

### 6.6.3 UB-04 CMS-1450 Blank Paper Claim Form

1		2		3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 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		31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE	
34 CODE		35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE	
38		39 CODE		40 VALUE CODES AMOUNT		41 CODE	
42		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
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UB-04 CMS-1450

APPROVED OMB NO. 0938-0997

NUBC<sup>®</sup> National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.