Billing Requirements
Institutional Claims

Effective March 1, 2016, WellSense Health Plan requires all providers to report specific data fields on all Institutional Claims Submissions. The following chart identifies the data field elements and requirements a provider must report for institutional claims. Failure to submit "Required" fields may result in the claim being returned to the provider, or in claim denial. The value to the left of the table represents the form locator field on the UB-04 paper claim form. For the corresponding electronic claim submission format, claims must be submitted in accordance with HIPAA compliant 837I standard format.

Applicable products: ☒ **MassHealth** ☒ **Clarity plans** ☒ **Senior Care Options**

Form Locator	Field Name	Submission Requirements	
		Paper UB-04	Electronic
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Optional	Optional
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a-b	Patient ID, Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Date of Birth	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	Required
13	Admission Hour	Required	Required
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	Required
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
44	HCPCS/Rates	Required	Required
45	Service Date	Required	Required
46	Service Units	Required	Required
47	Total Charges	Required	Required
48	Non Covered Charges	Required	Required

Billing Requirements
Institutional Claims

WellSense HEALTH PLAN

Box	Field Name	Submission Requirements	
		Paper CMS-1500	Electronic 837P
49	Untitled	N/A	N/A
50	Payer	Required	Required
51	Provider Number	Required	Required
52	Release of Information	N/A	N/A
53	Assignment of Benefits	N/A	N/A
54	Prior Payments		
55	Estimated Amount Due		
56	NPI	Required	Required
57	Other Provider ID	N/A	N/A
58	Insured's Name	Required	Required
59	Patient Relationship	Situational	Situational
60	Insured's Unique ID	Required	Required
62	Insured's Group Name	Optional	Optional
62	Insured's Group Number	Optional	Optional
63	Treatment Authorization Number	Situational	Situational
64	Document Control Number	N/A	N/A
65	Employer Name	Situational	Situational
66	DX Version Qualifier	N/A	N/A
67	Principal Diagnosis Code/Other Diagnoses	Required	Required
68	Reserved	N/A	N/A
69	Admitting Diagnosis Code	Required	Required
70	Patient's Reason for Visit	Optional	Optional
71	Prospective Payment System (PPS) Code	Optional	Optional
72	External Cause of Injury (ECI) Codes	Situational	Situational
73	Reserved	N/A	N/A
74	Principal Procedure Code	Required (Inpatient)	Required
75	Reserved	N/A	N/A
76	Attending Provider and Identifiers	Situational	Situational
77	Operating Provider and Identifiers	Situational	Situational
78-79	Other Provider Name and Identifiers	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code Field Qualifiers	Situational	Situational

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

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

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									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
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

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

66 DX	67 A	B	C	D	E	F	G	H	68
	I J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI			73

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

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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

NUBC National Uniform Billing Committee

LI03213257