

BILL TYPE FREQUENCY CODES FOR USE IN THE 837 PROFESSIONAL AND 837 DENTAL IMPLEMENTATION GUIDES

The developers of the Professional and Dental Health Care Claim Implementation Guides (837 ASC X12N 837 (004010X098A1 and 004010X097A1)) have indicated that the following UB-92 Bill Type Frequency Codes are acceptable for use in those transactions.

Frequency (3rd Digit)

<u>Code</u>	<u>Description</u>	<u>Definition</u>
1	Admit thru Discharge Claim	This code is to be used for a bill, which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills that represent an entire benefit period of the primary third party payer.
7	Replacement of Prior Claim	This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.
8	Void/Cancel of Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period." The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.