surgical Center	
25	Birthing Center	
26	Military Treatment Facility	
27-30	Unassigned	
31	Skilled Nursing Facility	A facility that primarily provides INPATIENT skilled nursing care and related services.
32	Nursing Facility	A facility that primarily provides skilled nursing care to patients who RESIDE at the facility.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility – OTHER THAN THE PATIENT’S HOME – where palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	
41	Ambulance – Land	
42	Ambulance – Air or Water	
43-49	Unassigned	
50	Federally Qualified Health Center (FQHC)	
51	Inpatient Psychiatric Facility	
52	Psychiatric Facility – Partial Hospitalization	
53	Community Mental Health Center	
54	Intermediate Care Facility or Facility for the Mentally Retarded	
55	Residential Substance Abuse Treatment Facility	
56	Psychiatric Residential Treatment Center	
57-59	Unassigned	
60	Mass Immunization Center	A location where providers administer

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POS Code	Description	Detailed Description
		pneumococcal pneumonia and influenza virus vaccinations.
61	Comprehensive Inpatient Rehabilitation Facility	
62	Comprehensive Outpatient Rehabilitation Facility	
63-64	Unassigned	
65	End-Stage Renal Disease (ESRD) Facility	
66-70	Unassigned	
71	State or Local Public Health Clinic	
72	Rural Health Center (RHC)	
73-80	Unassigned	
81	Independent Laboratory	A CLIA-certified lab performing diagnostic and clinical tests independent from an institution or physician's office.
82-96	Unassigned	
97	Non-Public School	
98	Public School	
99	Other Unlisted Facility	Other service facilities not identified above.

TYPE OF SERVICE CODES: Field 24C of CMS-1500 Form

TOS Code	Description
1	Medical
2	Surgical
4	Professional & Technical Component: X-Ray, Nuclear Medicine, EEG, or EKG
5	Professional & Technical Component: Lab
8	Assistant Surgery
9	Other Medical or ASC
D	Post-Op Care Only
E	Professional Component Only: X-ray, Nuclear Medicine, EEG, or EKG
G	Anesthesia
H	Technical Component Only: X-ray, Nuclear Medicine, EEG, or EKG
I	Technical Component Only: Lab
N	Surgery WITHOUT Post-Op Care
R	Professional Component Only: Lab
S	Supervision of Anesthesia
W	Certified Registered Nurse Anesthetist (CRNA)

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Field Requirements for CMS-1450 Claim Forms (UB92)

Field	Description	Required/Optional	Remarks
1	Provider Mailing Address	Required	Self explanatory
2	Unassigned	Not Required	
3	Patient Control Number	Required	Enter your patient account number
4	Bill Type	Required	
5	Federal Tax ID	Required	Enter number without dashes
6	Statement Covers From and Thru Dates	Required	Outpatient = enter the first and last dates of services billed on this claim. Inpatient = enter the admit and discharge date for this admission. If interim billing is being performed, enter the first and last dates of the services on the form.
7	Covered Days	Not Required	
8	Non-covered Days	Not Required	
9	C-I Days	Not Required	
10	L-R Days	Not Required	
11	Unassigned	Not Required	
12	Patient Name	Required	Enter name as it appears on DCHP ID card in Last, First, MI format.
13	Patient Address	Required	Enter the street address, city, state, and zip code of the patient.
14	Birthdate	Required	MMDDYY
15	Sex	Required	M for male of F for female
16	Marital Status	Required	Use appropriate UB92 taxonomy code to describe marital status of the patient.
17	Admission Date	Required	Outpatient: first date of service Inpatient: date of admission
18	Admission Hour	Required for Inpatient Optional for Outpatient	Enter the hour of admission in NN format
19	Admission Type	Required	Use appropriate UB92 taxonomy code to describe the type of admission
20	Admission Source	Required	Use appropriate UB92 taxonomy code to describe the source of the admission

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Field	Description	Required/Optional	Remarks
21	Discharge Hour	Required for Inpatient Not Required for Outpatient except for Observation claims	Enter the hour of discharge when required in NN format
22	Discharge Status	Required for Inpatient Not Required for Outpatient	On inpatient claims use appropriate UB92 taxonomy code to describe the discharge status
23	Medical Record Number	Required	Enter the facility's medical record number assigned to this patient
24-30	Condition Codes	Situational	Use appropriate UB92 taxonomy code sets that apply to this claim
31	Unassigned	Not Required	
32-35	Occurrence Codes	Situational	Use appropriate UB92 taxonomy code sets that apply to this claim with the appropriate date (MMDDYY) that applies
36	Occurrence Code and Occurrence Span From and Thru	Situational	Use appropriate UB92 taxonomy code sets that apply to this claim and show the from and thru date span (MMDDYY) to which the occurrence code applies
37	Unassigned	Not Required	
38	Subscriber name, address, city, state, and zip code	Required	Name should be the same as field 12. Show the remaining demographic data of the patient, which will be the same as field 13.
39-41	Value Codes and Amount	Situational	Use appropriate UB92 taxonomy code sets that apply to this claim and show the dollar amount associated with code
42	Revenue Code	Required	Use appropriate UB92 taxonomy code sets that apply to this claim. Array codes in numerical order down the 23 available detail lines.
43	Description	Required	Enter the appropriate description for the Revenue Code
44	HCPCS/Rates	HCPCS Required for Outpatient Rates Required for Inpatient when unit rate is applicable (e.g.	Self Explanatory

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Case Management: 1-877-222-2759 (FAX: 1-866-741-5650)
CHIP Member Services: 1-877-451-5598 STAR Member Services: 1-877-220-6376
Member Services FAX: 361-904-0187

Field	Description	Required/Optional	Remarks
		accommodation lines)	
45	Service Date	Required for Outpatient Not Required for Inpatient	On Outpatient enter the applicable date of service in MMDDYY format.
46	Service Units	Required for Outpatient Required for Inpatient on room accommodation lines only.	Self Explanatory
47	Total Charges	Required	Enter the total amount of charges applicable to the line item
48	Non-covered Charges	Situational	Enter the amount of non-covered charges that are included in the Total Charges amount (field 47)
49	Unassigned		
50	Payer	Required	Enter the name of the payer. There are up to 3 lines to identify payers for this claim.
51	Provider Number	Required on the line where DCHP is listed as payer	Enter your DCHP provider number applicable to this claim
52	Release of Information Flag	Required	Set Y or N flag
53	Benefit Assigned Flag	Required	Set U or N flag
54	Prior Payments	Required	Enter the amount of payment received from the patient and other insurers in this field
55	Estimated Amount Due	Not Required	
56	Unassigned		
57	Unassigned		
58	Insured's Name	Required	Name of the Insured Person. For CHIP or STAR this will be same as the patient
59	Relationship to Patient	Required	Use applicable UB92 taxonomy code. For CHIP or STAR this will "03" for SELF
60	Insurance ID Number	Required	Enter the insurance ID #. For CHIP or STAR this will be the DCHP ID Number
61	Insurance Group Name	Situational	If there were other insurance in addition to CHIP or STAR, this field would indicate the name of the group carrier.
62	Insurance Group Number	Situational	If there were other insurance in addition to CHIP or STAR, this field would indicate the

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Field	Description	Required/Optional	Remarks
			group number of the insurance.
63	Treatment Authorization Code	Required	Enter the referral number or prior authorization number applicable for this claim and provided by the insurer.
64	ESC	Not Required	
65	Employer Name	Situational	If there is insurance other than CHIP or STAR through an employer, put the employer's name here.
66	Employer Location	Situational	If there is insurance other than CHIP or STAR through an employer, put the employer's address here.
67	Principal Diagnosis Code	Required	Enter the principal diagnosis that was treated or determined for the visit. Enter a valid ICD9 code carried to the maximum available level of 4 th or 5 th digits.
68-75	Other Diagnosis Codes	Required	Enter up to 8 additional diagnosis codes relevant to the patient and/or the visit. Enter a valid ICD9 code carried to the maximum available level of 4 th or 5 th digits.
76	Admitting Diagnosis Code	Optional	Enter the diagnosis code that represents the reason the patient presented for care. Enter a valid ICD9 code carried to the maximum available level of 4 th or 5 th digits.
77	E-level Diagnosis Code	Situational	If the treatment, or part of the treatment, was provided pursuant to an accident, enter the appropriate ICD9 E-level accident code. Enter a valid ICD9 code carried to the maximum available level of 4 th or 5 th digits.
78	Unassigned		

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Field	Description	Required/Optional	Remarks
79	Procedure Code Indicator	Required	Enter "9" if procedure codes in fields 80 and 81 are ICD9 codes. Enter "4" if procedure codes in field 80 and 81 are CPT4 codes.
80	Principal Procedure	Required	Enter the appropriate ICD9 or CPT4 code for the surgical procedure performed.
81	Other Procedures	Required	Enter up to 5 other ICD9 or CPT4 codes for additional surgical procedures performed.
82	Attending Physician ID	Required	Enter provider's Medical License number or UPIN number and NAME.
83	Other Physician ID	Not Required	If used, enter UPIN or license #s and NAME for up to 2 applicable other physicians involved in this case.
84	Remarks	Not Required	Enter the name of the biller who processed this claim and sent it to DCHP.
85	Provider Representative	Required	Enter the date that this claim was created.
86	Date	Required	