UB-04 (CMS-1450) Hospital Billing Form Sample

1 Provider Name, Address, Telephone, Country, Zip Code	2 Pay-to Name & Address	3a Patient Control Number	3b Medical Record Number	4 Type of Bill	5 Federal Tax Number

6 Statement Covers Period From —— To ——	7. Covered Days 8. Non-Covered Days	9. Co-Insurance Days 10. Lifetime Reserve Days	11. NPI 12. Admission Date

13	Patient Name	14 Birthdate	15 Sex	16 Admission Time	17 Admission Type	18 Admission Source
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19 Discharge Date	20 Discharge Hour	21 Discharge Status	22 — Patient Status

23 Patient Address		24 City	25 State	26 ZIP	27 Phone

28 Guarantor Name		29 Relationship		30 Employer Name

Insurance Information

31 Insured's Name		32 Relationship		33 Insurance Group Name		34 Insurance Group No.
35 Employer Name		36 Insurance Plan Name				

Medical/Clinical Information

39 - 41 Value Codes & Amounts							
42 Revenue Code	43 Description	44 HCPCS/Rate/HIPPS	45 Service Date	46 Units	47 Total Charges	48 Non Covered Charges	
49. Totals							

Certification/Signature

Signature of Patient or Authorized Person	Date	Signature of Provider Representative