

Lactation Support Services Billing Manual

The lactation support services benefit program is administered by the Colorado Department of Health Care Policy & Financing (the Department). This billing manual provides information regarding coverage, policy and billing requirements. The information in this manual is subject to change as the Department periodically modifies the lactation support services program's benefits and services. The manual will be updated as new policies are implemented.

Refer to the [General Provider Information Manual \(/gen-info-manual\)](#) located on the [Billing Manuals web page \(/billing-manuals\)](#) under the General Provider Information drop-down for general information about Health First Colorado (Colorado's Medicaid program). The General Provider Information Manual provides information about billing Health First Colorado, reimbursement policies, provider participation, eligibility requirements and other useful information.

Table of Contents

- [Program Overview](#)
- [Provider Qualifications and Enrollment](#)
 - [Eligible Rendering Providers](#)
 - [Eligible Billing Providers](#)
 - [Facility Provider Types](#)
 - [Supply](#)
 - [Group Provider Types](#)
 - [Federally Qualified Health Centers/Rural Health Clinics](#)
 - [Indian Health Services](#)
 - [Clinics and Non-Physician Practitioner Groups](#)
 - [Lactation/Doula Professional Groups](#)
 - [Individual Billing Providers](#)
- [Supervision Requirement](#)
- [Billing Information](#)

- [Covered Lactation Support Services](#)
- [Coding Table for Lactation Support Services](#)
- [Determining What Time Counts Towards Time Codes](#)
- [National Correct Coding Initiative \(NCCI\)](#)
- [Recommendation for Lactation Support Services](#)
- [Documentation Requirements](#)
- [Physical Health Managed Care](#)
- [Outpatient Hospital](#)
- [Inpatient Hospital and Freestanding Birth Center Services](#)
- [Place of Service Codes](#)
- [Contact Information](#)
- [CMS 1500 Paper Claim Reference Table](#)
 - [CMS 1500 Lactation Support Services Claim Example](#)
- [UB-04 Paper Claim Reference Table](#)
 - [UB-04 Lactation Support Services Claim Example](#)
- [Timely Filing](#)
- [Lactation Support Services Revision Log](#)

[Return to Billing Manuals Web Page \(/billing-manuals\)](#)

Program Overview

On December 1, 2024, the Colorado Department of Health Care Policy and Financing (the Department) implemented a lactation support services benefit for Health First Colorado members. This program is based on legislation [HB22-1289 \(https://leg.colorado.gov/sites/default/files/2022a_1289_signed.pdf\)](https://leg.colorado.gov/sites/default/files/2022a_1289_signed.pdf).

Rules and Regulations

The lactation support services benefit program is administered by the Department. Rules governing the program are outlined in the [Code of Colorado Regulations \(/department-program-rules-and-regulations\)](#) 10 C.C.R. 2505-10 8.732.7. Providers are required to comply with all rules and guidance provided by the Department and are encouraged to contact the Department's policy specialists with any questions at HCPF_MaternalChildHealth@state.co.us. Updates to policy and guidance will be published in this manual. Providers will be given notice of updates through the Department's monthly [Provider Bulletin \(/bulletins\)](#).

This program gives people access to lactation support services, including training and counseling the breastfeeding (or lactating) member about breastfeeding and human lactation. It provides comprehensive, skilled care and evidence-based information for breastfeeding and human lactation.

To be eligible for the program, a member must meet the following criteria:

- Be eligible for Health First Colorado

- Be a pregnant, postpartum or pediatric member who is breastfeeding

Member Eligibility

Before rendering services, the provider should verify the member's eligibility to ensure that the member is eligible for benefits. Providers should retain documentation of the verified eligibility for billing purposes. In order to be eligible for reimbursement for services provided to Child Health Plan Plus (CHP+) members, all CHP+ providers must have an active contract with a CHP+ Managed Care Organization (MCO). Providers should submit claims to the MCO once a CHP+ member is enrolled into an MCO. Refer to the [Child Health Plan Plus \(CHP+\) web page \(/chp\)](#) for further guidance.

[Back to Top](#)

Provider Qualifications and Enrollment

Providers must be enrolled as Health First Colorado providers to:

- Treat a Health First Colorado member
- Submit claims for payment to Health First Colorado

Visit the [Provider Enrollment web page \(/provider-enrollment\)](#) if interested in becoming a Health First Colorado provider.

[Back to Top](#)

Eligible Rendering Providers

Lactation support services may only be provided by enrolled individual providers with training in advanced lactation support. Providers may not bill for services provided by un-enrolled providers, such as supervised interns or persons undergoing training to become a Certified Lactation Educator (CLE), Certified Lactation Counselor (CLC), or International Board-Certified Lactation Consultant (IBCLC).

The following enrolled provider types (PT) may provide lactation support services if it is within their scope of practice according to state licensing requirements and laws and the provider has training in advanced lactation support:

- International Board-Certified Lactation Consultant (IBCLC) - PT 70
- Certified Lactation Counselor (CLC) - PT 71
- Certified Lactation Educator (CLE) - PT 71
- Certified Professional Midwife (CPM)/Direct Entry Midwife (DEM) - PT 69
- Certified Midwife (CM) - PT 80
- Certified Nurse Midwife (CNM) - PT 22
- Licensed Physician (MD) - PT 05
- Licensed Osteopath (DO) - PT 26

- Licensed Physician Assistant (PA) - PT 39
- Licensed Advanced Practice Nurse (APN) - PT 41
- Licensed Registered Nurse (RN) - PT 24 (enrolled as a Non-Physician Practitioner-Individual)

Enrolled Doula providers who meet IBCLC, CLC or CLE qualifications per 10 C.C.R. 2505-10 8.732.9 may provide lactation support without separate PT 70 or 71 enrollment.

[Back to Top](#)

Eligible Billing Providers

Facility Provider Types

The only facility provider type that may bill for lactation support services is:

- Supply - PT 14

[Back to Top](#)

Supply (PT 14)

When claims are submitted using a supplier as the billing provider, the rendering provider's National Provider Identifier (NPI) listed on the claim must be the individual provider who rendered the service. The rendering provider does not need to be formally affiliated with the group in order for the claim to be processed.

[Back to Top](#)

Group Provider Types

The only group provider types that may bill for lactation support services are:

- Federally Qualified Health Center (FQHC) - PT 32
- Rural Health Clinic (RHC) - PT 45
- Indian Health Services (IHS) - PT 61
- Clinic - PT 16
- Non-Physician Practitioner Group - PT 25
- Lactation/Doula Professional Group - PT 72

[Back to Top](#)

Federally Qualified Health Centers and Rural Health Clinics (PT 32 and 45)

Refer to the [Federally Qualified Health Center \(FQHC\)/Rural Health Clinic \(RHC\) billing manual \(/fqhc-rhc\)](#) for details regarding billing lactation support services in an FQHC/RHC setting. Lactation support services provided by an employee at an FQHC/RHC site are billed as part of the encounter rate for the FQHC/RHC and may result in a payment when delivered by a provider included in the FQHC/RHC visit definition (10 CCR 8.700 & 8.740). Lactation support services are not billed separately on professional claim forms (CMS 1500). Lactation support services provided by an employee at an FQHC/RHC site that are not included in the FQHC/RHC visit definition should be included in the FQHC/RHC cost report.

Lactation support service providers who provide lactation support services at a FQHC or RHC but are not employed by the FQHC/RHC can bill for services separately on a professional claim form (CMS 1500) and use the applicable Place of Service codes. These claims are reimbursed at the Health First Colorado Fee Schedule rate.

[Back to Top](#)

Indian Health Services (PT 61)

Refer to the [Indian Health Services \(IHS\) billing manual \(/IHS-billing-manual\)](#) for details regarding billing lactation support services in an outpatient setting. Lactation support services provided at an IHS site are billed per encounter as part of the all-inclusive rate. They are not billed separately on professional claim forms (CMS 1500).

[Back to Top](#)

Clinics and Non-Physician Practitioner Groups (PT 16 and 25)

When claims are submitted using Clinics and Non-Physician Practitioner Groups as the billing provider, the rendering provider's National Provider Identifier (NPI) listed on the claim must be the individual provider who rendered the service. The rendering provider must be formally affiliated with the group in order for the claim to be processed.

[Back to Top](#)

Lactation/Doula Professional Groups (PT 72)

When claims are submitted using the Lactation/Doula Professional Group as the billing provider, the rendering provider's NPI listed on the claim must be the individual provider who rendered the service. The rendering provider must be formally affiliated with the group in order for the claim to be processed.

A Lactation/Doula Professional Group consists of any of the following professionals who are enrolled with the Department as approved providers:

- International Board-Certified Lactation Consultant (IBCLC) - PT 70
- Certified Lactation Counselor - PT 71
- Certified Lactation Educator - PT 71
- Doula - PT 79

This billing provider type must have at least one (1) IBCLC or Doula affiliated with the group.

[Back to Top](#)

Individual Billing Providers

Individual providers may choose to be their own billing provider for lactation support services. The following list of providers can have billing status when enrolling with Health First Colorado:

- International Board-Certified Lactation Consultant (IBCLC) - PT 70
- Certified Midwife (CM) - PT 80
- Certified Nurse Midwife (CNM) - PT 22
- Licensed Physician (MD) - PT 05

- Licensed Osteopath (DO) - PT 26
- Licensed Advanced Practice Nurse (APN) - PT 41

[Back to Top](#)

Supervision Requirements

International Board-Certified Lactation Consultants (IBCLCs) with current certification by the International Board of Lactation Consultant Examiners (IBLCE) may provide lactation support services without supervision.

Certified Lactation Counselors (CLCs) with current certification by the Academy of Lactation Policy and Practice, Inc. (ALPP) and Certified Lactation Educators (CLEs) with current certification by the Childbirth and Postpartum Professional Association (CAPP) may only provide lactation support services under the general supervision of enrolled:

- Physicians (MDs) - PT 05/65
- Osteopaths (DOs) - PT 26
- Physician Assistants (PAs) - PT 39
- Advanced Practice Nurses (APNs) - PT 41
- Certified Nurse Midwives (CNMs) - PT 22
- International-Board Certified Lactation Consultants (IBCLCs) - PT 70

A Certified Lactation Counselor (CLC)/Certified Lactation Educator (CLE) may render services but does not bill directly. Claims must be submitted through the enrolled group. Claims must identify the CLC/CLE with their NPI number as the rendering provider.

[Back to Top](#)

Billing Information

Refer to the [General Provider Information Manual \(/gen-info-manual\)](#) located on the [Billing Manuals web page \(/billing-manuals\)](#) under the General Provider Information drop-down for general information.

Covered Lactation Support Services

Lactation support services are billed using a single Healthcare Common Procedure Coding System (HCPCS) procedure code (S9443), one (1) of two (2) modifier codes indicating individual (U1) or group settings (U2) and one (1) of eight (8) modifier codes (U3, U4, U5, U6, U7, U8, U9, UA) to indicate the number of minutes spent providing direct contact services to the member. Add an additional modifier code if services are delivered via telemedicine (FQ, FR, 93, 95), as shown in the tables below. Refer to the current [Fee Schedule \(https://hcpf.colorado.gov/provider-rates-fee-schedule\)](#) for rates

Prior authorization requests are not required. There are no amount, duration or scope limitations for the lactation support services benefit.

Appropriate diagnosis codes must be utilized when billing for lactation support services (e.g., Z39.1: encounter for care and examination of a lactating mother, O92.70: unspecified disorders of lactation). If billing a claim for a breastfeeding child, use a child lactation-related code (e.g., R63.31: pediatric feeding difficulty, P92.5: neonatal feeding difficulties at breast).

Services for the lactating member and child must be billed on one (1) claim. Both the lactating member and the breastfeeding child must not have claims submitted for the same service and the same date of service. The provider should bill the claim under the eligible member for whom the visit was scheduled, or most closely aligns with the provider's scope of practice. For example, a pediatrician would bill under the Health First Colorado enrolled breastfeeding child, and an obstetrician would bill under the Health First Colorado enrolled lactating member.

When billing for lactation support services for twins, multiple infants or tandem breastfeeding, providers have two options:

1. Bill for extended time spent with the lactating member; OR
2. Bill separately for time spent with each breastfeeding child. Providers will need to ensure to bill for distinct and separate identifiable amounts of time for each pediatric member.

A lactation support provider who renders services to more than one (1) member at a time must bill appropriately using the approved group session modifier U2. The group session must be an instructor-led breastfeeding education group. Not all participants in the group need to be members of Health First Colorado, but a claim for payment may only be submitted for each enrolled Health First Colorado member who received services in the group session. Such claims must be coded using S9443 with the U2 modifier.

[Back to Top](#)

Coding Table for Lactation Support Services

Procedure Code	Description	First Position Modifier	second position Modifier
S9443	Lactation Support Services Telemedicine service delivery is allowed.	U1 = individual session U2 = group session	U3 = 8-22 minutes U4 = 23-37 minutes U5 = 38-52 minutes U6 = 53-67 minutes U7 = 68-82 minutes U8 = 83-97 minutes U9 = 98-112 minutes UA = 113-127 minutes

Example: A member received a total of 90 minutes of individual in-person lactation support services on a given date of service. The provider should report S9443 with the U1 modifier to indicate individual setting and the U8 modifier to indicate 90 minutes of direct member contact services provided.

Important Notes on S9443

Although the formal definition of HCPCS procedure code S9443 is “Lactation classes, non-physician provider, per session,” the Department instructs providers to use this procedure code under the direction detailed in this billing manual. Key differences are:

1. This procedure code should be reported for lactation support services by any eligible provider, including physicians, rather than just “non-physicians.”

Modifier Codes for Telemedicine Service Delivery for S9443	Description
FQ	The service was furnished using audio-only communication technology.
FR	The supervising practitioner was present through two-way audio/video communication technology.
93	Synchronous telemedicine service was rendered via telephone or other real-time interactive audio-only telecommunications system.

Modifier Codes for Telemedicine Service Delivery for S9443	Description
95	Synchronous telemedicine service was rendered via real-time interactive audio and video telecommunications system.

[Back to Top](#)

Determining What Time Counts Towards Timed Codes

Providers report the code for the time spent in direct member treatment. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the lactation provider is directly working with the member to deliver treatment services. Record-keeping documentation and travel time is not reimbursable. Time spent for preparation, report writing, processing of claims, or documentation regarding billing or service provision is not reimbursable.

[Back to Top](#)

National Correct Coding Initiative (NCCI)

When multiple services, including lactation support, are provided during a single visit, providers should not bill for overlapping time spent on different activities. Each billed procedure code must correspond to a distinct and separately identifiable amount of time and work for each service. For example, if during a visit both preventive medicine services and lactation support services are provided, the provider may bill each code only if the time spent on each is separately identifiable and does not overlap.

NCCI Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) may apply to certain combinations of procedure codes. Visit the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](https://www.cms.gov/medicare/coding-billing/ncci-medicare) (<https://www.cms.gov/medicare/coding-billing/ncci-medicare>) for a complete list of impacted codes, guidance on bypass modifier uses, and general information.

[Back to Top](#)

Recommendation for Lactation Support Services

Lactation support services are provided as preventative services and require a recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice in accordance with [42 CFR 440.130\(c\)](https://www.ecfr.gov/current/title-42/part-440/section-440.130#p-440.130(c)) ([https://www.ecfr.gov/current/title-42/part-440/section-440.130#p-440.130\(c\)](https://www.ecfr.gov/current/title-42/part-440/section-440.130#p-440.130(c))).

- The lactating individual-child dyad requires a recommendation on file from a physician or other licensed practitioner of the healing arts. This recommendation authorizes lactation support services from pregnancy through the duration of breastfeeding. The recommendation can come from the licensed healthcare provider of either the lactating individual or the child.
- All claims for lactation support services must have the NPI number of the enrolled provider who ordered the items to be indicated on the claim in the appropriate Ordering, Prescribing and Referring (OPR) field on the

claim. The enrolled provider types who may recommend these services are:

- Physicians - PT 05/65
 - Osteopaths - PT 26
 - Physician Assistants - PT 39
 - Advanced Practice Nurses - PT 41
 - Nurse Midwives - PT 22
- The recommending provider indicated on the claim must be actively enrolled with Health First Colorado ([42 CFR 455.410\(b\)](#) (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.410>)). The claim will be denied if the indicated provider is not actively enrolled. Reference the [Ordering, Prescribing, and Referring Claim Project Identifier \(/opr-claims\)](#) for further details.
 - If a licensed provider listed in this manual renders a service under their own ordering authority, then that rendering physician's NPI number should be placed in the applicable OPR field on the claim. This does not apply to providers enrolled as IBCLC, CLC and CLEs.

Professional Claims

- Paper claims use field 17.b.
- Electronic submissions use loop 2420 with qualifier DK (Ordering), DN (Referring) or DQ (Supervising).
- Claims submitted through the Provider Web Portal use the "Referring Provider" field.

Institutional Claims

- The Attending Provider field (#76) or the Other ID fields (#78 or #79) for both paper and electronic claims.
- Providers may refer to their applicable UB-04 billing manuals for guidance on how each field is used.

[Back to Top](#)

Documentation Requirements

The provider must maintain documentation in accordance with [10 CCR 2505-10 8.130.2 \(/department-program-rules-and-regulations\)](#) that complies with state and federal regulations. The provider must retain records that specifically record the dates and precise times at which direct services provided to a member began and ended, among other general requirements for documentation. These timestamps are critical for validating the number of units of service that are billed.

[Back to Top](#)

Physical Health Managed Care

Lactation support services are not included in Health First Colorado physical health managed care plans. Lactation support services are still covered benefits for members enrolled in those plans as "wrap-around" benefits of the plan.

All claims for lactation support services should be billed to the Department's Fiscal Agent, Gainwell Technologies, even if the member is attributed to a Health First Colorado physical health managed care plan.

[Back to Top](#)

Outpatient Hospital

Lactation support services provided at an Outpatient Hospital are reported on the institutional claim type and are reimbursed as part of the hospital's EAPG payment.

[Back to Top](#)

Inpatient Hospital and Freestanding Birth Center Services

Professional services provided by a lactation support services provider associated with newborn deliveries and immediate postnatal breastfeeding support care for the lactating individual are part of the hospital's facility All Patient Refined-Diagnosis Related Group (APR-DRG) payment and the Freestanding Birth Center's delivery payment. Such circumstances are not eligible for billing through the Lactation Support Services benefit. Place of Service codes 21 (Inpatient Hospital) and 25 (Freestanding Birth Center) are not available for billing use. HCPCS codes for lactation support services cannot be billed for dates on or during the date span of the delivery and inpatient stay. Refer to the [Obstetrical Care Billing Manual \(/OB-manual\)](#).

[Back to Top](#)

Place of Service Coding

Providers may provide lactation support services in a variety of settings, including the member's home, clinics, provider offices or via telehealth. The visit setting should be indicated on the claim using the Place of Service code. A full list of allowable places of service for lactation support services is indicated below.

Lactation support services can be provided via telemedicine with Place of Service codes 02 or 10. Telehealth services must adhere to the [Telemedicine Billing Manual \(/telemedicine-manual\)](#).

Official descriptors of the Place of Service (<https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>) can be found on the Centers for Medicare and Medicaid Services (CMS) website.

The following Place of Service codes are allowed:

Allowed Place of Service Code	Description (short)
02	Telehealth Provided Other than in Patient's Home
04	Homeless Shelter
10	Telehealth Provided in Patient's Home
11	Office
12	Home
15	Mobile Unit

Allowed Place of Service Code	Description (short)
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

[Back to Top](#)

Contact Information

Contact the [Provider Services Call Center \(/provider-help\)](/provider-help) with billing inquiries.

Contact the Department's Lactation Support Services policy specialist at [HCPF_MaternalChildHealth@state.co.us \(mailto:hcpf_maternalchildhealth@state.co.us\)](mailto:hcpf_maternalchildhealth@state.co.us) for all other inquiries.

[Back to Top](#)

CMS 1500 Paper Claim Reference Table

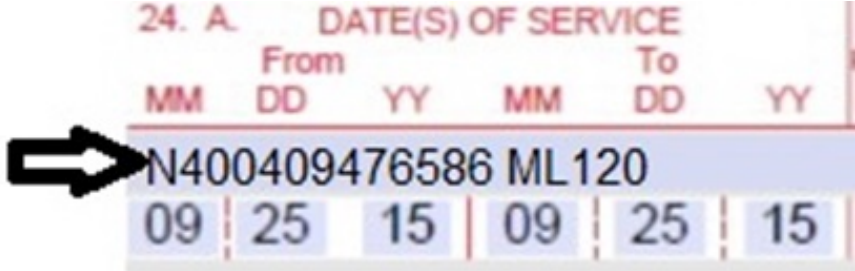
The following paper claim form reference table shows required, optional and conditional fields and detailed field completion instructions for the CMS 1500 professional claim form.

CMS Field Number & Label	Field is?	Instructions
1. Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a. Insured's ID Number	Required	Enter the member's Health First Colorado seven (7)-digit Health First Colorado ID number as it appears on the Medicaid Identification card. Example: A123456.
2. Patient's Name	Required	Enter the member's last name, first name and middle initial.
3. Patient's Date of Birth/Sex	Required	Enter the member's birth date using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.

CMS Field Number & Label	Field is?	Instructions
4. Insured's Name	Conditional	<p>Complete if the member is covered by a Medicare health insurance policy.</p> <p>Enter the insured's full last name, first name and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.</p>
5. Patient's Address	Not Required	
6. Patient's Relationship to Insured	Conditional	<p>Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.</p>
7. Insured's Address	Not Required	
8. Reserved for NUCC Use	Not Required	
9. Other Insured's Name	Conditional	<p>If field 11d is marked "YES," enter the insured's last name, first name and middle initial.</p>
9a. Other Insured's Policy or Group Number	Conditional	<p>If field 11d is marked "YES," enter the policy or group number.</p>
9b. Reserved for NUCC Use		
9c. Reserved for NUCC Use		
9d. Insurance Plan or Program Name	Conditional	<p>If field 11D is marked "YES" enter the insurance plan or program name.</p>
10a-c. Is patient's condition related to?	Conditional	<p>When appropriate, place an "X" in the correct box to indicate whether one (1) or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.</p>
10d. Reserved for Local Use		

CMS Field Number & Label	Field is?	Instructions
11. Insured's Policy, Group or FECA Number	Conditional	<p>Complete if the member is covered by a Medicare health insurance policy.</p> <p>Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.</p>
11a. Insured's Date of Birth, Sex	Conditional	<p>Complete if the member is covered by a Medicare health insurance policy.</p> <p>Enter the insured's birth date using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.</p> <p>Place an "X" in the appropriate box to indicate the sex of the insured.</p>
11b. Other Claim ID	Not Required	
11c. Insurance Plan Name or Program Name	Not Required	
11d. Is there another Health Benefit Plan?	Conditional	<p>When appropriate, place an "X" in the correct box. If marked "YES," complete 9, 9a and 9d.</p>
12. Patient's or Authorized Person's Signature	Required	<p>Enter "Signature on File," "SOF" or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."</p> <p>Enter the date the claim form was signed.</p>
13. Insured's or Authorized Person's Signature	Not Required	
14. Date of Current Illness, Injury or Pregnancy	Conditional	<p>Complete if information is known. Enter the date of illness, injury or pregnancy (date of the last menstrual period) using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.</p> <p>Enter the applicable qualifier to identify which date is being reported. 431 - Onset of Current Symptoms or Illness 484 - Last Menstrual Period</p>
15. Other Date Not	Not Required	

CMS Field Number & Label	Field is?	Instructions
16. Date Patient Unable to Work in Current Occupation	Not Required	
17. Name of Referring Physician	Conditional	
17b. NPI of Referring Physician	Required	Required in accordance with Program Rule 8.125.8.A
18. Hospitalization Dates Related to Current Service	Not Required	
19. Additional Claim Information	Conditional	
20. Outside Lab? \$ Charges	Conditional	<p>Complete if all laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if any laboratory work was performed in the office.</p> <p>Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>
21. Diagnosis or Nature of Illness or Injury	Required	<p>Enter at least one (1) but no more than 12 diagnosis codes based on the member's diagnosis/condition.</p> <p>Enter applicable ICD-10 code: Z33.1 or Z39.2 depending on the procedure code billed.</p>
22. Medicaid Resubmission Code	Conditional	<p>List the original reference number for resubmitted claims.</p> <p>When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.</p> <p>7 - Replacement of prior claim 8 - Void/Cancel of prior claim</p> <p>This field is not intended for use with original claim submissions.</p>
23. Prior Authorization	Not Required	<p>Prior Authorization</p> <p>Enter the six (6)-character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one (1) approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.</p>

CMS Field Number & Label	Field is?	Instructions												
24. Claim Line Detail	Information	<p>The paper claim form allows entry of up to six (6) detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p>Do not enter more than six (6) lines of information on the paper claim. If more than six (6) lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (e.g., Page 1 of 2).</p>												
24A. Dates of Service	Required	<p>The field accommodates the entry of two (2) dates: a "From" date of services and a "To" date of service. Enter the date of service using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 010124 for January 1, 2019.</p> <table border="1" data-bbox="602 877 914 1031"> <thead> <tr> <th colspan="3">From</th> <th colspan="3">To</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>01</td> <td>24</td> <td>01</td> <td>01</td> <td>24</td> </tr> </tbody> </table> <p>Single Date of Service: Enter the six (6)-digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two (2) fields.</p> <p>Span billing: Not permitted. All dates of service must have their own detailed line item on the claim.</p> 	From			To			01	01	24	01	01	24
From			To											
01	01	24	01	01	24									
24B. Place of Service	Required	Reference the billing policy found in this manual for allowed Place of Service codes.												
24C. EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom unshaded area of the field to indicate the service was rendered for a life-threatening condition or one that requires immediate medical intervention.												

CMS Field Number & Label	Field is?	Instructions
24D.Procedures, Services, or Supplies	Required	<p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested: S9443</p> <p>All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.</p> <p>HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only).</p> <p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
24D. Modifier	Conditional	<p>Enter the appropriate procedure-related modifier that applies to the billed service. Up to four (4) modifiers may be entered when using the paper claim form. Please reference the billing policy detailed in this manual for specific modifier code use.</p>
24E. Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one (1) diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first and other applicable services should follow.</p> <p>This field allows for the entry of four (4) characters in the unshaded area.</p>

CMS Field Number & Label	Field is?	Instructions
24F. \$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one (1) procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one (1) procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Health First Colorado-covered individuals for the same service.</p> <p>Do not deduct Health First Colorado co-pay or commercial insurance payments from the usual and customary charges.</p>
24G. Days or Units	Required	<p>Enter the number of services provided for each procedure code. Enter whole numbers only. Do not enter fractions or decimals.</p>
24H. EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis and Treatment related services, enter the response in the shaded portion of the field as follows: AV - Available- Not Used S2 - Under Treatment ST - New Service Requested NU - Not Used</p> <p>Family Planning (unshaded area) If the service is Family Planning (e.g., contraception, sterilization), enter "Y" for YES or "N" for NO in the bottom unshaded area of the field.</p>
24I. ID Qualifier	Not Required	
24J. Rendering Provider ID #	Required	<p>In the shaded portion of the field, enter the National Provider Identifier (NPI) or the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>

CMS Field Number & Label	Field is?	Instructions
25. Federal Tax ID Number	Not Required	
26. Patient's Account Number	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27. Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28. Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29. Amount Paid	Conditional	<p>Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services.</p> <p>Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p>
30. Rsvd for NUCC Use		
31. Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070116 for July 1, 2016.</p> <p>Unacceptable signature alternatives: Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.</p>

CMS Field Number & Label	Field is?	Instructions
32. Service Facility Location Information 32a- NPI Number 32b- Other ID #	Required	Enter the name, address and ZIP code of the individual or business where the member was seen or service was performed in the following format: 1st Line: Name 2nd Line: Address 3rd Line: City, State and ZIP Code If the PT is not able to obtain an NPI, enter the eight (8)-digit Health First Colorado provider number of the individual or organization.
33. Billing Provider Info & Ph #	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line: Name 2nd Line: Address 3rd Line: City, State and ZIP Code
33a- NPI Number	Required	
33b- Other ID #		If the PT is not able to obtain an NPI, enter the eight (8)-digit Health First Colorado provider number of the individual or organization.

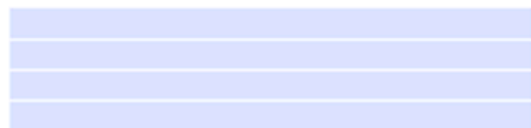
[Back to Top](#)

CMS 1500 Lactation Support Service Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12



CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <input type="checkbox"/> PICA												
1. MEDICARE <input type="checkbox"/> (Medicare) <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid) <input type="checkbox"/> TRICARE <input type="checkbox"/> (DA/DC/DF) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member/DFW) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA OR LUMP <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)				14. INSURED'S I.D. NUMBER (For Program in Item 1) D444444								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima				3. PATIENT'S BIRTH DATE 10 18 1990 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) 123 Main Street				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)				
CITY Anytown			STATE CO	8. RESERVED FOR NUCC USE				CITY			STATE	
ZIP CODE 8000		TELEPHONE (Include Area Code)	ZIP CODE					TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d</i>				
READBACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits due to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 04/14/2025						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QVAL _____				15. OTHER DATE QVAL _____ MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
17b. NPI 2345678901				19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to A-L to service line below (24E) ICD-10 _____												
A. _____			B. _____			C. _____			D. _____			
E. _____			F. _____			G. _____			H. _____			
I. _____			J. _____			K. _____			L. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. RUOE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPTHOCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PRIORITY (Only if P)	I. I.D. QVAL	J. RENDERING PROVIDER ID. #
04 14 25 04 14 25		11	09443	U1 U6			239.1	240.00	1	NP1	0123456789	
25. FEDERAL TAX I.D. NUMBER SSN EIN _____												
26. PATIENT'S ACCOUNT NO. Optional				27. ACCEPT ASSIGNMENT? (For gov't claims, see 14b) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 240.00		29. AMOUNT PAID \$ _____		30. Paid for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Signature SIGNED _____ DATE 04/14/2025				32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____				33. BILLING PROVIDER INFO & PH # () ABC Lactation Clinic 100 Any Street Any City a. 1234567890 b. f				



UB-04 Paper Claim Reference Table

Lactation Support Services outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following table provides instructions for completing form locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual* (<https://www.nubc.org/>). Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for Health First Colorado as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator may not be used for submitting paper claims to Health First Colorado. The appropriate code values listed in this manual must be used when billing Health First Colorado.

The UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address listed in Appendix A, under the Appendices drop-down section on the [Billing Manuals web page \(/billing-manuals\)](#).

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form.

Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted through the Provider Web Portal.

Bill with a date span (From and To dates of service) only if the service was provided every consecutive day within the span. The From and To dates must be in the same month.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to Health First Colorado for nursing facility services.

Form Locator and labels	Completion format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	<p>Required</p> <p>Enter the provider or agency name and complete mailing address of the provider who is billing for the services:</p> <ul style="list-style-type: none">• Street• City• State• Zip Code <p>Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>

Form Locator and labels	Completion format	Instructions
2. Pay-to Name, Address, City, State	Text	<p>Required only if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who is billing for the services:</p> <ul style="list-style-type: none"> • Street • City • State • Zip Code <p>Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	<p>Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).</p>
3b. Medical Record Number	17 digits	<p>Optional Enter the number assigned to the member to assist in retrieval of medical records.</p>

Form Locator and labels	Completion format	Instructions																																								
4. Type of Bill	3 digits	<p>Required For PRTF, use TOB 89X. Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <table border="1" data-bbox="621 470 1546 1969"> <thead> <tr> <th data-bbox="621 470 716 575">Digit 1</th> <th data-bbox="716 470 1546 575">Type of Facility</th> </tr> </thead> <tbody> <tr> <td data-bbox="621 575 716 642">1</td> <td data-bbox="716 575 1546 642">Hospital</td> </tr> <tr> <td data-bbox="621 642 716 709">2</td> <td data-bbox="716 642 1546 709">Skilled Nursing</td> </tr> <tr> <td data-bbox="621 709 716 777">3</td> <td data-bbox="716 709 1546 777">Home Health Services</td> </tr> <tr> <td data-bbox="621 777 716 844">4</td> <td data-bbox="716 777 1546 844">Religious Non-Medical Health Care Institution</td> </tr> <tr> <td data-bbox="621 844 716 911">6</td> <td data-bbox="716 844 1546 911">Intermediate Care</td> </tr> <tr> <td data-bbox="621 911 716 978">7</td> <td data-bbox="716 911 1546 978">Clinic (Rural Health/FQHC/Dialysis Center)</td> </tr> <tr> <td data-bbox="621 978 716 1045">8</td> <td data-bbox="716 978 1546 1045">Special Facility (Hospice, RTCs)</td> </tr> <tr> <th data-bbox="621 1045 716 1150">Digit 2</th> <th data-bbox="716 1045 1546 1150">Bill Classification (Except Clinics & Special Facilities):</th> </tr> <tr> <td data-bbox="621 1150 716 1218">1</td> <td data-bbox="716 1150 1546 1218">Inpatient (Including Medicare Part A)</td> </tr> <tr> <td data-bbox="621 1218 716 1285">2</td> <td data-bbox="716 1218 1546 1285">Inpatient (Medicare Part B only)</td> </tr> <tr> <td data-bbox="621 1285 716 1352">3</td> <td data-bbox="716 1285 1546 1352">Outpatient</td> </tr> <tr> <td data-bbox="621 1352 716 1457">4</td> <td data-bbox="716 1352 1546 1457">Other (for hospital referenced diagnostic services or home health not under a plan of treatment)</td> </tr> <tr> <td data-bbox="621 1457 716 1524">5</td> <td data-bbox="716 1457 1546 1524">Intermediate Care Level I</td> </tr> <tr> <td data-bbox="621 1524 716 1591">6</td> <td data-bbox="716 1524 1546 1591">Intermediate Care Level II</td> </tr> <tr> <td data-bbox="621 1591 716 1696">7</td> <td data-bbox="716 1591 1546 1696">Sub-Acute Inpatient (Revenue Code 019X required with this bill type)</td> </tr> <tr> <td data-bbox="621 1696 716 1764">8</td> <td data-bbox="716 1696 1546 1764">Swing Beds</td> </tr> <tr> <td data-bbox="621 1764 716 1831">9</td> <td data-bbox="716 1764 1546 1831">Other</td> </tr> <tr> <th data-bbox="621 1831 716 1936">Digit 2</th> <th data-bbox="716 1831 1546 1936">Bill Classification (Clinics Only):</th> </tr> <tr> <td data-bbox="621 1936 716 1969">1</td> <td data-bbox="716 1936 1546 1969">Rural Health/FQHC</td> </tr> </tbody> </table>	Digit 1	Type of Facility	1	Hospital	2	Skilled Nursing	3	Home Health Services	4	Religious Non-Medical Health Care Institution	6	Intermediate Care	7	Clinic (Rural Health/FQHC/Dialysis Center)	8	Special Facility (Hospice, RTCs)	Digit 2	Bill Classification (Except Clinics & Special Facilities):	1	Inpatient (Including Medicare Part A)	2	Inpatient (Medicare Part B only)	3	Outpatient	4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)	5	Intermediate Care Level I	6	Intermediate Care Level II	7	Sub-Acute Inpatient (Revenue Code 019X required with this bill type)	8	Swing Beds	9	Other	Digit 2	Bill Classification (Clinics Only):	1	Rural Health/FQHC
Digit 1	Type of Facility																																									
1	Hospital																																									
2	Skilled Nursing																																									
3	Home Health Services																																									
4	Religious Non-Medical Health Care Institution																																									
6	Intermediate Care																																									
7	Clinic (Rural Health/FQHC/Dialysis Center)																																									
8	Special Facility (Hospice, RTCs)																																									
Digit 2	Bill Classification (Except Clinics & Special Facilities):																																									
1	Inpatient (Including Medicare Part A)																																									
2	Inpatient (Medicare Part B only)																																									
3	Outpatient																																									
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)																																									
5	Intermediate Care Level I																																									
6	Intermediate Care Level II																																									
7	Sub-Acute Inpatient (Revenue Code 019X required with this bill type)																																									
8	Swing Beds																																									
9	Other																																									
Digit 2	Bill Classification (Clinics Only):																																									
1	Rural Health/FQHC																																									

Form Locator and labels	Completion format	Instructions	
		2	Hospital Based or Independent Renal Dialysis Center
		3	Freestanding
		4	Outpatient Rehabilitation Facility (ORF)
		5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
		6	Community Mental Health Center
		Digit 2	Bill Classification (Special Facilities Only):
		1	Hospice (Non-Hospital Based)
		2	Hospice (Hospital Based)
		3	Ambulatory Surgery Center
		4	Freestanding Birthing Center
		5	Critical Access Hospital
		6	Residential Facility
		Digit 3	Frequency:
		0	Non-Payment/Zero Claim
		1	Admit through discharge claim
		2	Interim - First claim
		3	Interim - Continuous claim
		4	Interim - Last claim
		7	Replacement of prior claim
		8	Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.	

Form Locator and labels	Completion format	Instructions
6. Statement covers period From/Through	From:6 digits MMDDYY Through: 6 digits MMDDYY	Required This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier	Text	Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters, letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address - Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address - City	Text	Required Enter the member's city as determined at the time of admission
9c. Patient Address - State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address - ZIP	Text	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address - Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Not Required
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Not Required
15. Source of Admission	1 digit	Required
16. Discharge Hour	2 digits	Not Required

Form Locator and labels	Completion format	Instructions
17. Patient Discharge Status	2 digits	<p>Required</p> <p>Dialysis must use code 01.</p>
18-28. Conditions Codes	2 digits	<p>Conditional</p> <p>Complete with as many codes necessary to identify conditions related to this bill.</p> <p>Condition Codes</p> <p>06 ESRD member - First 18 months entitlement</p> <p>Renal dialysis settings</p> <p>71 Full care unit</p> <p>72 Self care unit</p> <p>73 Self care training</p> <p>74 Home care</p> <p>75 Home care - 100 percent reimbursement</p>
29. Accident State	2 digits	Optional

Form Locator and labels	Completion format	Instructions																																						
31-34. Occurrence Code/Date	2 digits & 6 digits	<p>Conditional</p> <p>Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.</p> <p>Occurrence Codes:</p> <table border="1" data-bbox="623 470 1544 1948"> <tbody> <tr><td>1</td><td>Accident/Medical Coverage</td></tr> <tr><td>2</td><td>Auto Accident - No Fault Liability</td></tr> <tr><td>3</td><td>Accident/Tort Liability</td></tr> <tr><td>4</td><td>Accident/Employment Related</td></tr> <tr><td>5</td><td>Other Accident/No Medical Coverage or Liability Coverage</td></tr> <tr><td>6</td><td>Crime Victim</td></tr> <tr><td>20</td><td>Date Guarantee of Payment Began</td></tr> <tr><td>24*</td><td>Date Insurance Denied</td></tr> <tr><td>25*</td><td>Date Benefits Terminated by Primary Payer</td></tr> <tr><td>26</td><td>Date Skilled Nursing Facility Bed Available</td></tr> <tr><td>27</td><td>Date of Hospice Certification or Re-certification</td></tr> <tr><td>40</td><td>Scheduled Date of Admission (RTD)</td></tr> <tr><td>50</td><td>Medicare Pay Date</td></tr> <tr><td>51</td><td>Medicare Denial Date</td></tr> <tr><td>53</td><td>No longer used</td></tr> <tr><td>55</td><td>Insurance Pay Date</td></tr> <tr><td>A3</td><td>Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50</td></tr> <tr><td>B3</td><td>Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50</td></tr> <tr><td>C3</td><td>Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50</td></tr> </tbody> </table>	1	Accident/Medical Coverage	2	Auto Accident - No Fault Liability	3	Accident/Tort Liability	4	Accident/Employment Related	5	Other Accident/No Medical Coverage or Liability Coverage	6	Crime Victim	20	Date Guarantee of Payment Began	24*	Date Insurance Denied	25*	Date Benefits Terminated by Primary Payer	26	Date Skilled Nursing Facility Bed Available	27	Date of Hospice Certification or Re-certification	40	Scheduled Date of Admission (RTD)	50	Medicare Pay Date	51	Medicare Denial Date	53	No longer used	55	Insurance Pay Date	A3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50	B3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50	C3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50
1	Accident/Medical Coverage																																							
2	Auto Accident - No Fault Liability																																							
3	Accident/Tort Liability																																							
4	Accident/Employment Related																																							
5	Other Accident/No Medical Coverage or Liability Coverage																																							
6	Crime Victim																																							
20	Date Guarantee of Payment Began																																							
24*	Date Insurance Denied																																							
25*	Date Benefits Terminated by Primary Payer																																							
26	Date Skilled Nursing Facility Bed Available																																							
27	Date of Hospice Certification or Re-certification																																							
40	Scheduled Date of Admission (RTD)																																							
50	Medicare Pay Date																																							
51	Medicare Denial Date																																							
53	No longer used																																							
55	Insurance Pay Date																																							
A3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50																																							
B3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50																																							
C3	Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50																																							

Form Locator and labels	Completion format	Instructions
		<div data-bbox="625 226 1546 371" style="border: 1px solid black; padding: 5px;"> <p>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third-party information.</p> </div>
35-36. Occurrence Span Code From/ Through	Digits	Leave blank
38. Responsible Party Name/Address	None	Leave blank

Form Locator and labels	Completion format	Instructions																														
39-41. Value Codes and Amounts	2 characters and up to 9 digits	<p>Conditional</p> <p>Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code <i>must</i> always be entered.</p> <p>Most Common Codes:</p> <table border="1" data-bbox="623 600 1544 1692"> <tbody> <tr> <td data-bbox="623 600 675 663">01</td> <td data-bbox="675 600 1544 663">Semiprivate rate (Accommodation Rate)</td> </tr> <tr> <td data-bbox="623 663 675 726">06</td> <td data-bbox="675 663 1544 726">Medicare blood deductible</td> </tr> <tr> <td data-bbox="623 726 675 789">14</td> <td data-bbox="675 726 1544 789">No fault including auto/other</td> </tr> <tr> <td data-bbox="623 789 675 852">15</td> <td data-bbox="675 789 1544 852">Worker's Compensation</td> </tr> <tr> <td data-bbox="623 852 675 915">31</td> <td data-bbox="675 852 1544 915">Member Liability Amount*</td> </tr> <tr> <td data-bbox="623 915 675 978">32</td> <td data-bbox="675 915 1544 978">Multiple Member Ambulance Transport</td> </tr> <tr> <td data-bbox="623 978 675 1041">37</td> <td data-bbox="675 978 1544 1041">Pints of Blood Furnished</td> </tr> <tr> <td data-bbox="623 1041 675 1104">38</td> <td data-bbox="675 1041 1544 1104">Blood Deductible Pints</td> </tr> <tr> <td data-bbox="623 1104 675 1167">40</td> <td data-bbox="675 1104 1544 1167">New Coverage Not Implemented by HMO</td> </tr> <tr> <td data-bbox="623 1167 675 1367">45</td> <td data-bbox="675 1167 1544 1367"> Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). </td> </tr> <tr> <td data-bbox="623 1367 675 1430">49</td> <td data-bbox="675 1367 1544 1430">Hematocrit Reading - EPO Related</td> </tr> <tr> <td data-bbox="623 1430 675 1493">58</td> <td data-bbox="675 1430 1544 1493">Arterial Blood Gas (PO2/PA2)</td> </tr> <tr> <td data-bbox="623 1493 675 1556">68</td> <td data-bbox="675 1493 1544 1556">EPO-Drug</td> </tr> <tr> <td data-bbox="623 1556 675 1619">80</td> <td data-bbox="675 1556 1544 1619">Covered Days</td> </tr> <tr> <td data-bbox="623 1619 675 1682">81</td> <td data-bbox="675 1619 1544 1682">Non-Covered Days</td> </tr> </tbody> </table> <p>Enter the deductible amount applied by indicated payer: Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C</p>	01	Semiprivate rate (Accommodation Rate)	06	Medicare blood deductible	14	No fault including auto/other	15	Worker's Compensation	31	Member Liability Amount*	32	Multiple Member Ambulance Transport	37	Pints of Blood Furnished	38	Blood Deductible Pints	40	New Coverage Not Implemented by HMO	45	Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour).	49	Hematocrit Reading - EPO Related	58	Arterial Blood Gas (PO2/PA2)	68	EPO-Drug	80	Covered Days	81	Non-Covered Days
01	Semiprivate rate (Accommodation Rate)																															
06	Medicare blood deductible																															
14	No fault including auto/other																															
15	Worker's Compensation																															
31	Member Liability Amount*																															
32	Multiple Member Ambulance Transport																															
37	Pints of Blood Furnished																															
38	Blood Deductible Pints																															
40	New Coverage Not Implemented by HMO																															
45	Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour).																															
49	Hematocrit Reading - EPO Related																															
58	Arterial Blood Gas (PO2/PA2)																															
68	EPO-Drug																															
80	Covered Days																															
81	Non-Covered Days																															

Form Locator and labels	Completion format	Instructions
		<p>Enter the amount applied to member's co-insurance by indicated payer:</p> <p>A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C</p> <hr/> <p>Enter the amount paid by indicated payer:</p> <p>A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C</p>
42. Revenue Code	4 digits	<p>Required</p> <p>Enter the revenue code which identifies the specific service provided. List revenue codes in ascending order. These codes are listed in Appendix Q, under the Appendices drop-down section on the Billing Manuals web page (/dialysis-manual), for valid dialysis revenue codes.</p> <p>A revenue code must appear only once per date of service.* If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly.</p> <p>Complete with as many codes necessary to identify conditions related to this bill.</p>

Form Locator and labels	Completion format	Instructions				
43. Revenue code Description	Text	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p> <p>When reporting an NDC:</p> <ul style="list-style-type: none"> • Enter the NDC qualifier of "N4" in the first two positions on the left side of the field, immediately followed by the 11-digit NDC numeric code • Enter one space for separation. • Enter the NDC unit of measure qualifier (examples include): <ul style="list-style-type: none"> ◦ F2 - International Unit ◦ GR - Gram ◦ ML - Milliliter ◦ UN - Units • Enter one period for separation • Enter the quantity (number of NDC units). <p>Example:</p> <table border="1" data-bbox="623 1083 1131 1234"> <thead> <tr> <th data-bbox="623 1083 812 1167">42 REV.CD.</th> <th data-bbox="812 1083 1131 1167">43 <u>DESCRIPTION</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="623 1167 812 1234">0636</td> <td data-bbox="812 1167 1131 1234">N467066000501 ME.016</td> </tr> </tbody> </table>	42 REV.CD.	43 <u>DESCRIPTION</u>	0636	N467066000501 ME.016
42 REV.CD.	43 <u>DESCRIPTION</u>					
0636	N467066000501 ME.016					

Form Locator and labels	Completion format	Instructions
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	<p>Conditional</p> <p>Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services.</p> <p>Complete for laboratory, radiology, physical therapy, occupational therapy and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed.</p> <p>Services Requiring HCPCS Anatomical Laboratory: Bill with TC modifier Hospital Based Transportation Outpatient Laboratory: Use only HCPCS 80000s - 89000s. Outpatient Radiology Services</p> <p>Enter HCPCS and revenue codes for each radiology line. The only valid modifier for OP radiology is TC. Refer to the annual HCPCS bulletin for instructions in the Provider Services Bulletins (/bulletins) section of the website.</p> <p>With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services.</p> <p>HCPCS codes must be identified for the following revenue codes:</p> <ul style="list-style-type: none"> • 030X Laboratory • 032X Radiology - Diagnostic • 033X Radiology - Therapeutic • 034X Nuclear Medicine • 035X CT Scan • 040X Other Imaging Services • 042X Physical Therapy • 043X Occupational Therapy • 054X Ambulance • 061X MRI and MRA <p>HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services.</p>

Form Locator and labels	Completion format	Instructions
45. Service Date	6 digits	<p>For span bills only Enter the date of service using MMDDYY format for each detail line completed.</p> <p>Each date of service must fall within the date span entered in the "Statement Covers Period" field (FL 6).</p>
46. Service Units	3 digits	<p>Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit).</p> <p>For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.</p>
47. Total Charges	9 digits	<p>Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third-party payments from line charge entries. Do not enter negative amounts. A grand total on line 23 is required for all charges.</p>
48. Non-covered Charges	Up to 9 digits	<p>Conditional Enter incurred charges that are not payable by Health First Colorado.</p> <p>Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total on line 23.</p> <p>Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.</p>

Form Locator and labels	Completion format	Instructions																						
50. Payer Name	1 letter and text	<p>Required</p> <p>Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate Health First Colorado.</p> <table border="1" data-bbox="623 451 1364 1180"> <thead> <tr> <th colspan="2" data-bbox="623 451 1364 535">Source Payment Codes</th> </tr> </thead> <tbody> <tr> <td data-bbox="623 535 722 598">B</td> <td data-bbox="722 535 1364 598">Workmen's Compensation</td> </tr> <tr> <td data-bbox="623 598 722 661">C</td> <td data-bbox="722 598 1364 661">Medicare</td> </tr> <tr> <td data-bbox="623 661 722 724">D</td> <td data-bbox="722 661 1364 724">Health First Colorado</td> </tr> <tr> <td data-bbox="623 724 722 787">E</td> <td data-bbox="722 724 1364 787">Other Federal Program</td> </tr> <tr> <td data-bbox="623 787 722 850">F</td> <td data-bbox="722 787 1364 850">Insurance Company</td> </tr> <tr> <td data-bbox="623 850 722 913">G</td> <td data-bbox="722 850 1364 913">Blue Cross, including Federal Employee Program</td> </tr> <tr> <td data-bbox="623 913 722 976">I</td> <td data-bbox="722 913 1364 976">Other</td> </tr> <tr> <td data-bbox="623 976 722 1039">Line A</td> <td data-bbox="722 976 1364 1039">Primary Payer</td> </tr> <tr> <td data-bbox="623 1039 722 1102">Line B</td> <td data-bbox="722 1039 1364 1102">Secondary Payer</td> </tr> <tr> <td data-bbox="623 1102 722 1180">Line C</td> <td data-bbox="722 1102 1364 1180">Tertiary Payer</td> </tr> </tbody> </table>	Source Payment Codes		B	Workmen's Compensation	C	Medicare	D	Health First Colorado	E	Other Federal Program	F	Insurance Company	G	Blue Cross, including Federal Employee Program	I	Other	Line A	Primary Payer	Line B	Secondary Payer	Line C	Tertiary Payer
Source Payment Codes																								
B	Workmen's Compensation																							
C	Medicare																							
D	Health First Colorado																							
E	Other Federal Program																							
F	Insurance Company																							
G	Blue Cross, including Federal Employee Program																							
I	Other																							
Line A	Primary Payer																							
Line B	Secondary Payer																							
Line C	Tertiary Payer																							
51. Health Plan ID	10 digits	<p>Required</p> <p>Enter the NPI number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>																						
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.																						
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.																						
54. Prior Payments	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third-party payments. Enter third party and/or Medicare payments.</p>																						

Form Locator and labels	Completion format	Instructions
55. Estimated Amount Due	Up to 9 digits	<p>Conditional Complete when there are Medicare or third-party payments. Enter the net amount due from Health First Colorado after provider has received other third party, Medicare or member liability amount.</p> <p>Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third-party payments and member payments.</p>
56. National Provider Identifier (NPI)	10 digits	<p>Required Enter the billing provider's 10-digit National Provider Identifier (NPI).</p>
57. Other Provider ID		<p>Optional Submitted information is not entered into the claim processing system.</p>
58. Insured's Name	Up to 30 characters	<p>Required Enter the member's name on the Health First Colorado line.</p> <p>Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name and middle initial.</p>
60. Insured's Unique ID	Up to 20 characters	<p>Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.</p>
61. Insurance Group Name	14 letters	<p>Conditional Complete when there is third party coverage.</p> <p>Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.</p>
62. Insurance Group Number	17 digits	<p>Conditional Complete when there is third party coverage.</p> <p>Enter the identification number, control number or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.</p>
63. Treatment Authorization Code	Up to 18 characters	<p>Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.</p>

Form Locator and labels	Completion format	Instructions
64. Document Control Number	None	Conditional
65. Employer Name	Text	<p>Conditional</p> <p>Complete when there is third party coverage.</p> <p>Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).</p>
66. Diagnosis Version Qualifier		<p>Submitted information is not entered into the claim processing system.</p> <p>Enter applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>0ICD-10-CM (DOS 10/1/15 and after)</p>
67. Principal Diagnosis Code	Up to 6 digits	Not required
67A.-67Q. - Other Diagnosis	6 digits	<p>Optional</p> <p>Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.</p>
69. Admitting Diagnosis Code	6 digits	Not required
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury code (E-Code)	6 digits	<p>Optional</p> <p>Enter the diagnosis code for the external cause of an injury, poisoning or adverse effect. This code must begin with an "E".</p>
74. Principal Procedure Code/Date	7 characters and 6 digits	<p>Conditional</p> <p>Enter the ICD-10-CM procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principal procedure:</p> <p>The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment, and</p> <p>The principal procedure is most related to the primary diagnosis.</p>

Form Locator and labels	Completion format	Instructions
74A. Other Procedure Code/Date	7 characters and 6 digits	<p>Conditional</p> <p>Complete when there are additional significant procedure codes.</p> <p>Enter the procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. Enter the date using MMDDYY format.</p>
76. Attending NPI - Required	NPI - 10 digits	<p>Health First Colorado ID Required</p> <p>NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician and cannot be a clinic or group number.</p> <p>(If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)</p> <p>Hospitals and FQHCs may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Health First Colorado.</p> <p>QUAL - Enter "1D" for Health First Colorado</p> <p>Enter the attending physician's last and first name.</p> <p>This form locator must be completed for all services.</p>
77. Operating NPI		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>

Form Locator and labels	Completion format	Instructions
78-79. Other ID	NPI - 10 digits	<p>Conditional</p> <p>Complete when attending physician is not the PCP or to identify additional physicians.</p> <p>Ordering, Prescribing or Referring NPI - when applicable</p> <p>NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility or PCP. Health First Colorado does not require that the PCP number appear more than once on each claim submitted.</p> <p>The attending physician's last and first name are optional.</p>
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code - QUAL/CODE/VALUE (a-d)	Qualifier: 2 digits Taxonomy Code: 10 digits	<p>Optional</p> <p>Complete both the qualifier and the taxonomy code for the billing provider in field 81CC-a.</p> <p>Field 81CC-a must be billed with qualifier B3 for the taxonomy code to be captured in the claims processing system. If B3 is missing, no taxonomy code will be captured in the claims processing system. Only one taxonomy code can be captured from field 81CC. If more than one taxonomy code is provided, only the first instance of B3 and taxonomy code will be captured in the claims processing system.</p>

[Back to Top](#)

UB-04 Lactation Support Service Example

1 City Hospital		2		3a PAT. CNTL #		4 TYPE OF BILL	
100 Saginaw St				b MED. REC. #		131	
Anytown, CO 80000				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
333-333-3333						THROUGH	
						12/01/2024	
						12/01/2024	

8 PATIENT NAME		a		9 PATIENT ADDRESS		a		123 Main Street	
b		Client, Ima		b		Anytown		c CO d 80000	

10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES 22 23 24 25 26		Insert text 27 28		29 WACDT STATE		30	
01/04/2004		F				3		1																			

31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37	

38		39 CODE		VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT	
a													
b													
c													
d													

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	942 Lactation Support Services	S9443	12/01/2024	1	60.54		1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
9							9	
10							10	
11							11	
12							12	
13							13	
14							14	
15							15	
16							16	
17							17	
18							18	
19							19	
20							20	
21							21	
22							22	
PAGE ____ OF ____					CREATION DATE	TOTALS	60.54	

50 PRYER NAME		51 HEALTH PLAN ID		52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
A D - Health First Colorado		1234567890										57	
B												OTHER	
C												PRV ID	

58 INSURED'S NAME		59 PREL.		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
A Client, Ima				Y123456					
B									
C									

63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
A					
B					
C					

68 Z391												68																																																											
69 ADMIT DX												70 PATIENT REASON DX												71 PPS CODE												72 EDI												73																							
74 PRINCIPAL PROCEDURE CODE												a. OTHER PROCEDURE CODE												b. OTHER PROCEDURE CODE												75												76 ATTENDING NPI 1234567890												QUAL											
																																																LAST												FIRST											
c. OTHER PROCEDURE CODE												d. OTHER PROCEDURE CODE												e. OTHER PROCEDURE CODE																								77 OPERATING NPI												QUAL											
																																																LAST												FIRST											
80 REMARKS												81 CC a																								78 OTHER NPI 0123456789												QUAL																							
												b																																				LAST												FIRST											
												c																																				79 OTHER NPI												QUAL											
												d																																				LAST												FIRST											

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

[Back to Top](#)

Timely Filing

Refer to the [General Provider Information Manual \(/gen-info-manual\)](#) located on the [Billing Manuals web page \(/billing-manuals\)](#) under the General Provider Information drop-down for more information on timely filing policy, including the resubmission rules for denied claims.

[Back to Top](#)

Lactation Support Specialist Billing Manual Revision Log

Revision Date	Addition/Changes	Made by
11/12/2024	Creation of Manual	HCPF
02/03/2025	Added information for lactation support services provided by a dually-qualified Doula; added fee schedule information; updated billing information for twins (multiple infants); added information for determining what time counts towards 15-minute time codes; added information about National Correct Coding Initiative (NCCI); updated OPR policy information.	HCPF
04/30/2025	Updated billing information for lactation support services. Updated CMS 1500 lactation support services claim example.	HCPF

Revision Date	Addition/Changes	Made by
05/20/2025	Added Supply PT 14 to eligible billing providers; updated diagnosis code information; updated billing guidance for submitting claims under lactating member or breastfeeding child; added information for outpatient hospital; added UB-04 paper claim reference table; added UB-04 lactation support services example.	HCPF

[Back to Top](#)