

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
11U			090109	1	500.00		
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME Medicare HMO Indicator MC		51 HEALTH PLAN ID 123456 123456789A	52 REL. INFO	53 ASS. BEN.	54 PRIOR PAYMENTS 100.00	55 EST. AMOUNT DUE 50.00	56 NPI 1234567890 57 OTHER PRV ID 123XXX 340XXXX
58 INSURED'S NAME		59 P. REL.	60 INSURED'S UNIQUE ID		61 GROUP NAME	62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		
66	67	A	B	C	D	E	F
68	I	J	K	L	M	N	O
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 BCI	a b c
74 PRINCIPAL PROCEDURE CODE	DATE	75 OTHER PROCEDURE CODE	DATE	76 OTHER PROCEDURE CODE	DATE	76 ATTENDING NPI	QUAL
LAST		FIRST		77 OPERATING NPI	QUAL	FIRST	
LAST		FIRST		78 OTHER NPI	QUAL	FIRST	
LAST		FIRST		79 OTHER NPI	QUAL	FIRST	
LAST		FIRST		80 REMARKS			
LAST		FIRST		81 CC	B3 282N00000X		
LAST		FIRST		This is a Medicare HMO			
LAST		FIRST					
LAST		FIRST					

The UB-04 claim form with the Medicare HMO EOB attached should be mailed to:  
 DMA/Third Party Recovery  
 2508 Mail Service Center  
 Raleigh, NC 27699-2508