



UB-04 Claim Filing Guidelines

To ensure prompt and accurate processing of your claim, it is important that you follow the correct claim filing guidelines. Below are the claim filing guidelines for secondary, corrected and void only claims. These claims should be submitted electronically according to the referenced guidelines.

UB-04 Filing Guidelines for Secondary Claims

Secondary claims should be submitted electronically as indicated below:

- Accurate and complete information must be filed on all UB-04 secondary claims. This includes contractual obligation amounts as well as amounts applied to deductible, coinsurance, copay, allowed and paid.
- The primary payer’s allowed amount must balance to the amount applied to the deductible, coinsurance, copay and payment or the claim may be denied.
- Primary payment information must be sent on UB-04 secondary claims in the following format:

This format is also the method used to file primary payment information on Medicare claims.

To follow this format:

- Send the Primary Payer information in Loop 2320 of the 837 claim submission.
- Send the deductible, coinsurance and copay amount in the ‘CAS’ segment of the 837 claim submission.
- Send the paid and allowed amounts in the ‘AMT’ segment of the 837 claim submission.

For example, to file a claim with a charge of \$1500.00 where the primary payer applied \$600.00 to deductible, \$26.85 to coinsurance and \$20.00 to copay with a payment of \$421.74, allowable of \$1068.59 and contractual write off of \$431.41; you would send the information in Loop 2320 in the following format:

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CAS*PR*1*600**2*26.85**3*20~
CAS*CO*45*431.41~
AMT*B6*1068.59~
AMT*C4*421.74~
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- If the primary insurance denied the claim as ‘not a covered service,’ submit a ‘24’ occurrence code with the denial date. If the primary insurance denied the claim as ‘not a covered member,’ submit a ‘25’ occurrence code with the denial date.

- Report all non-covered charges in the appropriate segment of the UB-04 format as follows:
 - Send line level information in the ‘SV2’ segment seventh position.
 - Send claim level information in the ‘AMT’ segment with the ‘A8’ qualifier.

UB-04 Filing Guidelines for Corrected Claims

To ensure prompt and accurate processing of corrected claims, it is important that you use these Corrected Claims Filing Guidelines. A corrected claim should only be filed if there is a change in the clinical or member information. Corrected claims should be submitted electronically.

- Corrected claims should be submitted with a ‘7’ as the third position of the bill type (XX7). The bill type must be reported in the ‘CLM’ segment, element ‘05’ in the 837 claim submission. The first two positions of the bill type are reported in the sub-element 1 and the third position is reported in the sub-element 3.

Example:

CLM*A336235011*307***13:A:7*Y*A*Y*Y*****N~

- The value ‘F8’ must be reported in the ‘REF’ segment, element ‘01’ and the original claim number in the ‘REF’ segment, element ‘02’ in the 837 claim submission.

Example:

REF*F8*123456789~

- Corrected claims must be submitted within 12 months from the payment date of the original claim.
- Only 1 corrected claim will be accepted per original claim.

UB-04 Filing Guidelines for Void Only Claims

To ensure prompt and accurate processing of void only claims, it is important that you use these Void Only Claims Filing Guidelines. Void Only claims should be submitted electronically.

- Void only claims should be submitted with an ‘8’ as the third position of the bill type (XX8). The bill type must be reported in the ‘CLM’ segment, element ‘05’ in the 837 claim submission. The first two positions of the bill type are reported in the sub-element 1 and the third position is reported in the sub-element 3.

Example:

CLM*A336235011*307***13:A:8*Y*A*Y*Y*****N~

- The value ‘F8’ must be reported in the ‘REF’ segment, element ‘01’ and the original claim number in the ‘REF’ segment, element ‘02’ in the 837 claim submission.

Example:

REF*F8*123456789~

- Void only claims must be submitted within 12 months from the payment date of the original claim.