



Required Data Elements for Claim Forms

Required Data Elements	CMS-1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Sex	X	X
Subscriber (Member) Name/Address	X	X
Member ID Number	X	X
Coordination of Benefits (COB)/other insured's information	X	X
Date(s) of Service	X	X
ICD-10 Diagnosis Code(s), highest level of specificity	X	X
CPT-4 Procedure Code(s)	X	X
HCPS Code(s)	X	X
Service Code Modifier (if applicable)	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and Total Charges	X	X

Provider Name	X	
Provider Address / Phone Number	X	
National Provider Identifier (NPI) / Provider ID Numbers submitted on HIPAA standard transactions(X	X
Tax ID Number	X	X
Provider Number (For Paper Claims Only)	X	X
VNSNY CHOICE Payer ID Number XXXX-For EDI Claims Only	X	X
Hospital/Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X
Revenue Code(s) and corresponding CPT/HCPCS Codes when billing		X
Principal, Admitting, and Other ICD-10 Diagnosis Codes		X
Present on Admission (POA) Indicator (if applicable)		X
Attending Physician Name and NPI		X
VNSNY CHOICE Authorization Number	X	X

CMS-1500 forms and UB-04's can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and by facilities billing on behalf of employed providers