

# CMS 1450 (UB-04) Claim Form

Field	Information
Provider Name	
Provider Address	
Provider Telephone Number	
Patient Control Number	
Type of Bill	
Federal Tax Number	
Patient's Name	
Patient's Address	
Statement Covers Period	
Patient's Date of Birth	
Patient's Sex	
Admission Date and Hour	
Discharge Hour	
Condition Codes	
Diagnosis Codes	
Procedure Codes	
Provider's Name	
Provider's Address	
Provider's Contact Information	
Signature of provider	