UB-04 Form Processing

Patient Details		
Name:		
Patient ID:	Date of Birth:	Gender:
Address:		
Provider Details		
Provider Name:		
Provider ID (NPI):	Contact Number:	
Address:		
Insurance Details		
Insurance Company:		
Policy Number:	Group Number:	
Medical Service Details		
Date of Admission:	Date of Discharge:	
Diagnosis Code(s):		
Procedure Code(s):		
Total Charges:		
Billing and Coding Staff		
Prepared by:		
Checked by:		
Date Submitted:		