Wellcare
P.O. Box 31368
Tampa, FL 33631-3368

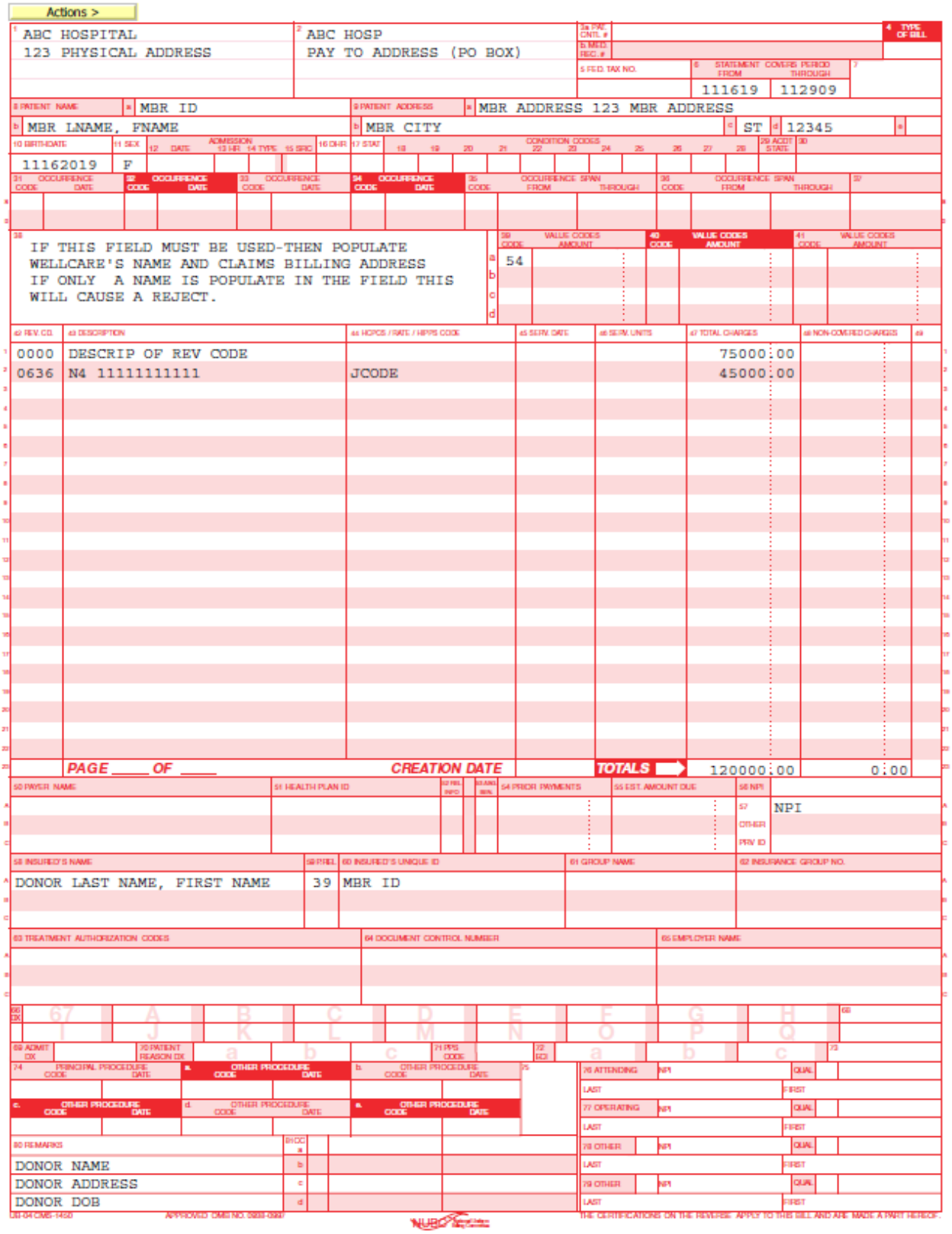
Billing Tips for Transplant Service Claims

As a valued Wellcare Health Plan provider partner, we want to share some important tips for submitting transplant service claims to adhere to guidance from the Centers for Medicare & Medicaid Services (CMS).

In order for Wellcare to properly identify a transplant claim and validate a member's eligibility, the following data must be correctly filled in on the UB04 claim form/boxes. To ensure accurate and timely claims processing and payment, the data you provide must correspond with the outlined fields below:

UB04 Form Box	Information Needed
Box 8a	Patient/Wellcare Member ID
Box 8b	Patient/Wellcare Member Name
Box 9a and 9b	Patient/Wellcare Member Address and City
Box 58	Transplant Donor's Last Name, First Name *Information is for provider/CMS tracking purposes*
Box 59	39 (Organ Donor) or 40 (Cadaver Donor)
Box 60	Patient/Wellcare Member ID
Box 80	Not required- *Information is for provider tracking purposes*

Please see the below example UB04 claim form: (*Next page*)



Actions >

1 ABC HOSPITAL 123 PHYSICAL ADDRESS	2 ABC HOSP PAY TO ADDRESS (PO BOX)	3a PAT. CNTL. #	4 TYPE OF BILL
		3b MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 111619 THROUGH 112909

8 PATIENT NAME a MBR ID	9 PATIENT ADDRESS a MBR ADDRESS 123 MBR ADDRESS				
b MBR LNAME, FNAME	b MBR CITY	c ST	d 12345	e	
10 BIRTHDATE 11162019	11 SEX F	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC
16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30	

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						
b						

38 IF THIS FIELD MUST BE USED-THEN POPULATE WELLCARE'S NAME AND CLAIMS BILLING ADDRESS IF ONLY A NAME IS POPULATE IN THE FIELD THIS WILL CAUSE A REJECT.

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	54					
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0000	DESCRIP OF REV CODE				75000.00		
2	0636	N4 11111111111	JCODE			45000.00		
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23		PAGE ____ OF ____	CREATION DATE		TOTALS	120000.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A						57 OTHER PRV ID	NPI
B							
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DONOR LAST NAME, FIRST NAME	39	MBR ID		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI	QUAL	
				LAST	FIRST	
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI	QUAL	
				LAST	FIRST	
				78 OTHER NPI	QUAL	
				LAST	FIRST	
				79 OTHER NPI	QUAL	
				LAST	FIRST	

80 REMARKS	81 CC	
DONOR NAME	a	
DONOR ADDRESS	b	
DONOR DOB	c	
	d	

CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Thank you for continuing to provide our Medicare members with high quality and compassionate care. If you have questions about any of this information, please contact Provider Services.