BEACON

837P / 837I Health Care Claim Companion Guide

For use with ASC X12N 837 Health Care Professional and Institutional Transactions Set Implementation Guides and Addenda (Version HIPAA 5010)

www.beaconhealthstrategies.com

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Contents

CHAPTER 1:

Introduction

1.1. What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the establishment of national standards for electronic transmission of health data and ensuring privacy protection. The Administrative Simplification provisions of HIPAA, Title II, require the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in health care.

Beacon Health Strategies, as a covered entity and health insurance payer accepts X12 837 Professional (837P) and Institutional (837I) Health Care Claims as mandated by the administrative simplification provisions of HIPAA.

1.2. Purpose

This document has been prepared as a Beacon Health Strategies (Beacon)-specific companion document to the X12 implementation guide and to clarify when conditional data elements and segments must be used for Beacon reporting, and identify those codes and data elements that do not apply to Beacon. This companion guide document *supplements*, but does not contradict any requirements in the 837 version 5010 implementation guide. This companion is to be used in conjunction with the X12 implementation guide. The implementation guides for all HIPAA transactions are available from Washington Publishing Company and are available electronically to download at www.wpc-edi.com/HIPAA.

This document will be subject to revisions as new versions of the X12 837 Professional and Institutional Health Care Claim Transaction Set Implementation Guides are released.

1.3. Intended Audience

The intended audience for this document is the technical department/team responsible for submitting electronic claims transactions to Beacon Health Strategies. In addition, this information should be communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

1.4. Contact Information

For HIPAA, 837 transactions, EDI, EDI Gateway, documentation and testing questions relating to Beacon, you can get answers by contacting any one of the following:

EDI Operations

Contact with EDI-related questions
617.747.1210
edi.operations@beaconhs.com

Compliance Department

Contact for compliance/legal concerns
781.994.7500
compliance@beaconhs.com

CHAPTER 2:

Transaction Submission Procedures

2.1. Submission Methods

Providers/trading partners may submit 837 claim transactions using the EDI gateway, which requires an Internet a browser that supports 128-bit encryption.

2.2. Setup/Certification Process

1. Providers/trading partners interested in submitting electronic claim transactions must complete one of the following forms supplied by Beacon:
    a. EDI Clearinghouse Setup Form
    b. EDI Direct Submitter Setup Form
2. These forms can be downloaded from Beacon's website at www.beaconhealthstrategies.com or can be requested by contacting EDI Operations at Beacon (edi.operations@beaconhs.com).
3. The EDI Clearinghouse Setup Form has to be completed by every provider who will be submitting via a clearinghouse.
4. The EDI Direct Submitter Form has to be completed by the technical resource for the health care provider.
5. Complete the applicable form and return by FAX to 617.747.1200 or email edi.operations@beaconhs.com.
6. When Beacon Edi receives the form, we will send you an email acknowledgement letter that indicates your setup has been completed with Beacon EDI Operations.
7. A submitter ID is assigned to each trading partner. You will utilize the submitter ID to create a login ID and password on the EDI Gateway for file transmission.

2.3. Testing

Beacon requires testing for all direct submitters submitting 837P and 837I transactions. Please follow the appropriate format specifications listed in the specific data requirements and submission directions. Test files must be submitted using the secure protocols and submission methodology selected.

Once a test Submitter ID is set up for a trading partner, the submitter can begin to send claims transactions for testing. In order to test, it is imperative that a technical contact at the provider/ submitter organization be established. This contact must be able to monitor, change and submit the 837P and 837I transaction files to Beacon. This contact should be familiar with 837P, 837I, and 997 files. During the testing process, Beacon will examine submitted transactions for required formats and elements and will get responses during the testing process. This testing stage will continue until testing satisfaction is achieved in both sides.

Beacon's testing procedures will validate the test file in its entirety. The entire file will either pass or fail validation. Beacon does not allow partial file submissions. If the file fails validation, a failure report will be provided explaining the failure messages.

Upon the completion of successful testing, you will be notified and assigned a new submitter ID for the production system. The ID number must be used in all files submitted for production claims processing. communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

2.4. Technical Requirements

During testing of the 837P and 837I transactions, Beacon recommends that test claim files contain a minimum of 25 claims and not exceed 100 claims in any one batch. File contents must simulate claims from normal business. Creating small files for testing provides for easier trouble-shooting and re-creation of the test file. Once your files have passed testing, you may send larger files.

CHAPTER 3:

Reports

All reports will be available to providers/trading partners via the EDI Gateway in the respective mailboxes. To access your mailbox, log in to the EDI Gateway and click on the *download files* link. Providers/trading partners are responsible for downloading these reports when available.

Report/ File Number	Report/File Name	Purpose	Source	Turnaround from Time of Submission
997	Functional Acknowledgement	This is a X12 file response report	Folder/Mailbox	Day of Submission
Result*	Results File	To report claim level rejections and to report on total claims accepted along with their total claim amount	Folder/Mailbox	Day of Submission

FUNCTIONAL ACKNOWLEDGMENT REPORT (997)

File level summary indicating accepted and rejected transaction sets within a file. Please refer the *Implementation Guide for Health Care Claims*.

RESULTS REPORT FILE

When a file is uploaded from the EDI Gateway, the submitter is provided with a reference ID for the submission. The file name of the Results Report file will be <reference ID>_results.txt

** All files that are rejected at file level will not have a results file.*

CHAPTER 4:

Considerations

4.1. Transactions Supported (inbound)

Currently Beacon will support and accept the following HIPAA 5010 inbound transactions:

- 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)
- 837 Institutional Health Care Claim – ASC X12N 837 (005010X223A2)

4.2. Delimiters Supported

A delimiter is a character used to separate two data elements or sub elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Beacon recommends utilizing the following default delimiters:

Description	**Default Delimiter**
Data element separator	* (Asterisk)
Sub-element separator	: (Colon)
Segment Terminator	~ (Tilde)

Note: If the data contains any of the above delimiters, different delimiters can be utilized and specified in the ISA segment.

4.3. Size/Maximum Limitations

Claims files submitted in *production* mode cannot exceed 5000 claims (CLM segments) in any one file as stated in the *Implementation Guides*.

CHAPTER 5:

Loop Details

FOR PROVIDERS

- Loop 2010AA – NM1 segment contains NPI for the Billing Provider
- Loop 2310B (837P) – NM1 segment contains NPI for the Rendering Provider.
- Loop 2310A (837I) – NM1 segment contains NPI for the Attending Provider.
- Loop 2310D (837P) – NM1 segment contains NPI for the service facility location if it is different from the Billing Provider NPI. If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2310E (837I) – NM1 segment contains NPI for the service facility location if it is different from the Billing Provider NPI. If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.

FOR BILLING AGENCIES

- Loop 2010AA – NM1 segment contains NPI for each of the provider they are billing for.
- Loop 2310B (837P) – NM1 segment contains NPI for the Rendering Provider.
- Loop 2310A (837I) – NM1 segment contains NPI for the Attending Provider.
- Loop 2310D (837P) – NM1 segment contains NPI for the service facility location if it is different from the Billing Provider NPI. If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2310E (837I) – NM1 segment contains NPI for the service facility location if it is different from the Billing Provider NPI. If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.

CHAPTER 6:

Specific Data Requirements

6.1. Interchange Control and Functional Group Specifications

GENERAL

This section outlines the specifications for the Interchange Control and Functional Group header and trailer information.

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
ISA	**Interchange Control Header**			**Fixed record length segment**	
	ISA01 - Authorization Info Qualifier		R	No Authorization Info Present	00
	ISA02 - Authorization Information		R	10 spaces	
	ISA03 - Security Info Qualifier		R		00
	ISA04 - Security Information		R	10 spaces	
	ISA05 - Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA06 - Interchange Sender ID		R	Submitter ID Provided by Beacon	
	ISA07 - Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA08 - Interchange Receiver ID		R	Use "BHS-963116116"	
	ISA09 - Interchange Date		R	Format YYMMDD	
	ISA10 - Interchange Time		R	Format HHMM	
	ISA11 - Repetition Separator		R		^
	ISA12 - Interchange Version Number		R		00501
	ISA13 - Interchange Control Number		R	Assigned by sender. Must equal IEA02	
	ISA14 - Acknowledgement Required		R		0
	ISA15 - Usage Indicator		R	"T" for testing, "P" for production	
	ISA16 - Component Element Separator				:

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
GS	**Functional Group Header**				
	GS01 - Functional ID Code		R		HC
	GS02 - Application Sender's Code		R	Submitter ID Provided by Beacon	
	GS03 - Application Receiver's Code		R	Use "BHS-963116116"	
	GS04 - Date		R	Format "CCYYMMDD"	
	GS05 - Time		R	Format "HHMM"	
	GS06 - Group Control Number			Assigned by sender. Must equal GE02	
	GS07 - Responsible Agency Code		R		X
	GS08 - Version/Release		R	"005010X223A2" for 837 Institutional; "005010X222A1" for 837 Professional	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
GE	**Functional Group Trailer**				
	GE01 - Number of Transaction sets		R		
	GE02 - Group Control Number		R	Same as GS06	
IEA	**Interchange Control Trailer**				
	IEA01 - Number of Functional Groups		R		
	IEA02 - Interchange Control Number		R	Same as ISA13	

6.2. Professional Claims (837P) Data Requirements

GENERAL

The purpose of this section is to clarify the data elements and segments that must be used for professional claims transactions. The following information is designed to help you complete the 837P transaction. If you follow these guidelines, we'll be better able to process your claims accurately and efficiently.

DETAIL DATA

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
ST	**Transaction Set Header**	**1**	**R**		
	ST01 - Transaction set ID code		R	This element should be hard coded when submitting the claim.	837
	ST02 - Transaction set control number		R	Assigned by sender. Must equal SE02	
	ST03 - Transaction		R	Same as GS08	005010X222A
BHT	**Beginning of HL Transaction**	**1**	**R**		
	BHT01 - Hierarchical Structure Code		R	This element should be hard coded when submitting the claim.	0019
	BHT02 - Transaction Set Purpose Code		R	Allowed values: "00", "18". Use "00"	00
	BHT03 - Reference ID		R	Assigned by sender.	
	BHT04 - Date		R	Claim file creation date. Format CCYYMMDD	
	BHT05 - Time		R	Claim file creation time. Format HHMM	
	BHT06 - Transaction Type Code		R	Allowed values: "CH", "RP". Use "CH"	CH

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
1000A	**Submitter Name**	**1**			
NM1	**Submitter Name**	**1**	**R**		
	NM101 - Entity ID Code		R		41
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non-person.	
	NM103 - Last Name or Organization Name		R	Last name of physician or organization name	
	NM104 - First Name		R	Required if NM102 = "1"	
	NM105 - Middle Name		R	Required if NM102 = "1"	
	NM107 - Name Suffix		R	Required if NM102 = "1"	
	NM108 - ID Code Qualifier		R		46
	NM109 - ID Code		R		
1000B	**Receiver Name**	**1**			
NM1	**Receiver Name**	**1**	**R**		
	NM101 - Entity ID Code		R		40
	NM102 - Entity Type Qualifier		R		2
	NM103 - Last Name or Organization Name		R	Use “Beacon Health Strategies, LLC”	
	NM108 - ID Code Qualifier		R	ETIN	46
	NM109 - ID Code		R	Use “BHS-963116116”	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000A	**Billing Provider Loop**	**>1**			
HL	**Billing Provider HL**	**1**	**R**		
	HL01 - Hierarchical ID Number		R	Sequence number incremented for each occurrence of HL.	
	HL03 - Hierarchical Level Code		R		20
	HL04 - Hierarchical Child Code		R		1
PRV	**Billing Provider Taxonomy Code**		**R**		
	PRV01		R		BI
	PRV02		R		PXC
	PRV03		R		
2010AA	**Billing Provider**	**1**			
NM1	**Billing Provider Name**	**1**	**R**		
	NM101 - Entity ID Code		R		85
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non-person.	
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		S	Required if NM102 = "1"	
	NM105 - Middle Name		S	Required if NM102 = "1"	
	NM107 - Name Suffix		S	Required if NM102 = "1"	
	NM108 - ID Code Qualifier		R	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		R	National Provider ID / NPI	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010AA	**Billing Provider**	**1**			
N3	**Billing Provider Address**	**1**	**R**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Billing Provider City/State/Zip**	**1**	**R**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
	N404 - Country		S	Required if billing address is outside of the US	
REF	**Billing Provider Secondary Identifcation**	**>=1**	**R**		
	REF01 - Reference ID Qualifier		R	EI – Employer's Identification Number 1G – Medicaid Number (Seton Only) 1G – ImpactPlusProviderNo (HumanaCareKY) 1G – ImpactPlusProviderNo (Passport)	EI, 1G
	REF02 - Reference ID		R	Provider Tax ID Medicaid Number ImpactPlusProviderNo	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000B	**Subscriber HL Loop**	**>1**			
HL	**Subscriber HL**	**1**	**R**		
	HL01 - Hierarchical ID Number		R	Assigned by sender	
	HL02 - Hierarchical Parent ID Number		R	Assigned by sender	
	HL03 - Hierarchical Level Code		R	Subscriber	22
	HL04 - Hierarchical Child Code		R	"0" if subscriber is the patient. "1" if subscriber is not the patient	
SBR	**Subscriber Information**	**1**	**R**		
	SBR01 - Payer Resp Seq No Code		R		
	SBR02 - Individual Relationship code		S	Used if subscriber is the patient	18
	SBR03 - Reference ID		S	For Providers submitting via EMDEON: Use PlanID located "Provider Tools-Bulletins and Manual – Current Beacon Plan List on beaconhealthstrategies.com"	
	SBR04 - Name		S	Plan name	
	SBR05 - Insurance Type Code		S		
	SBR09 - Claim File Indicator Code		R	Type of claim	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010BA	**Subscriber Name**	**1**			
NM1	**Subscriber Name**	**1**	**R**		
	NM101 - Entity ID Code		R		IL
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non-person.	
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		S		
	NM105 - Middle Name		S		
	NM107 - Name Suffix		S		
	NM108 - ID Code Qualifier		S		MI
	NM109 - ID Code		S	Use Member ID from membership card	
N3	**Subscriber Address**	**1**	**R**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Subscriber City/State/Zip**	**1**	**R**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
DMG	**Subscriber Demographic Info**	**1**	**S**		
	DMG01 - Date Time Format Qualifier		R		
	DMG02 - Date Time Period		R	Date of Birth of subscriber (CCYYMMDD format)	
	DMG03 - Gender Code		R	Allowed Values: "M", "F", "U"	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010BB	**Payer Name**	**1**			
NM1	**Payer Name**	**1**	**R**		
	NM101 - Entity ID Code		R		PR
	NM102 - Entity Type Qualifier		R		2
	NM103 - Last Name or Organization Name		R	For Providers submitting via EMDEON: Allowed Value: Beacon Health Strategies, LLC For all other Providers: Use PlanID Name located "Provider Tools-Bulletins and Manual – Current Beacon Plan List on beaconhealthstrategies.com"	
	NM108 - ID Code Qualifier		R		PI
	NM109 - ID Code		R	For Providers submitting via EMDEON: Allowed Value: 43324 For all other Providers: Use PlanID located "Provider Tools-Bulletins and Manual – Current Beacon Plan List on beaconhealthstrategies.com"	
REF	**Billing Provider Secondary Identifcation**	**>=1**	**R**		
	REF01 - Reference ID Qualifier		R	G2 - Medicaid Number	G2
	REF02 - Reference ID		R	Medicaid Number	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000C	**Patient HL**	**>1**	**S**	**Required when the patient is different from the subscriber**	
HL	**Patient HL**	**1**	**S**		
	HL01 - Hierarchical ID Number		R	Assigned by sender	
	HL02 - Hierarchical Parent ID Number		R	Assigned by sender	
	HL03 - Hierarchical Level Code		R		23
	HL04 - Hierarchical Child Code		R		0
PAT	**Patient Information**	**1**	**R**		
	PAT01 - Individual Relationship Code		R		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010CA	**Patient Name**	**1**			
NM1	**Patient Name**		**R**		
	NM101 - Entity ID Code		R		QC
	NM102 - Entity Type Qualifier		R		1
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		R		
	NM105 - Middle Name		S		
	NM107 - Name Suffix		S		
	NM108 - ID Code Qualifier		R		MI
	NM109 - ID Code		R	Use Member ID from membership card	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010CA	**Patient Name**	**1**			
N3	**Patient Address**	**1**	**R**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Patient City/State/Zip**	**1**	**R**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
DMG	**Patient Demographic Info**	**1**	**S**		
	DMG01 - Date Time Format Qualifier		R		D8
	DMG02 - Date Time Period		R	Date of birth of subscriber (CCYYMMDD format)	
	DMG03 - Gender Code		R	Allowed values: "M", "F", "U"	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
CLM	**Claim Information**	**1**	**R**		
	CLM01 - Patient Account Number		R	Claim number. Will be sent back in 835 for CLP01	
	CLM02 - Monetary Amount		R	Total claim amount	
	CLM05-1 - Facility Code Value		R	Place of Service Code (First two positions of Bill Type)	
	CLM05-2 - Facility Code Qualifier		R		B
	CLM05-3 - Claim Frequency Type Code		R		
	CLM06 - Yes/No Condition or Response Code		R		
	CLM07 - Provider Accept Assignment Code		S	Third position of Bill Type Original = 1, Resend = 7, Void = 8	
	CLM08 - Yes/No Condition or Response Code		R		
	CLM09 - Release of Information Code		R		
	CLM10 - Patient Signature Source Code		S		
	CLM11		S	CLM11 contains RELATED CAUSES INFORMATION and is only required when Accident or Employment Related Causes are indicated.	
	CLM11-1 - Related Cause Code		R		
	CLM11-2 - Related Cause Code				
	CLM11-3 - Related Cause Code				
	CLM11-4 - State				
	CLM11-5 - Country				
	CLM12 - Special Program Code				
	CLM16 - Provider Agreement Code				
	CLM20 - Delay Reason Code				

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
DTP	**Date - Admission**	**1**	**S**		
	DTP01 - Date/Time Qualifier		R		435
	DTP02 - Date/Time Period Format Qualifier		R		D8
	DTP03 - Date/Time Period		R	In the format of CCYYMMDD	
DTP	**Date - Discharge**	**1**	**S**		
	DTP01 - Date/Time Qualifier		R		096
	DTP02 - Date/Time Period Format Qualifier		R		D8
	DTP03 - Date/Time Period		R	In the format of CCYYMMDD	
REF	**Original Reference Number**	**1**	**S**	**Must send if CLM05-3 = 7**	
	REF01 - Reference ID Qualifier		R		F8
	REF02 - Reference ID		R	Use 8 digit Beacon ClaimID (provided by Beacon on EOB Report)	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Health Care Diagnosis**	**1**	**R**		
	HI01 - Healthcare Code Information		R		
	HI01-1 - Code List qualifier code		R	Principal diagnosis	ABK
	HI01-2 - Industry Code		R	ICD-10 Code	
	HI02 - Healthcare Code Information				
	HI02-1 - Code List qualifier code			Other diagnosis	ABF
	HI02-2 - Industry Code			ICD-10 Code	
	HI03 - Healthcare Code Information				
	HI03-1 - Code List qualifier code			Other diagnosis	ABF
	HI03-2 - Industry Code			ICD-10 Code	
	HI04 - Healthcare Code Information				
	HI04-1 - Code List qualifier code			Other diagnosis	ABF
	HI04-2 - Industry Code			ICD-10 Code	
	HI05 - Healthcare Code Information				
	HI05-1 - Code List qualifier code			Other diagnosis	ABF
	HI05-2 - Industry Code			ICD-10 Code	
	HI06 - Healthcare Code Information				
	HI06-1 - Code List qualifier code			Other diagnosis	ABF
	HI06-2 - Industry Code			ICD-10 Code	
	HI07 - Healthcare Code Information				
	HI07-1 - Code List qualifier code			Other diagnosis	ABF
	HI07-2 - Industry Code			ICD-10 Code	
	HI08 - Healthcare Code Information				
	HI08-1 - Code List qualifier code			Other diagnosis	ABF
	HI08-2 - Industry Code			ICD-10 Code	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2310B	**Rendering Provider**		**R**		
NM1	**Rendering Provider Name**	**1**	**R**		
	NM101 - Entity ID Code		R		82
	NM102 - Entity Type Qualifier		R		
	NM103 - Last Name or Organization Name		R	Rendering physician last name	
	NM104 - First Name		S	Rendering physician first name	
	NM105 - Middle Name		S		
	NM108 - ID Code Qualifier		R	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		R	Rendering provider National Provider ID / NPI	
PRV	**Rendering Physician Taxonomy Code**		**R**		
	PRV01		R		PE
	PRV02		R		PXC
	PRV03		R		
REF	**Rendering Provider Secondary Identification**	**1**	**R**		
	REF01 - Reference ID Qualifier		R	G2 - Medicaid Number 1G – Medicaid Number (Seton Only)	G2, 1G
	REF02 - Reference ID		R	Medicaid Number	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2310D	**Service Facility Location**		**R**		
NM1	**Service Facility Location Name**	**1**	**R**		
	NM101 - Entity ID Code		R		77
	NM102 - Entity Type Qualifier		R		
	NM103 - Last Name or Organization Name		R	Provider site name	
	NM104 - First Name		S		
	NM105 - Middle Name		S		
	NM108 - ID Code Qualifier		R	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		R	National Provider ID / NPI	
REF	**Service Facility Location Secondary Identification**	**1**	**S**		
	REF01 - Reference ID Qualifier		R		LU
	REF02 - Reference ID		R	Provider Site ID Number (provided by Beacon)	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2400	**Service Line**	**50**			
LX	**Service Line**	**1**	**R**		
	LX01 - Assigned Number		R	Counter. Assigned by sender	
SV1	**Professional Service**	**1**	**R**		
	SV101-1 - Product/Service ID Qualifier		R		
	SV101-2 - Product/Service ID		R	Procedure code	
	SV101-3 - Procedure Modifier		S	Modifier 1	
	SV101-4 - Procedure Modifier		S	Modifier 2	
	SV101-5 - Procedure Modifier		S	Modifier 3	
	SV101-6 - Procedure Modifier		S	Modifier 4	
	SV102 - Monetary Amount		R	Service line charge	
	SV103 - Units or basis of measurement code		R		UN
	SV104 - Quantity		R	Service units	
	SV105 - Facility Code value		S	Place of service	
	SV107-1 - Diagnosis Code Pointer		R		
	SV107-2 - Diagnosis Code Pointer		S		
	SV107-3 - Diagnosis Code Pointer		S		
	SV107-4 - Diagnosis Code Pointer		S		
	SV109 - Yes/No Condition or Response Code		S	Should be blank for Medicare claims	
DTP	**Service Date**	**1**	**R**	**Service line Start/End**	
	DTP01 - Date/Time Qualifier		R		472
	DTP02 - Date/Time Period Format Qualifier		R	Allowed values: "D8" for Date, "R8" for Date Range	
	DTP03 - Date/Time Period		R	Format "CCYYMMDD" for D8, "CCYYMMDD-CCYYMMDD" for R8	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2400	**Service Line**	**50**			
SE	**Transaction Set Trailer**	**1**	**R**		
	SE01 - Number of Included Segments		R		
	SE02 - Transaction Set Control Number		R	Assigned by sender. Must equal SE02	

6.3. Institutional Claims (837I) Data Requirements

GENERAL

The purpose of this section is to clarify the data elements and segments that must be used for institutional claims transactions. The following information is designed to help you complete the 837I transaction. If you follow these guidelines, we'll be better able to process your claims accurately and efficiently.

DETAIL DATA

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
ST	**Transaction Set Header**	**1**	**R**		
	ST01 - Transaction set ID code		R	This element should be hard coded when submitting the claim.	837
	ST02 - Transaction set control number		R	Assigned by sender. Must equal SE02	
	ST03 - Transaction		R	Same as GS08	005010X223A2

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
BHT	**Beginning of HL Transaction**	**1**	**R**		
	BHT01 - Hierarchical Structure Code		R	This element should be hard coded when submitting the claim.	0019
	BHT02 - Transaction Set Purpose Code		R	Allowed values: "00", "18". Use "00"	00
	BHT03 - Reference ID		R	Assigned by sender.	
	BHT04 - Date		R	Claim file creation date. Format CCYYMMDD	
	BHT05 - Time		R	Claim file creation time. Format HHMM	
	BHT06 - Transaction Type Code		R	Allowed values: "CH", "RP". Use "CH"	C

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
1000A	**Submitter Name**	**1**			
NM1	**Submitter Name**	**1**	**R**		
	NM101 - Entity ID Code		R		41
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non-person.	
	NM103 - Last Name or Organization Name		R	Last name of physician or organization name	
	NM104 - First Name		S	Required if NM102 = "1"	
	NM105 - Middle Name		S	Required if NM102 = "1"	
	NM107 - Name Suffix		S	Required if NM102 = "1"	
	NM108 - ID Code Qualifier		R		46
	NM109 - ID Code		R		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
1000B	**Receiver Name**	**1**			
NM1	**Receiver Name**	**1**	**R**		
	NM101 - Entity ID Code		R		40
	NM102 - Entity Type Qualifier		R		2
	NM103 - Last Name or Organization Name		R	Use "Beacon Health Strategies, LLC"	
	NM108 - ID Code Qualifier		R	ETIN	46
	NM109 - ID Code		R	Use "BHS-963116116"	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000A	**Billing Provider Loop**	**>1**			
HL	**Billing Provider HL**	**1**	**R**		
	HL01 - Hierarchical ID Number		R	Sequence number incremented for each occurrence of HL.	
	HL03 - Hierarchical Level Code		R		20
	HL04 - Hierarchical Child Code		R		1
PRV	**Billing Provider Taxonomy Code**		**R**		
	PRV01		R		BI
	PRV02		R		PXC
	PRV03		R		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010AA	**Billing Provider**	**1**			
NM1	**Billing Provider Name**	**1**	**R**		
	NM101 - Entity ID Code		R		85
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non- person.	
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		S	Required if NM102 = "1"	
	NM105 - Middle Name			Required if NM102 = "1"	
	NM107 - Name Suffix		S	Required if NM102 = "1"	
	NM108 - ID Code Qualifier		Y	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		Y	National Provider ID / NPI	
N3	**Billing Provider Address**	**1**	**R**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Billing Provider City/State/Zip**	**1**	**R**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
	N404 - Country		S	Required if billing address is outside of the US	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010AA	**Billing Provider**	**1**			
REF	**Billing Provider Secondary Identifcation**	**>=1**	**R**		
	REF01 - Reference ID Qualifier		R	EI – Employer's Identification Number 1G – Medicaid Number (Seton Only) 1G – ImpactPlusProviderNo (HumanaCareKY) 1G – ImpactPlusProviderNo (Passport)	EI, 1G
	REF02 - Reference ID		R	Provider Tax ID Medicaid Number ImpactPlusProviderNo	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000B	**Subscriber HL Loop**	**>1**			
HL	**Subscriber HL**	**1**	**R**		
	HL01 - Hierarchical ID Number		R	Assigned by sender	
	HL02 - Hierarchical Parent ID Number		R	Assigned by sender	
	HL03 - Hierarchical Level Code		R	Subscriber	22
	HL04 - Hierarchical Child Code		R	"0" if subscriber is the patient. "1" if subscriber is not the patient	
SBR	**Subscriber Information**	**1**	**R**		
	SBR01 - Payer Resp Seq No Code		R		
	SBR02 - Individual Relationship code		S	Used if subscriber is the patient	18
	SBR03 - Reference ID		S	For Providers submitting via EMDEON: Use PlanID located "BHS Plan code web Page"	
	SBR04 - Name		S	Plan name	
	SBR05 - Insurance Type Code		S		
	SBR09 - Claim File Indicator Code		R	Type of claim	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010BA	**Subscriber Name**	**1**			
NM1	**Subscriber Name**	**1**	**R**		
	NM101 - Entity ID Code		R		IL
	NM102 - Entity Type Qualifier		R	Allowed values: "1" for person, "2" for non-person.	
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		S		
	NM105 - Middle Name		S		
	NM107 - Name Suffix		S		
	NM108 - ID Code Qualifier		S		MI
	NM109 - ID Code		S	Use Member ID from membership card	
N3	**Subscriber Address**	**1**	**S**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Subscriber City/State/Zip**	**1**	**S**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
DMG	**Subscriber Demographic Info**	**1**	**S**		
	DMG01 - Date Time Format Qualifier		R		D8
	DMG02 - Date Time Period		R	Date of birth of subscriber (CCYYMMDD format)	
	DMG03 - Gender Code		S	Allowed values: "M", "F", "U"	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010BB	**Payer Name**	**1**			
NM1	**Payer Name**	**1**	**R**		
	NM101 - Entity ID Code		R		PR
	NM102 - Entity Type Qualifier		R		2
	NM103 - Last Name or Organization Name		R	For Providers submitting via EMDEON: Allowed Value: Beacon Health Strategies, LLC For all other Providers: Use PlanID Name located "BHS Plan code web Page"	
	NM108 - ID Code Qualifier		R		
	NM109 - ID Code		R	For Providers submitting via EMDEON: Allowed Value: 43324 For all other Providers: Use PlanID located "BHS Plan code web Page"	
REF	**Billing Provider Secondary Identifcation**	**>=1**	**R**		
	REF01 - Reference ID Qualifier		R	G2 - Medicaid Number	G2
	REF02 - Reference ID		R	Medicaid Number	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2000C	**Patient HL**	**>1**	**S**	**Required when the patient is different from the subscriber**	
HL	**Patient HL**	**1**	**S**		
	HL01 - Hierarchical ID Number		R	Assigned by sender	
	HL02 - Hierarchical Parent ID Number		R	Assigned by sender	
	HL03 - Hierarchical Level Code		R		23
	HL04 - Hierarchical Child Code		R		0
PAT	**Patient Information**	**1**	**R**		
	PAT01 - Individual Relationship Code		R		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010CA	**Patient Name**	**1**			
NM1	**Patient Name**		**R**		
	NM101 - Entity ID Code		R		QC
	NM102 - Entity Type Qualifier		R		1
	NM103 - Last Name or Organization Name		R		
	NM104 - First Name		R		
	NM105 - Middle Name		S		
	NM107 - Name Suffix		S		
	NM108 - ID Code Qualifier		R		MI
	NM109 - ID Code		R	Use Member ID from membership card	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2010CA	**Patient Name**	**1**			
N3	**Patient Address**	**1**	**R**		
	N301 - Address		R		
	N302 - Address		S		
N4	**Patient City/State/Zip**	**1**	**R**		
	N401 - City		R		
	N402 - State		R		
	N403 - Zip		R		
DMG	**Patient Demographic Info**	**1**	**S**		
	DMG01 - Date Time Format Qualifier		R		D8
	DMG02 - Date Time Period		R	Date of birth of subscriber (CCYYMMDD format)	
	DMG03 - Gender Code		S	Allowed values: "M", "F", "U"	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
CLM	**Claim Information**	**1**	**R**		
	CLM01 - Claim Submitters ID		R	Claim number. Will be sent back in 835 for CLP01	
	CLM02 - Monetary Amount		R	Total claim amount	
	CLM05-1 - Facility Code Value		R	First two positions of Bill Type	
	CLM05-2 - Facility Code Qualifier		R		A
	CLM05-3 - Claim Frequency Type Code		R	Third position of Bill Type Original = 1, Resend = 7, Void = 8	
	CLM06 - Yes/No Condition or Response Code		R		
	CLM07 - Provider Accept Assignment Code		S		
	CLM08 - Yes/No Condition or Response Code		R		
	CLM09 - Release of Information Code		R		
	CLM10 - Patient Signature Source Code		S		
	CLM11		S	CLM11 contains RELATED CAUSES INFORMATION and is only required when Accident or Employment Related Causes are indicated.	
	CLM11-1 - Related Cause Code		R		
	CLM11-2 - Related Cause Code				
	CLM11-3 - Related Cause Code				
	CLM11-4 - State				
	CLM11-5 - Country				
	CLM12 - Special Program Code				
	CLM16 - Provider Agreement Code				
	CLM20 - Delay Reason Code				

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
DTP	**Discharge Hour**	**1**	**S**	**Inpatient Claims Only**	
	DTP01 - Date/Time Qualifier		R		096
	DTP02 - Date/Time Period Format Qualifier		R		TM
	DTP03 - Date/Time Period		R	In the format of HHMM	
DTP	**Statement Dates**	**1**	**S**	**Inpatient Claims Only**	
	DTP01 - Date/Time Qualifier		R		434
	DTP02 - Date/Time Period Format Qualifier		R	Allowed values: "D8" for Date, "R8" for Date Range	D8, R8
	DTP03 - Date/Time Period		R	Format "CCYYMMDD" for D8, "CCYYMMDD - CCYYMMDD" for R8	
DTP	**Admission Date / Hour**	**1**	**S**		
	DTP01 - Date/Time Qualifier		R		435
	DTP02 - Date/Time Period Format Qualifier		R		TM
	DTP03 - Date/Time Period		R	In the format of CCYYMMDDHHMM	
CL1	**Institutional Claim Code**	**1**	**S**		
	CL101 - Admission Type Code		R	From code source 231	
	CL102 - Admission Source Code		R	From code source 230	
	CL103 - Patient Status Code		R	From code source 239	
REF	**Original Reference Number**	**1**	**S**	**Must send if CLM05-3 = 7 or 8**	
	REF01 - Reference ID Qualifier		R		F8
	REF02 - Reference ID		R	Use 8 digit Beacon ClaimID (provided by Beacon on EOB Report)	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Principal Diagnosis Information**	**1**	**R**		
	HI01 - Healthcare Code Information		R	Principal Diagnosis	
	HI01-1 - Code List qualifier code		R		ABK
	HI01-2 - Industry Code		R	ICD-10 Code	
	HI01-9 - Yes/No Condition or Resp. Code			Present on Admission Indicator	"Y" or "N" or "U"
HI	**Admitting Diagnosis Information**	**1**	**S**		
	HI01 - Healthcare Code Information		R	Admitting Diagnosis	
	HI01-1 - Code List qualifier code		R		ABJ
	HI01-2 - Industry Code		R	ICD-10 Code	
HI	**Diagnosis Related Group (DRG) Info**	**1**	**S**		
	HI01-1 - Code List qualifier code		R		DR
	HI01-2 - Industry Code		R	Diagnosis Related Group	
HI	**Other Diagnosis Information**	**1**	**S**	**Diagnosis Codes**	
	HI01 - Healthcare Code Information		S	Other Diagnosis	
	HI01-1 - Code List qualifier code		R		ABF
	HI01-2 - Industry Code		R	ICD-10 Code	
	HI01-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI02 - Healthcare Code Information		S	Other Diagnosis	
	HI02-1 - Code List qualifier code		R		ABF
	HI02-2 - Industry Code		R	ICD-10 Code	
	HI02-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI03 - Healthcare Code Information		S	Other Diagnosis	
	HI03-1 - Code List qualifier code		R		ABF
	HI03-2 - Industry Code		R	ICD-10 Code	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Other Diagnosis Information**	**1**	**S**	**Diagnosis Codes**	
	HI03-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI04 - Healthcare Code Information		S	Other Diagnosis	
	HI04-1 - Code List qualifier code		R		ABF
	HI04-2 - Industry Code		R	ICD-10 Code	
	HI04-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI05 - Healthcare Code Information		S	Other Diagnosis	
	HI05-1 - Code List qualifier code		R		ABF
	HI05-2 - Industry Code		R	ICD-10 Code	
	HI05-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI06 - Healthcare Code Information		S	Other Diagnosis	
	HI06-1 - Code List qualifier code		R		ABF
	HI06-2 - Industry Code		R	ICD-10 Code	
	HI06-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI07 - Healthcare Code Information		S	Other Diagnosis	
	HI07-1 - Code List qualifier code		R		ABF
	HI07-2 - Industry Code		R	ICD-10 Code	
	HI07-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI08 - Healthcare Code Information		S	Other Diagnosis	
	HI08-1 - Code List qualifier code		R		ABF
	HI08-2 - Industry Code		R	ICD-10 Code	
	HI08-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI09 - Healthcare Code Information		S	Other Diagnosis	
	HI09-1 - Code List qualifier code		R		ABF

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Other Diagnosis Information**	**1**	**S**	**Diagnosis Codes**	
	HI09-2 - Industry Code		R	ICD-10 Code	
	HI09-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI10 - Healthcare Code Information		S	Other Diagnosis	
	HI10-1 - Code List qualifier code		R		ABF
	HI10-2 - Industry Code		R	ICD-10 Code	
	HI10-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI11 - Healthcare Code Information		S	Other Diagnosis	
	HI11-1 - Code List qualifier code		R		ABF
	HI11-2 - Industry Code		R	ICD-10 Code	
	HI11-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"
	HI12 - Healthcare Code Information		S	Other Diagnosis	
	HI12-1 - Code List qualifier code		R		ABF
	HI12-2 - Industry Code		R	ICD-10 Code	
	HI12-9 - Yes/No Condition or Resp. Code		R	Present On Admission Indicator	"Y" or "N" or "U"

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Value Information**	**1**	**S**		
	HI01 - Healthcare Code Information		S		
	HI01-1 - Code List qualifier code		R		BE
	HI01-2 – Industry Code		R	Value Code	
	HI01-5 – Monetary Amount		R	Value Code Amount	
	HI02 - Healthcare Code Information		S		
	HI02-1 - Code List qualifier code		R		BE
	HI01-2 – Industry Code		R	Value Code	
	HI02-5 – Monetary Amount		R	Value Code Amount	
	HI03 - Healthcare Code Information		S		
	HI03-1 - Code List qualifier code		R		BE
	HI03-2 – Industry Code		R	Value Code	
	HI03-5 – Monetary Amount		R	Value Code Amount	
	HI04 - Healthcare Code Information		S		
	HI04-1 - Code List qualifier code		R		BE
	HI04-2 – Industry Code		R	Value Code	
	HI04-5 – Monetary Amount		R	Value Code Amount	
	HI05 - Healthcare Code Information		S		
	HI05-1 - Code List qualifier code		R		BE
	HI05-2 – Industry Code		R	Value Code	
	HI05-5 – Monetary Amount		R	Value Code Amount	
	HI06 - Healthcare Code Information		S		
	HI06-1 - Code List qualifier code		R		BE
	HI06-2 – Industry Code		R	Value Code	
	HI06-5 – Monetary Amount		R	Value Code Amount	
	HI07 - Healthcare Code Information		S		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2300	**Claim Information**	**100**			
HI	**Value Information**	**1**	**S**		
	HI07-1 - Code List qualifier code		R		BE
	HI07-2 – Industry Code		R	Value Code	
	HI07-5 – Monetary Amount		R	Value Code Amount	
	HI08 - Healthcare Code Information		S		
	HI08-1 - Code List qualifier code		R		BE
	HI08-2 – Industry Code		R	Value Code	
	HI08-5 – Monetary Amount		R	Value Code Amount	
	HI09 - Healthcare Code Information		S		
	HI09-1 - Code List qualifier code		R		BE
	HI09-2 – Industry Code		R	Value Code	
	HI09-5 – Monetary Amount		R	Value Code Amount	
	HI10 - Healthcare Code Information		S		
	HI10-1 - Code List qualifier code		R		BE
	HI10-2 – Industry Code		R	Value Code	
	HI10-5 – Monetary Amount		R	Value Code Amount	
	HI11 - Healthcare Code Information		S		
	HI11-1 - Code List qualifier code		R		BE
	HI11-2 – Industry Code		R	Value Code	
	HI11-5 – Monetary Amount		R	Value Code Amount	
	HI12 - Healthcare Code Information		S		
	HI12-1 - Code List qualifier code		R		BE
	HI12-2 – Industry Code		R	Value Code	
	HI12-5 – Monetary Amount		R	Value Code Amount	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2310A	**Attending Physician**		**R**		
NM1	**Attending Physician Name**	**1**	**R**		
	NM101 - Entity ID Code		R		71
	NM102 - Entity Type Qualifier		R		
	NM103 - Name Last or Organization Name		R	Attending physician last name	
	NM104 - Name First		R	Attending physician first name	
	NM105 - Name Middle		S		
	NM108 - ID Code qualifier		R	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		R	National Provider ID (NPI)	
PRV	**Attending Physician Taxonomy Code**		**R**		
	PRV01		R		AT
	PRV02		R		PXC
	PRV03		R		
REF	**Attending Physician Secondary Identification**	**1**	**S**		
	REF01 - Reference ID Qualifier		R	G2 – Medicaid Number 1G – Medicaid Number (Seton Only)	G2, 1G
	REF02 - Reference ID		R		

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2310E	**Service Facility Location**	**1**	**S**		
NM1	**Service Facility Location**	**1**	**S**		
	NM101 - Entity ID Code		R		77
	NM102 - Entity Type Qualifier		R		
	NM103 - Name Last or Organization Name		R	Provider site name	
	NM104 - Name First		S		
	NM105 - Name Middle		S		
	NM108 - ID Code qualifier		S	"XX" - Health Care Financing Administration National Provider Identifier	XX
	NM109 - ID Code		S	National Provider ID (NPI)	
REF	**Service Facility Location Secondary Identification**	**1**	**S**		
	REF01 - Reference ID Qualifier		R		LU
	REF02 - Reference ID		R	Provider Site ID Number provided by Beacon	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2400	**Service Line**	**50**		**Refer to notes below**	
LX	**Service Line**	**1**	**R**		
	LX01 - Assigned Number		R	Counter. Assigned by sender	
SV2	**Institutional Service**	**1**	**R**		
	SV201 - Product/Service ID		R	UB92 Rev Code	
	SV202 -Composite Medical Procedure ID		S		
	SV202-1 - Product/Service ID Qualifier		R		HC
	SV202-2 - Product/ Service ID		R	Procedure Code	
	SV202-3 - Procedure Modifier		S	Modifier 1	
	SV202-4 - Procedure Modifier		S	Modifier 2	
	SV202-5 - Procedure Modifier		S	Modifier 3	
	SV202-6 - Procedure Modifier		S	Modifier 4	
	SV203 - Monetary Amount		R	Service line charge	
	SV204 - Units or basis of code measurement		R		DA / UN
	SV205 – Quantity		R	Service Units	
	SV206 - Unit Rate		S	For Inpatient Claim, Service Line Accommodation rate amount	
	SV207 - Monetary Amount		S	Non covered charge amount	
DTP	**Service Date**	**1**	**R**	**Service Line Start/End**	
	DTP01 - Date/Time Qualifier		R		472
	DTP02 - Date/Time Period Format Qualifier		R	Allowed values : "D8" for Date, "R8" for Date Range	
	DTP03 - Date/Time Period		R	Format "CCYYMMDD" for D8, "CCYYMMDD-CCYYMMDD" for R8	

Loop ID/ Segment	Element/Description	Usage	RQD	Comments	Values
2400	**Service Line**	**50**		**Refer to notes below**	
SE	**Transaction Set Trailer**	**1**	**R**		
	SE01 - Number of Included Segments		R		
	SE02 - Transaction Set Control Number		R	Assigned by sender. Must equal SE02	

Note: *For Institutional claims the first claim line is treated as the primary claim line and the rest are treated as ancillary claim lines. The claim is paid based on the units and revenue/procedure code of the primary claim line.*

CHAPTER 7:

Document Version History

Version	Date Published	Notes
1.0	July 8 2011	5010 testing-Production version
1.1	Aug 18 2011	Substituted version 005010X222A1 in place of 005010X222, Substituted version 005010X223A2 in place of 005010X223A1
1.2	Nov 12 2011	Substituted Qualifier 5010 LU for 4010 Qualifier G5 for Site data.
2.0	April 01, 2012	NEW 5010 Production version – added text for Seton and Amida Care
2.1	June 14, 2012	Added text for Center Light
3.0	Jan 10, 2013	Added text for (SeniorWholeHealthMA, SeniorWholeHealthNY, HumanaCareSourceKY) • Add/Updated text for APG,POA, and Value Codes • Added text for TX MedicaidNo and KY ImpactPlusProviderNo
3.1	August 15, 2013	Added text for: Health Net NJ, Managed Health Net NJ, Empire, Inc. NJ
3.2	August 28, 2013	Corrected States for: Health Net changed to CA, Managed Health Net changed to CA, Empire, Inc. changed to NY
3.3	December 12, 2013	Updated Medicaid Number information and added additional 3-digit plan codes.
3.4	August 12, 2014	Editorial update
3.5	September 14, 2015	ICD 10 Update