

**Example of a UB-04 HMO Claim Form:**

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
110			100108	1	500.00		
PAGE ____ OF ____		CREATION DATE		TOTALS		500.00	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ACC. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Medicare HMO Indicator MC		123456 1234567890A				100.00	56 NPI 1234567890
							57 340XXX
							OTHER 3400XXX
							PRV ID
58 INSURED'S NAME		59 REL.	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.