Optum

Assurance Reimbursement Management™

UB claim field help

This document contains all Help topics for claim fields in the UB institutional claim form. It does not contain lists for ICD-9-CM, HCPCS, modifier, or other industry-standard codes. You must refer to your official source for those codes.

Tips:

- Print this document to use as reference.
- The *837 Institutional Implementation Guide* contains allowed codes for any field added to the UB claim to meet 5010 requirements. The implementation guides can be downloaded from WPC-EDI.com.
- Two documents in the product Help - *Help Index, Claim Field Help*, *4010 1500 837 Fields (PDF*) and *5010 837 Fields (PDF)* match the claim fields in CFI with their locations in the implementation guides.

Claim-level fields

The fields in this section occur only once in a claim - claim data, patient, provider, etc.

Admission type and source

(FL 19 and 20)

Allowable codes for **admission type**:

1	=	Emergency
2	=	Urgent
3	=	Elective
4	=	Newborn
5	=	Trauma
6-8	=	Reserved for national assignment
9	=	Information not available

Allowable codes for **admission source**:

1	=	Physician referral
2	=	Clinic referral
4	=	Transfer from a hospital
5	=	Transfer from a Skilled Nursing Facility
6	=	Transfer from another healthcare facility
8	=	Court/Law enforcement
9	=	Information not available
D	=	Transfer from one distinct unit of hospital to another
E	=	Transfer from Ambulatory Surgery Center
F	=	Transfer from Hospice and is under Hospice plan
G-Z	=	Reserved for national assignment
3	=	HMO referral *(discontinued 10/1/07)*
7	=	Emergency room *(discontinued 7/1/2010)*
A	=	Transfer from a critical access hospital *(discontinued 10/1/07)*
B	=	Transfer from another Home Health agency *(discontinued 7/1/2010)*
C	=	Readmission to same Home Health agency *(discontinued 7/1/2010)*

When the **type of admission code** is 4 (Newborn), the following codes apply:

5	=	Born inside of this Hospital
6	=	Born outside of this Hospital
7-9	=	Reserved for national assignment
1	=	Normal delivery *(discontinued 10/1/07)*
2	=	Premature delivery *(discontinued 10/1/07)*
3	=	Sick baby *(discontinued 10/1/07)*
4	=	Extramural birth in a non-sterile environment *(discontinued 10/1/07)*

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

EPSDT Indicator

(Electronic tab, Miscellaneous Information, EPSDT)

Early periodic screening, diagnosis, and treatment

1 = Treatment resulted from EPSDT screening (performed no longer than one year before date of surgery)
2 = Treatment did not result from EPSDT screening/referral
3 = Not known if treatment resulted from EPSDT screening

Financial class

(Top of form)

0 = No payer
1 = Medicaid
2 = Private insurance
3 = Blue Cross
4 = Employer/Union
5 = Medicare Part B
6 = Other state agency
9 = Other

Patient marital status

(FL 16)

S = Single
M = Married
P = Life partner
X = Legally separated
D = Divorced
W = Widowed
U = Unknown

Patient birth weight

(Electronic tab, Miscellaneous Information, BIRTH WEIGHT) / Dropped in the 5010 837 standard.)

Patient birth weight is entered in grams. When required, it applies to patients who are less than one month old at the time of service.

Tip: To convert ounces to grams, use the Windows calculator and multiply ounces by 28.35.

Patient race

(Electronic tab, Miscellaneous Information, RACE)

A = Asian or Pacific Island
B = Black
H = Hispanic
I = American Indian/Alaskan
N = Other
U = Unknown
W = White

Pay-to provider

Contains information for the provider that should receive payment for services on this claim. It is needed when the payment address differs from the standard provider/facility address in the facility master.

- **On a UB claim**, pay-to provider name and address is FL 2. The pay-to provider IDs are on the Electronic tab.
- **On a 1500 claim**, all pay-to provider information and IDs appear together at the bottom of the Electronic tab.

The facility's pay-to address can be set up in the *facility master*. When set up in *facility master*, claim submission will copy pay-to provider address to the claim as it is submitted into the product. Also in claim display, facility auto-entry will copy the pay-to provider information to the claim.

Physician qualifying codes

This information applies to any physician (claim -level or service line-level) that uses an ID qualifier code to distinguish legacy ID numbers.

- **On a UB claim**, these physicians are on the Electronic and Detail tabs.
- **On a 1500 claim**, they are on the Additional and Detail tabs.

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

5010 update: Only four of the codes shown here are recognized by 5010: **0B**, **1G**, **G2**, **LU**

Allowable codes include:

0B = State license number
1A = Blue Cross provider number
1B = Blue Shield provider number
1C = Medicare provider number
1D = Medicaid provider number
1G = Provider UPIN
1H = **CHAMPUS ID Number**
EI = **Employer ID number**
G2 = Provider commercial number
LU = Location number
N5 = **Provider plan network ID number**
SY = **Social Security number**
X5 = **State industrial accident provider number**

Procedure coding method

(FL 79)

Shows which coding method is used on this claim.

1-3 = Reserved for state assignment
4 = CPT-4
5 = HCPCS (HCFA Common Procedure Coding System, including Level I National Codes, Level II - CPT-4 Codes, and Level III - State-Assigned Codes)
6-8 = **Reserved for national assignment**
9 = ICD-9-CM

Release status code

Release status code indicates the claim's release status and format. In CFI, the release code displays in RELEASE STATUS at the top of the claim form tab. The allowable codes include:

Y = Yes, release this claim for transmission to the clearinghouse.
P = Yes, release this claim for transmission; send the claim on paper (non-electronic).
L = Yes, release this claim; print the claim locally on paper claim form.
N = No, do not release this claim for transmission to the clearinghouse.

Notes:

- Any other characters will cause an error on Release Status and must be changed before the claim can be released.
- When this product detects certain problems with a claim, it places an error on Release Code. To eliminate the error, correct the reported problem and validate the claim.

Relation to insured (P_RELA)

FL 59

The ANSI allowable codes include:

18 = Patient is insured (Self)
01 = Spouse
04 = Grandfather or grandmother
05 = Grandson or granddaughter
07 = Nephew or niece
09 = Adopted child (1500 only)
10 = Foster child
15 = Ward
17 = Stepson or stepdaughter
19 = Child
20 = Employee
21 = Unknown relationship to insured
22 = Handicapped dependent
23 = Sponsored dependent
24 = Dependent of a minor dependent
29 = Significant other
32 = Mother
33 = Father
34 = Other adult (1500 only)
36 = Emancipated minor
39 = Organ donor
40 = Cadaver donor
41 = Injured plaintiff
43 = Child where insured has no financial responsibility
53 = Life partner
G8 = Other relationship

Bold codes are supported by the 5010 837 format. Not all codes are applicable to all payers and/or states.

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

Responsible party information

Dropped in the 5010 837 standard.

Contains name and address information of the person who bears some financial responsibility for the claim but is not the patient nor the insured.

Status codes - Local (History tab)

Local status codes are added to the claim by events that occur in its history. These codes are always three (3) digits and display on the Status History tab. When the claim form appears, click the History tab. To print a current list of codes, click the Help for STATUS CODES on the History tab and open the list for local codes.

You can filter for claims with these codes. In the advanced filter range group, click the Select a Field box and scroll down to Local Status Codes. Enter a code in the From box. You can also enter a second code in the Through box. In addition, you can use a combination of Assoc Status Date and a range of local codes to filter for claims that were marked with a code on a specific day. For instance, an Assoc Status Date of Today and a Local Status Code 145 will return all claims that were rebilled today.

Status codes - CLS/Payer (History tab)

CLS/Payer status codes are added to the claim by responses returned to the claim by the clearinghouse or payer. These codes are always four (4) digits and show in the Status History table. When the claim form appears, click the History tab. To print a current list of codes, click the Help for STATUS CODES on the History tab and open the list for local codes.

You can filter for claims with these codes. In the advanced filter range group, click the Select a Field box and scroll to Local Status Codes. Enter a code in the From box. You can also enter a second code in the Through box.

Type of claim (Managed care)

(Electronic tab, Managed Care Information, TYPE OF CLAIM)

1	=	Managed care (HMO, IPA)	**3**	=	DMO
2	=	PPO	**4**	=	Indemnity

Payer fields

Payer indicator

(Top of claim)

Each claim can contain up to three payers (primary, secondary, and tertiary). The payer indicator is the code letter that identifies the payer to whom the claim is being sent. The payer indicator for a claim is shown at the top of every claim. Claims that contain secondary and tertiary payers can be automatically secondary billed by eHospital. Payers must be entered in the following order:

- Put information for the **primary** payer on lines labeled **A**.
- Put information for the **secondary** payer on lines labeled **B**.
- Put information for the **tertiary** payer on lines labeled **C**.

For example: If the claim is being sent to the secondary payer, the payer indicator will be B.

Authorization payer indicator (AU_TPIND)

(Electronic tab, Authorization Information, REC PAY IND)

This is the payer indicator of the payer doing the authorization.

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

A	=	Primary payer	**B**	=	Secondary payer	**C**	=	Tertiary payer

Coordination of benefits (TP_COB)

(Electronic tab, Additional Payer Information, COB)

- **1** = Coordination of benefits
- **2** = Coordination of benefits applies to spouse only
- **3** = Coordination of benefits applies to spouse and dependents
- **4** = Coordination of benefits applies to dependents only
- **5** = Unknown
- **6** = No Coordination of benefits
- **7** = Coordination of benefits applies to subscriber only

Employment status (TP_ESC ESC)

(FL 64)

- **1** = Employed full-time
- **2** = Employed part-time
- **3** = Not employed
- **4** = Self-employed
- **5** = Retired
- **6** = On active military duty
- **7-8** = Reserved for national assignment
- **9** = Unknown

Insured sex (TP_SEX)

(Electronic tab, Insured Information)

M	=	Male	F	=	Female	U	=	Unknown

Pacemaker record ID code (IDCODE)

(Electronic tab, Pacemaker, REC ID)

- **1** = Implanted pulse generator
- **2** = Implanted atrial lead
- **3** = Implanted ventricular lead
- **5** = Explanted pulse generator
- **6** = Explanted atrial lead
- **7** = Explanted ventricular lead

Payer code (TP_PCODE Payer Code on Electronic)

(Electronic tab, Additional Payer Information, PAYER CODE)

- **A** = Working aged beneficiary/Spouse with employer group health plan
- **B** = ESRD beneficiary in 12-month period with employer group health insurance
- **C** = Any conditional payment situation
- **D** = Automobile no-fault or any liability insurance
- **E** = Workers Compensation, including black lung
- **F** = VA, PHS, other federal agency
- **Z** = Medicare is primary

For CCN NEIC, the allowable codes include:

- **1** = Third-Party PPO (Claim requires review and pricing).
- **2** = PPO (Preferred provider organization)
- **3** = HMO (Health maintenance organization)
- **4** = TPA (Third-Party administration)
- **5** = Other TPO (Third-party organization). Claim requires review by other TPO.
- **6** = Other

Payer ID

On each service line up to four (4) additional IDs (REF segments) for physicians, three (3) additional IDs for service facility, five (5) authorization numbers, and five (5) referral numbers are supported for the 837 5010. The 5010 expansion provides display fields and storage for these additional IDs. To tie each extra

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

ID back to the payer that assigns it, a new Payer ID field has been added for each extra ID. The Payer ID is the main ID of the payer that has assigned the extra ID.

For example, if “Some insurance” has assigned ID 2 to the referring physician on a service line, the number in Payer ID 2 will be the main ID number of “Some insurance.”

Notes:

- If the assigning payer is the active payer on the claim, the Payer ID field can be empty.
- When NHPIDs become required, the payer ID will be the NHPID of the payer.

Payer IDs have been added to the IDs of the following service line items:

Entity	ID range	Claim form
Attending/Rendering physician	IDs 2-5	UB and 1500
Referring physician	IDs 2-5	UB and 1500
Service facility	IDs 2-4	1500 only
Supervising physician	IDs 2-5	1500 only
Purchased service physician	IDs 2-5	1500 only
Ordering physician	IDs 2-5	1500 only
Prior authorization no.	IDs 1-5	1500 only
Referral no.	IDs 1-5	1500 only
Operating physician	IDs 2-5	UB only
Other physician 1	IDs 2-5	UB only

Payer LOB (TP_LOB)

(Electronic tab, Additional Payer Information, LOB)

1 = Medicare	3 = Blue Cross/Blue Shield	5 = Other
2 = Medicaid	4 = CHAMPUS	

Release of information code (TP_ROI)

(FL 52)

Indicates the type of signed release form on file at your facility.

A = Appropriate ROI on file.	M = Restricted or modified release.	O = On file at payer or plan sponsor.
I = Informed consent ROI on file.	N = No release.	Y = Yes.

Secondary billing calculation fields

The secondary billing calculation values are two figures that are used when calculating the prior payment and estimated amount due amount that are placed on the secondary or subsequent claims. These figures are displayed in the 835 (Payer Activity tab) on claims that have remits attached to them.

- **Prior payment** is the amount paid by the current payer. It will be placed in the Prior Payment field on the secondary claim.
- **Excluded amount** is the figure used to calculate the estimated amount due for a subsequent claim. Generally, it is the total of any charges that should not be sent on to the subsequent payer. Examples of these charges are contractual adjustments and patient responsibility charges.

The calculations that result in the values for these fields can be adjusted on a per-client basis. Contact Support for information about customizing calculations.

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.

Source of payment (TP_SOP source of payment on Electronic tab)

(Electronic tab, Additional Payer Information, SOURCE OF PAYMENT)

Type of Claim	CFI	837
Automobile medical	Q	AM
Blue Cross/Blue Shield	G	BL
TRICARE/CHAMPUS	3	CH
Commercial	F	CI
Dental maintenance organization	X	17
Disability	R	DS
Exclusive provider organization (EPO)	W	14
Federal employees program	Y	FI
HMO	6	HM
HMO Medicare risk	P	16
Indemnity insurance	O	15
Liability medical	U	LM
Medicaid	D	MC
Medicare Part A	C	MA
Medicare Part B	N	MB
Mutually defined	Z	ZZ
Other federal program	5	OF
Other non-federal programs	J	11
Point of service (POS)	M	13
Preferred provider organization (PPO)	L	12
Title V	T	TV
Veterans affairs plan	V	VA
Workers' comp	9	WC

© 2025 Optum, Inc. and/or one of its subsidiaries. All rights reserved.