1 Provider Name, Address, and Phone #	2 Pay-to Name, Address	3a PAT. CNTL # Required b. MED. REC. # Recommended	4 TYPE OF BILL
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 04012012 (1) THROUGH 04012012

8 PATIENT NAME	9 PATIENT ADDRESS			
a	a Recipient Street			
b Recipient, Last, First, MI	b City	c ST	d Zip	e

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

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
50 (2)	MMDDYY	24 (3)	MMDDYY											

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
Name and address of party responsible for the bill	a A8 (4)	xx xx	A9	xx xx	49	36 0
	b D5	x xx				
	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
0250	N412345678912UN12345 (5)		MM/DD/YY	X	$$	$$		
0270	Syringe	A4657	MM/DD/YY	X	$	$$		
0300	AMCC Lab	8xxxx CD	MM/DD/YY	X	$$	$$		
0300	Lab	8xxxx CD	MM/DD/YY	X	$$	$$		
0630	N412345678912UN12345		MM/DD/YY	X	$$	$$		
0300	Lab	8xxxx CD	MM/DD/YY	X	$$$	$$		
0821 (7)	Hemodialysis	90999 G3 V9	MM/DD/YY	1 (1)	$$$	$$		

(6) List all labs performed by the facility; include modifiers if needed.

(1) Single date of service only; span dates/multiple units no longer allowed on dialysis claims.
(2) On every dialysis claim, include occurrence code 50 and the date of the patient's initial dialysis treatment.
(3) Additional Occurrence Code guidelines to be issued at a future date.
(4) Use FL 39-41 when applicable.
(5) The NDC, in proper format, is required for each drug.
(6) List all labs performed by the facility; include modifiers if needed.
(7) Must include a dialysis revenue code or claim will be denied.
(8) Enter comorbidity diagnosis code(s).

0001	PAGE 1 OF 1	CREATION DATE	TOTALS		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	NPI #
Alaska Medicaid						57	XXXXX
						OTHER	XXXXX
						PRV ID	XXXXX

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Recipient's Name		Recipient ID #		xxxxxxxxx

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
xxxxxx		

66 DX	67																			68
	A 5856	XXX.XX (8)																		

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	76 ATTENDING	NPI	QUAL	
							LAST xxxxxxxxx		FIRST xxxxxx	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC	78 OTHER	NPI	QUAL

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